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 02/07/2023

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	F 000		

COMPLAINT #:
NJ00158022, NJ00160765
NJ00160791, NJ00160776
NJ00161009, NJ00161051

CENSUS: 209

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 BASED ON THIS COMPLAINT SURVEY.

The following Immediate Jeopardy (IJ) situations were identified for F600, F835.

During a complaint survey conducted on 1/20/23 through 2/7/23, the survey team identified the following.

F600 scope and severity (s/s) of J:
(Refer to F600)

The surveyors identified an immediate jeopardy situation for F600 (Free from Abuse/Neglect) which began on [redacted]. The facility was notified of the IJ on [redacted]. The facility provided an acceptable removal plan and verified on-site on [redacted]

a.) On 1[redacted] Resident #2, who had [redacted] and known history of [redacted] r exhibited [redacted] staff with a water bottle, and [redacted] them. Resident #2

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

Electronically Signed | 03/17/2023

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	F 000		

was evaluated at the hospital on [redacted] and returned on [redacted] On [redacted] the [redacted] medication (given for NJ EX Order. 264b1 NJ EX Order. 264b1) was changed when Resident # 2 returned to the facility from the Acute Care Hospital (ACH).

The facility did not initiate a formal behavior monitoring process, develop a care plan (CP), and/or start interventions for this [redacted] r. Resident #2's CP and progress notes (PN) lacked documentation that the resident was being supervised or monitored to address his/her [redacted] behavior displayed on [redacted]

This deficient practice resulted into a NJ EX Order. 264b1 when on [redacted] at 3:05 pm, a staff member witnessed Resident #1 ambulating in the hallway past Resident #2's doorway. Resident #2 was coming out of his/her room and [redacted] Resident #1 in the [redacted] causing Resident #1 to [redacted]. Resident #1 was observed [redacted] and noted with NJ EX Order. 264b1 to the NJ EX Order. 264b1 and [redacted]. Resident #1 was hospitalized with an intracranial hemorrhage and [redacted] on [redacted]

This resulted in an IJ which began on [redacted] and the facility was notified of the IJ on [redacted] The facility provided an acceptable removal plan which was verified on-site on [redacted]

b.) Resident #7 and #8 who are roommates, both NJ EX Order. 264b1 with a known behavior of NJ EX Order. 264b1 and NJ EX Order. 264b1 had a NJ EX Order. 264b1 on [redacted] at 2:00 PM. Resident #7 [redacted] Resident #8 and Resident #8 [redacted] Resident #7 on his/her [redacted] in return. Resident #8 was offered a

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F 000	Continued From page 2	F 000		

room change in which the Responsible Party (RP) agreed however, Resident #8 NJ EX Order. 264b1. Resident #7 was not offered a room change because he/she was not a candidate. Although the facility indicated a room change was to be actively worked on as an intervention, there was no documentation to indicate that another room change was attempted, and the residents remained roommates. Consequently, another NJ EX Order. 264b1 occurred between Resident #7 and Resident #8 on NJ EX Order. 264 at 11:00 AM. The incident occurred in the room and was unwitnessed.

The facility failed to provide supervision, and consistently document/monitor resident behavior in the Medical Record (MR) in accordance with their policy and ensure that a NJ EX Order. 264b1 did not recur. Additionally, there was no indication that Resident #8's revised care plan was implemented.

This resulted in an IJ which began on NJ EX Order. 264b1 and the facility was notified of the IJ on NJ EX Order. 26. The facility provided an acceptable removal plan and which was verified on-site on NJ EX Order. 2

The facility's failure to provide adequate supervision, consistently document/monitor resident behavior in the MR, and implement an appropriate plan of care posed a serious and immediate risk to the safety and well-being of all the residents in the facility. This deficient practice placed Resident #1, #2, #7, and #8 and all other residents at risk for a NJ EX Order. 264b1 NJ EX Order. 264b1

The non-compliance for F600 remained on NJ EX Order. 2 for no actual harm with the potential for more

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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F 000	Continued From page 3	F 000		

than minimal harm that is not immediate jeopardy.

F835 s/s of J:
(Reference: F600 and F689)

The surveyors notified the Licensed Nursing Home Administrator (LNHA) of an immediate jeopardy for F835 at s/s K on [redacted] The facility provided an acceptable removal plan and verified on-site on [redacted]

The F835 IJ began on 11/10/22 when the facility was identified to be non-compliant with F600 (s/s of level K) for their failure to provide adequate supervision, consistently document/monitor resident behavior in the MR, and implement an appropriate plan of care posed a serious and immediate risk to the safety and well-being of all the residents in the facility. This deficient practice placed Resident #1, #2, #7, and #8 and all other residents at risk for a resident-to-resident physical abuse/altercation.

The LNHA failed to follow the facility's "Administrator" job description to ensure that policies and procedures were implemented by staff under "Behavior Assessment and Monitoring", "RESIDENT ABUSE NEGLECT AND MISTREATMENT "THE LAW"", "Abuse", "Charting and Documentation", "Care Plans-Comprehensive", and "Behavioral Assessment, Intervention and Monitoring", "Accidents and Incidents", and "Acute Condition Changes - Clinical Protocol".

The non-compliance for F835 remained on [redacted] for no actual harm with the potential for more

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F 000	Continued From page 4 than minimal harm that is not immediate jeopardy.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F 580		3/28/23

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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F 580	Continued From page 5 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #: NJ00160765, NJ00160776 NJ00160791, NJ00161051 Based on interview, record review, and review of pertinent facility documents on 1/20/23, 1/23/23, 1/27/23, 2/2/23, and 2/7/23, it was determined that the facility failed to notify the Responsible Party (RP) and the primary physician (PP) of a change in condition in accordance with the current standards of practice for 3 out 4 residents (Resident #2, #7, and #9) reviewed for change in condition. This deficient practice was evidenced by the following: On 1/20/23, 1/23/23, and 1/27/23, the surveyor reviewed the electronic medical record (EMR) of Resident # 2. 1. According to the "ADMISSION RECORD (AR)", Resident #2 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: NJ EX Order. 264b1	F 580	F580 Notify of Changes Immediate Action Resident #2 no longer resides at the facility. Resident #9 responsible party/medical practitioner were made aware of medication change verablly on [redacted] and documented in medical record on [redacted] Resident #7 on [redacted] documented in medical record resident responsible party/medical practitioner made aware that medication found at bedside. Audit of meds at beside was done on [redacted] by social worker/designee of all residents rooms and no other medications were found. LPN #3, #5, and #6 were immediately	

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F 580	Continued From page 6 NJ EX Order. 264b1 The Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated a [redacted] status and the resident required supervision assistance with Activities of Daily Living (ADLs). The care plan (CP) dated [redacted], revealed Resident #2 presented with a NJ EX Order. 264b1 related to a NJ EX Order. 264b1 as well as NJ EX Order. 264b1 included but were not limited to: Administer medications as ordered, educate the resident/family/caregivers regarding expectation of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. The "Order Summary Report" (OSR), dated from NJ EX Order. 264b1, indicated an order for [redacted] tablet [redacted] milligram (mg) give [redacted] tablet by mouth [redacted] times a day for NJ EX Order. 264b1 on [redacted] The "Order Audit Report" revealed that the aforementioned medication was discontinued on [redacted] The [redacted] "MEDICATION ADMINISTRATION RECORD (MAR)", confirmed the aforementioned medications orders. The progress notes (PN) had no documented evidence that Resident's #2's RP was notified that [redacted] was discontinued on [redacted] The surveyor conducted a telephone interview with the Resident's #2's RP on [redacted] at 1:13 pm. Resident's #2's RP stated that she received a	F 580	re-educated on [redacted] on notification to DON of resident changes, initiating and completing investigation, incident/accident reports. DON completed an audit of current residents psychiatric medication changes and where necessary responsible party/family/medical practitioner notifications were made. Re-educated licensed nurses with multiple re-in-services beginning on [redacted] regarding change of condition, incident/accidents, and where necessary to notify responsible party/family/medical practitioners. No issues were identified. Audit of meds at beside was done by social worker/designee of all residents rooms and no other medication were found. Identification of Others Residents who have a change in condition have the potential to be affected by this practice. Systemic Changes The Quality Assurance Performance Improvement Committee meeting was moved from quarterly to monthly. The nursing unit managers/designee will do a random audits of 6 rooms per unit weekly x 6 months to ensure medication/supplements are not found at bedside using audit tool. DON/designee will conduct a weekly audit on all psychiatric medication changes and that responsible party/medical practitioner notification were made and documented.	

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F 580	Continued From page 7 call from Resident #2's PP on [NJ EX Order.] informing her that Resident #2's NJ EX Order. 264b1 at the hospital and will continue all the medications from the hospital. Resident's #2's RP further stated that she was not aware that the aforementioned medication was discontinued on [NJ EX Order. 264] 2. On 1/27/23, 2/2/23, and 2/7/23, the surveyor reviewed the EMR of Resident # 9. According to the AR, Resident #9 was admitted to the facility on [NJ EX Order. 264], with diagnoses which included but were not limited to: NJ EX Order. 264b1 NJ EX Order. 264b1 The MDS dated [NJ EX Order. 264b], revealed Resident #9 had a BIMS score of [NJ EX Orde], which indicated a NJ EX Order. 264b1 status and the resident required supervision assistance with ADLs. The OSR revealed an order dated [NJ EX Order. 264b] [NJ EX Order. 264b] tablet [NJ] mg give [NJ] tablet by mouth [NJ E] o times a day for [NJ EX Order. 264]. [NJ EX Order. 264b] mg [NJ E] times a day was discontinued on [NJ EX Order. 264b] and a new order on [NJ EX Order. 264] revealed [NJ EX Order. 264b] e was decreased to [NJ EX Orde] daily; [NJ EX Order. 264b] tablet [NJ] mg give [NJ E] tablet by mouth [NJ EX O] time a day for [NJ EX Order. 26]. The 1[NJ EX Order. 2] MAR confirmed the aforementioned medication orders. The PN had no documented evidence that the Resident #9's RP was notified that the aforementioned medication was changed. The surveyor conducted a telephone interview with the Resident #9's RP on 2/13/23 at 9:54 am. Resident #9's RP stated he/she was not aware	F 580	Quality Monitoring The DON/designee will bring results of weekly random room audits to Quality Assurance Performance Improvement Committee monthly x 6 months. Quality Assurance Performance Improvement Committee, based on results of these audits, a decision will be made regarding the need for continued submission and reporting to the committee. DON/designee will bring results of weekly audit to Quality Assurance Performance Improvement Committee on all psychiatric medication changes and that responsible party/medical practitioner notification were made and documented, based on results of these audits, a decision will be made regarding the need for continued submission and reporting to the committee.	

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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F 580	Continued From page 8	F 580		

that the aforementioned medication was changed on [redacted].

The surveyor conducted an interview with Licensed Practical Nurse (LPN) #3 on 1/23/23 at 11:36 am. LPN #3 stated that when there is a resident's change in condition, included but were not limited to, change in medications such as antibiotic, psychotropic, and antidepressant, RPs had to be notified. He also stated that the nurse who called the RP must document in the PN to indicated that the family was notified. LPN #3 further stated that "sometimes" he calls the RP's, however, he admitted that calling RP's was sometimes "missed or forgotten" because they were busy.

The surveyor conducted an interview with DON and Assistant of Licensed Nursing Home Administrator (ALNHA) on 1/23/23 at 3:50 pm. The DON stated that when there is a resident's change in condition including but were not limited to, hospitalization, change in medications such as [redacted] and [redacted] medication, and room change, RPs had to be called and notified. She also stated that the nurse must document the notification in the PN.

3. On 1/23/23, 1/27/23, 2/2/23, and 2/7/23 the surveyor reviewed the EMR of Resident #7.

According to the Admission Record (AR), Resident #7 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted].

The MDS revealed a BIMS score of [redacted] which indicated a [redacted] status and

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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F 580	Continued From page 9	F 580		

the resident required minimal supervision with ADL.

The OSR reflected that Resident #7 was receiving the following supplements: NJ EX Order. 264b1 [redacted].

On 12/6/22 at 10:32 PM, LPN #6 documented the following in the PN: Resident #7 was in bed sleeping, "NJ EX Order. 264b1, was NJ EX Order. 264b1" LPN #6 and LPN #5 "found three bottles of supplements, supplements were removed and educated Resident not to keep medication in his/her room for safety." LPN #6 took the Resident's vital sign (VS) and recorded them in MR VS section. There was no indication in the PN that that the PP or RP was notified.

Review of the summary on the incident dated [redacted] with the DON's name stamp, unsigned, provided to the surveyor via email on [redacted] indicated the following: On [redacted] this writer was made aware that on [redacted] a nurse, LPN #6 discovered [redacted] bottles of supplements in a drawer of Resident #7. On [redacted] Resident #7's belongings were immediately checked, and no supplements of any kind were found. LPN #6 was interviewed and confirmed that she looked at the resident's drawer because the resident seemed [redacted] and found the supplements, one was [redacted] s with [redacted] and could not recall the others. Review of the resident's chart confirm that the vital signs were normal. The NS confirmed that she was not notified of the incident. The DON made the RP aware of the incident and the RP was not aware where the supplements came from. The DON asked

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F 580	Continued From page 10	F 580		

Resident #7 who could not recall where the supplements came from. There was no documented conclusion, but it was indicated that it was unclear how the supplements arrived in Resident #7's drawer on [redacted].

The surveyor reviewed the document "Full QA Report" Incident date/time: NJ EX Order. 264b1, 5:00 PM forwarded by the DON post survey on 2/10/23. It was indicated on the form that LPN #6 was the assigned care giver and LPN #5 was the witness. The location of the incident was at the resident's room. There was no injury noted. Additionally, the form indicated that there was no staff interview, and the details of the incident was not documented. The form indicated that the Administrator and DON were not notified of the incident until [redacted].

The surveyor reviewed LPN #6 signed written witness statement dated [redacted] forwarded by the DON post survey on 2/10/23. LPN #6 indicated that Resident #7 was sleeping around 5PM but the resident usually paces on the unit. Due to this, she "[redacted]" the resident and took his/her VS because Resident #7 was [redacted] LPN #6 indicated that she "checked the resident's drawer and found supplements such as NJ EX Order. 264b1 and two others". "She could not recall. She removed them and put them in the cart."

The surveyor reviewed LPN #5's signed and undated written witness statement, forwarded by the DON post survey on 2/10/23. LPN #5 wrote that LPN #6 asked her to check Resident #7's room because "she thinks Resident #7 took something from the med carts." LPN #5 indicated "nurse searched the room and found bottles of

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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 580	Continued From page 11	F 580		

supplements in the drawer."

The written witness statements of LPN #6 and LPN #5 did not indicate that Resident #7's RP or PP was notified.

There was no statement documented from the 11-7 shift assigned nurse on [redacted].

The surveyor was unable to interview the 11-7 shift assigned nurse on [redacted].

During a telephone interview with the surveyor on 1/23/23 at 2:01 PM, LPN #6 stated that on [redacted] during her medication pass at approximately 5:00 PM, Resident #7 was not wandering out of the room, which she stated was unusual. Because of that, she decided to check on the resident with LPN #5. Resident #7 was found in bed [redacted]" when awakened, [redacted], and [redacted], and for that reason, she searched the room. While searching, LPN #6 found "[redacted] bottles of supplements" in the resident's nightstand drawer. It was confirmed during interview that she did not notify the PP or RP. However, she stated that nurses are responsible for informing the PP or RP of changes in condition, incident, accident, and initiating an incident report. LPN #6 acknowledged that she should have called the PP or RP and started an incident report.

During a telephone interview with the surveyor on 1/30/23 at 1:10 PM, LPN #5 stated that she was in the room when LPN #6 found bottles of supplements or medications in the nightstand drawer. She confirmed that she did not report the incident to the NS or the DON, notify the PP or RP or initiate an investigation as she was busy

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 02/07/2023

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 580	Continued From page 12	F 580		

with her residents.

During a telephone interview with the surveyor on 2/6/23 at 11:28 AM, the PP stated that she was unaware of the incident on [redacted]. She explained that she expects nurses to call her for any incident or accidents and changes in resident's condition so that she can make appropriate clinical decisions. She added that Resident #7's nurse should have notified her about the [redacted] and the medications found in the resident's room, regardless of the type of medication.

During a telephone interview with the surveyor on 1/23/23 at 1:44 PM, Resident #7's RP stated that he/she was not informed about the bottles of supplements or medication found in the Resident's nightstand drawer when the Resident was found [redacted] on [redacted].

During an interview with the surveyor on 1/23/23 at 3:50 PM, the DON stated that nurses did not notify her or the NS about the abovementioned incident that occurred on [redacted]. She explained that nurses are expected to report any incident/accident to the NS and initiate an incident report immediately. Also, nurses are expected to notify the RP and PP of changes in condition and when an incident or accident occurs.

During an interview with the surveyor on 1/27/23 at 1:55 PM, the Administrator stated that nursing staff must report incidents and accidents immediately to the supervisor unless it's an emergency then the DON or the Administrator must be notified immediately. The Administrator stated that he was unaware of the abovementioned incident. The surveyor explained

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 02/07/2023

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 580	Continued From page 13 the details of the incident to the Administrator then he stated that he would have to look because he was not sure of the specifics. The Administrator confirmed that the nurse should have followed the protocol for incident and accidents which include reporting to the NS, and notification of PP and RP. "Accidents and Incidents" undated, under "Policy Interpretation and Implementation" indicated 1. The Nurse Supervisor/Charge Nurse...shall promptly initiate and document investigation of the accident or incident. 2. shall be included in the report...a. the date and time...b. the nature of the injury...g. the date/time attending physician was notified as well as the time the physician responded...h. the date/time the family was notified and by whom...3. The Nurse Supervisor/Charge Nurse...shall complete a Report of Incident/Accident form and submit to the Director of Nursing Services within 24 hours..." NJAC 8:39-13.1 (c)	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		3/28/23

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 02/07/2023

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 600	Continued From page 14 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00160765, NJ00160776 NJ00160791, NJ00161051 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 1/20/23, 1/23/23, 1/27/23, 2/2/23, and 2/7/23, it was determined that the facility failed to provide the services necessary to avoid physical harm. The facility failed to ensure that residents who are NJ EX Order. 264b1 were protected from a NJ EX Order. 264b1 and recurrence, failed to initiate a care plan (CP) when behaviors started for consistent behavior monitoring, failed to provide adequate supervision and documentation to protect from physical abuse, and to follow their own policies titled: "Behavior Assessment and Monitoring", "RESIDENT ABUSE NEGLECT AND MISTREATMENT "THE LAW"", "Abuse", "Charting and Documentation", "Care Plans-Comprehensive", and "Behavioral Assessment, Intervention and Monitoring", and "Acute Condition Changes - Clinical Protocol", for 4 of 11 residents (Resident #1, #2, #7, and #8) reviewed for abuse; when a.) On 1/11/23, Resident #2, who had NJ EX Order. 264b1 NJ EX Order. 264b1 and known history of NJ EX Order. 264b1 NJ EX Order. 264b1 r exhibite NJ EX Order. 264b1 staff with a water bottle, and NJ EX Order. 264b1. Resident #2 was evaluated at the hospital on NJ EX Order. 264b1 and	F 600	F600 Free From Abuse and Neglect Immediate Action Resident #1 and #2 no longer reside at the facility. Staff were re-educated with multiple re-in-services beginning on NJ EX Order. 264b1 on policy included but was not limited to the following areas: Accidents and Incidents Investigating and Reporting, Electronic Risk Reporter Documentation, Behavioral Charting/Progress Notes, Behavioral Assessment, Behavioral Intervention and Monitoring, Charting Interventions/Outcomes, Acute Condition Changes Clinical Protocol Assessment and Recognition with Cause Identification Treatment Management Monitoring, Comprehensive Care Plans, and Reporting Unusual Findings, Reporting incidents to responsible party/medical practitioner/ DON, Abuse, Neglect, Exploitation, and Misappropriation of Property. Residents #7 and #8 care plans were updated on 1 NJ EX Order. 264b1 with the following: Resident #7 interventions included but are not limited to: monitoring whereabouts on unit and in dining room, consider room/unit change if necessary, seat away	

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 02/07/2023

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 600	Continued From page 15 returned on [redacted] On [redacted], the [redacted] medication (given for [redacted] and [redacted] NJ EX Order. 264b1) was changed when Resident # 2 returned to the facility from the Acute Care Hospital (ACH). The facility did not initiate a formal behavior monitoring process, develop a CP, and/or start interventions for this [redacted] behavior. Resident #2's CP and progress notes (PN) lacked documentation that the resident was being supervised or monitored to address his/her [redacted] behavior displayed on [redacted] This deficient practice resulted a NJ EX Order. 264b1 when on [redacted] at 3:05 pm, a staff member witnessed Resident #1 [redacted] in the hallway past Resident #2's doorway. Resident #2 was coming out of his/her room and [redacted] Resident #1 in the [redacted] causing Resident #1 to [redacted] Resident #1 was observed [redacted] and noted with NJ EX Order. 264b1 to the [redacted] and [redacted] Resident #1 was hospitalized with an NJ EX Order. 264b1 and NJ EX Order. 264b1 . This resulted in an Immediate Jeopardy (IJ) which began on [redacted] and the facility was notified of the IJ on [redacted] The facility provided an acceptable removal plan and was verified on-site on [redacted] b.) Resident #7 and #8 who are roommates, both NJ EX Order. 264b1 with a known behavior of NJ EX Order. 264b1 had a NJ EX Order. 264b1 on [redacted] at 2:00 PM. Resident #7 [redacted] Resident #8 and Resident #8 [redacted] Resident #7 on his/her [redacted] in return. Resident #8 was offered a room change in which the Responsible Party	F 600	from [redacted] residents in dining room, staff to be NJ EX Order. 264b1 and attempt to separate residents Resident #8 interventions included but are not limited to: room change, gently attempt to re-direct, invite and guide to group activities of interest as able/tolerated, observe within group activities to assess anything which seems to help calm her, encourage recognition of or conversation with peers, provide informal reality orientation within group programs. Resident #7 and #8, as a further intervention, these two residents were separated into different rooms on 1/25/2023 post agreement of responsible parties. Resident #7 and #8 investigation was reported to the NJDOH by administration on 1/25/2023. An audit of current resident behaviors by DON/designee was initiated in conjunction with [redacted] services to ensure care plans reflect current behaviors and person-centered interventions and is ongoing. Identification of Others All residents have the ability to be affected by this practice. Systematic Changes Daily audits by DON/designee were initiated on 1/23/2023 for auditing resident	

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 02/07/2023

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 600	Continued From page 16 (RP) agreed, however, Resident #8 NJ EX Order. 264b1 Resident #7 was not offered a room change because he/she was not a candidate. Although the facility indicated a room change was to be actively worked on as an intervention, there was no documentation to indicate that another room change was attempted, and the residents remained roommates. Consequently, another NJ EX Order. 264b1 occurred between Resident #7 and Resident #8 on NJ EX Order. 264 at 11:00 AM. The incident occurred in the room and was unwitnessed. The facility's failure to provide supervision, consistently document/monitor resident behavior in the MR, and implement the plan of care posed a serious and immediate risk to the safety and well-being of all the residents in the facility. This deficient practice placed Residents #1, #2, #7, and #8 and all other residents who were at risk for a NJ EX Order. 264b1 in an IJ situation for serious injuries, harm and death. This resulted in an IJ which began on NJ EX Order. 264b and the facility was notified of the IJ on NJ EX Order. 264. The facility provided an acceptable removal plan and which was verified on-site on NJ EX Order. 2 The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Clinical Nurse of Operation (CNO) were notified of the IJ and provided with the IJ template on NJ EX Order. 264 at 4:44 pm. The facility provided an acceptable removal plan and was verified on-site on NJ EX Order. 26 during the survey. On 2/2/23, the Surveyors conducted a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan which included;	F 600	behaviors and care planning. The DON will review resident behavioral charting daily for 6 months to identify any residents behavior and to ensure licensed nurse staff are monitoring behaviors, updating care plans related to identified behaviors. A behavior monitoring tool was created and will be completed by DON/designee will use behavioral audit tool to monitor weekly 6 random resident medical records x 6 months to ensure the behavioral care plans are updated. The Quality Assurance Performance Improvement Committee meeting was moved from quarterly to monthly. The DON will review resident behavioral charting daily for 6 months to identify any residents behavior and ensure licensed nurse staff are monitoring behaviors, updating care plans, related to identified behaviors. New audit process was created using the electronic medical record. Quality Monitoring The DON/designee will bring review resident behavioral charting daily for 6 months to identify any residents behavior and to ensure licensed nurse staff are monitoring behaviors, updating care plans related to identified behaviors to the Quality Assurance Performance Improvement Committee monthly x 6 months. Based on results of these audits, a decision will be made regarding the need for continued submission and	

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 02/07/2023

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 600	Continued From page 17 a. The Resident was no longer at the facility. All facility staff were educated on behavior care plans and behavior monitoring policy. Resident audits were initiated, reviewed and updated on all resident behavior interventions and CPs. b. Residents #7 and #8 CPs were updated on [redacted] and, as a further intervention were separated into different rooms on [redacted] post agreement of RPs. Residents #7 and Resident #8 are being monitored and the responsible parties were notified. All current resident with behaviors were audited and reviewed residents with behavior and their interventions and CPs were updated. The non-compliance remained on [redacted] for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This deficient practice was further evidenced by the following: Review of the "REPORTABLE EVENT RECORD/REPORT" (RERR), dated [redacted] at 3:05 pm, revealed a NJ EX Order. 264b1 incident involving Resident #1 and Resident #2 that was reported to the New Jersey Department of Health (NJDOH) on [redacted] at 5:00 pm. Attached with the RERR was the investigation summary report (ISR). The ISR indicated that Resident #1 was ambulating when Resident #2 came toward Resident #1 and [redacted] Resident #1's NJ EX Order. 264b1, causing him/her to [redacted] First aid was provided to Resident #1. The Nurse practitioner (NP #1) immediately assessed Resident #1. Resident #1 was transferred to an Acute Care Hospital (ACH) via 911 and admitted with an NJ EX Order. 264b1. The ISR further	F 600	reporting. The DON/designee will bring results of review using the behavior monitoring audit tool that was created and will completed by DON/designee will use behavioral audit tool to monitor weekly 6 random resident medical records x 6 months to ensure that behavioral care plans are updated.	

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 02/07/2023

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 600	Continued From page 18	F 600		

indicated that Resident #2 remained NJ EX Order. 264b1 NJ EX Order. 264b1 staff, and was kept away from other residents. Resident #2 was transferred to the ACH via 911 at approximately 4:15 pm.

On NJ EX Order. 26 , NJ EX Order. 26 , and NJ EX Order. 264 the surveyor reviewed the electronic medical record (EMR) of Resident #1 and Resident #2.

1.) According to Admission Report (AR), Resident #1 was admitted to the facility on NJ EX Order. 264 , with diagnoses which included but were not limited to: NJ EX Order. 264b1 .

The Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 26 , revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ EX Or , indicating Resident #1's cognition was NJ EX Order. 264b1 and the resident required supervision for Activities of Daily Living (ADLs).

A PN, dated 1/16/23 at 3:51 pm, documented by Nurse Practitioner (NP #1) indicated that she responded to a call from NJ EX Order unit. When she arrived in the unit, Resident #1 was found on the floor in a NJ EX Order. 264b1 , the resident NJ EX Order. 264b and began to move her/his NJ EX Order She further indicated that the staff reported that Resident #1 was ambulating in the hallway when Resident #2 randomly NJ EX Order. 264b1 Resident #1 causing Resident #1 to NJ EX O to the floor. Resident #1 was observed to have NJ EX Order. 264b1 to the NJ EX Or NJ EX Order. 264b1 , and NJ EX Or . Staff was able to stop the NJ EX Order. 264b1 Resident #1 to a NJ EX Order. 26 position. Staff applied NJ EX Order. 264b1 NJ EX Order. 264b1 vital signs were: Pulse of NJ EX beats per minute (bpm), respiration of NJ EX bpm, blood pressure of NJ EX Order. 264 and oxygen saturation

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 02/07/2023

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 600	Continued From page 19	F 600		

was NJ EX O percent. NP #1 further indicated that Resident #1 had an NJ EX Order. 264b1 after the NJ EX O to the floor and a NJ EX Order. 264b1 of NJ EX Order. 264b1

A PN, dated 1/16/23 at 10:25 pm, documented by Licensed Practical Nurse (LPN #5) indicated that Resident # 1 was being admitted to the hospital for an NJ EX Order. 264b1.

Review of Resident #1's incident report (IR), provided by the DON on NJ EX Order. 264 dated 1 NJ EX Order. 2 at 3:05 pm, revealed that a fall occurred in the hallway while Resident #1 was ambulating, the NJ EX was witnessed by the Certified Nursing Assistant (CNA #1), and Resident #1 was transferred to the ACH on NJ EX Order. 264 at 3:45 pm.

1a.) According to AR, Resident #2 was admitted to the facility on NJ EX Order. 2 with diagnoses which included but were not limited to: NJ EX Order. 264b1 .

The MDS dated NJ EX Order. 264b1 revealed that Resident #2 had a BIMS score NJ EX Order. 26 indicating Resident #2's NJ EX Order. 264b1 and the resident required supervision for ADLs.

The CP, dated NJ EX Order. 26 revealed that Resident #2 presented with a NJ EX Order. 264b1 related to recent NJ EX Order. 264b1 to the facility as well as overall condition. Interventions included but not limited to: Monitor and record NJ EX Order to determine if problems seem to be related to NJ EX Order. 264b1 The CP further revealed that Resident #2 had potential for side effects related to NJ EX Order. 264b1 NJ E drug use of Paxil and NJ EX Order. 264b1 for NJ EX Order. 264b1 The CP also revealed that on

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 02/07/2023

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 600	Continued From page 20	F 600		

NJ EX Order. 264b1 Resident #2's CP was initiated for NJ EX Order. 264b1. Interventions were to "Administer antibiotics as ordered...Educate (patient/family) on handwashing...On going communication with infection control nurse...strict handwashing ..."

A review of the hospital record (HR), NJ EX Order. 264b1 progress note, dated NJ EX Order. at 10:57 am, revealed that Resident #2 had a diagnosis of NJ EX Order. 264b1. The HR indicated "a resident of long-term care [gender] has a longstanding history of NJ EX Order. 264b1 and NJ EX Order. 264b1. Patient tend to become NJ EX Order. 264b1 with other residents. [Gender] NJ EX Order. 264b1 and brought to the [to the] emergency room and admitted for further evaluation. Due to acute NJ EX Order. 26 and NJ EX Order. 264b1 requires NJ Ex Order. 264b1 e supervision for [gender] safety and medication is being adjusted.. NJ EX Order. 264b1 evaluation is in progress and medication is being adjusted [gender] is started on NJ EX Order. 264b1 also continue with NJ EX Order. 264b1 and NJ EX Order. 2 as needed for NJ EX Order. 264b1. Patient very NJ EX Order. 264b1 ...[gender] does not follow and tend to become NJ EX Order. 264b1 and very NJ EX O NJ EX Order. 264b1 c ...Patient requires NJ EX Orde ob NJ EX Order. 264b1 for [gender] NJ EX Order. 264b1

Review of the facility PN, dated NJ EX Order. 264 at 9:32 pm, documented by NP #3, indicated Resident #2 was "seen today for follow up on NJ EX Order. 264b1 behavior, stabilization visit. Admitted to facility on NJ EX Ord Order after discharge from [hospital]. Patient with multiple chronic medical conditions including NJ EX Order. 264, who was previously at Assisted Living,

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 02/07/2023

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 600	Continued From page 21	F 600		

presents to the ED [emergency department] due to NJ EX Order. 264b1 behavior. Workup at the ED was negative for infection."

Review of a facility PN, dated 1/11/23 at 7:25 pm, by the Telehealth Nurse Practitioner (TNP #1) revealed the following: Resident #2 had "Change in Condition...Resident became NJ EX Order. 264b1. NJ EX Order. 264b1f, danger to self and others...Onset: few minutes ago. wandering in other pt's [patient's] room, became NJ EX Order. 264b throwing things at everybody and other residents, NJ EX Order. 264b1 and NJ EX Order. 264b1, running up and down and not able to contain [Resident #2]. Nurse says sometimes NJ EX Order. 2 but 'never like this'. Nurse says [Resident #2] tried to hurt others physically...ASSESSMENT/DIAGNOSIS: NJ EX Order. 264b1 ...General Assessment/Diagnosis Plan Notes:-NJ EX Order. 264b1 NJ EX Order. 264b1 l in ER [emergency room]; NJ EX O monitoring until EMS arrives for transport..."

Review of a facility PN, dated NJ EX Order. 26 at 8:00 pm, Registered Nurse (RN #1) documented "&;20pm [7:20] call from NJ EX Order. 264b1 for an emergency. When I arrived pt [patient] was NJ EX Order. 264b1 . We attempted to calm pt [patient] down. Hit this writer in head with a full water bottle. All residents placed in their room with doors closed. pt [patient] attempting to get into rooms and screaming NJ EX Order. 264b1 Call placed to 911, telehealth made aware we were sending [gender for a NJ EX Order eval at [hospital emergency room]. [Family members] came and [family members] were placed in the day room with the doors closed. Pt [Patient] calmed down with them here. Call placed to [hospital emergency room]. Police

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 02/07/2023

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 600	Continued From page 22	F 600		

and ambulance transported [gender] to [hospital]".

Review of the facility PN, dated [redacted] at 8:10pm, RN #1 documented "All residents checked on third floor no injuries noted ".

Review of the facility PN, dated [redacted] at 3:17 pm, LPN #1 documented that Resident #2 was still at ACH being evaluated and was waiting to be seen by the [redacted]

Review of the CP did not include any indication that interventions were implemented to address the [redacted] behavior displayed on [redacted].

Review of the HR, psychiatry consult, dated [redacted] at 2:54 pm, revealed that Resident #2 "was brought in the ED [emergency department] for NJ EX Order. 264b1, [gender] has been a resident at [facility] since [redacted], reportedly [gender] has been having NJ EX Order. 264b1 according to staffs [gender] has frequent NJ EX Order. 264b1."

Review of the facility PN, dated [redacted] at 7:18 pm, LPN #2 documented that Resident #2 returned to the facility from the ACH with a diagnosis of NJ EX Order. 264b1). Resident #2 was seen and cleared by the ACH [redacted] to return to the facility.

The "Order Summary Report" (OSR), dated [redacted], reflected that the [redacted] milligram (mg), give [redacted] milliliter (ml) was increased from every [redacted] to every [redacted] hours for [redacted] NJ EX Order. 264b1.

There was no indication in the MR that behavior

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 02/07/2023

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 600	Continued From page 23	F 600		

monitoring was initiated when the medication was changed on [redacted].

Review of the "TASK" form for the month of [redacted] indicated that CNAs were to monitor Resident #2's behavior every shift. The TASK form for monitoring was not signed/initialed as completed on the following dates and shifts after Resident #2 returned from the hospital: [redacted] during the shift of 7:00 am to 3:00 pm on [redacted] 1/14/23, and [redacted] during the shift 3:00 pm to 11:00 pm, and [redacted] during 11:00 pm to 7:00 am which was not according to the "Charting and Documentation" policy.

On [redacted] at 3:15, unit manager LPN (UM/LPN #3), who was the nurse for Resident #2 on [redacted] documented that at 2:30 pm Resident #2 was in his/her room, at 3:05 pm, another resident was walking down the hallway when Resident #2 [redacted] the resident causing Resident #1 [redacted] to the ground and [redacted] near the [redacted] and [redacted].

On 1/16/23 at 4:53 pm, Nurse Practitioner (NP #1) documented "Called to [redacted] floor stat. Patient seen on bed with 2-3 staff members monitoring and maintaining [redacted] position and location in the room after [redacted] randomly [redacted] another resident. [Resident #2] appears [redacted] and [redacted] but otherwise appears medically stable. Of note, patient just returned from the hospital on [redacted] s/p [status post] [redacted] eval for similar [redacted]. [Resident #2] was treated for [redacted] and completes oral [redacted] therapy] tomorrow". NP #1 further documented that her "Impression/Plan: Patient with [redacted] exhibiting [redacted] towards staff and

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 02/07/2023

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 600	Continued From page 24	F 600		

another resident. Day #4/5 Keflex for [redacted] in progress. ER [emergency room] for psych and medical evaluation and treatment."

Further review of Resident #2's medical record (MR) revealed there was no documented evidence that Resident #2's behavior was being monitored consistently after the incident on [redacted] when there was a change in condition or when the medication, [redacted] was changed on [redacted].

The surveyor conducted an interview with CNA #1 on 1/20/23 at 9:27 am. The CNA stated that she documented the residents' behavior in the Kiosks (kiosk or mobile devices that enables care staff to document activities of daily living at or near the point of care to help improve accuracy and timeliness of documentation). She stated that not all residents were being monitored, only those residents that appear in the Kiosks. She explained that a questionnaire would appear, and CNAs had to indicate if behavior occurred by answering "Y for yes and N for no". She also explained that the Kiosks had to be answered and cannot be left blank to indicate that the behavior was being monitored.

The surveyor conducted an interview with CNA #2 on 1/20/23 at 2:00 pm. The CNA stated that she documents residents' behavior in the Kiosks but not for all residents, only when being asked in the Kiosks. She explained that a questionnaire will appear, and the CNA had to indicate if behavior occurred by answering "Y for yes and N for no". She stated that sometimes she documents in the Kiosks and at times she forgets or had no time to sign the Kiosks.

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 02/07/2023

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 600	Continued From page 25	F 600		

The surveyor conducted an interview with CNA #4 on 2/7/23 at 10:36 am. The CNA stated that CNAs should document the care provided to the Resident to indicate that it was done.

The surveyor conducted an interview with the UM/LPN #3 on 2/7/23 at 11:07 am. The LPN stated that CNAs should document the task provided at the end of the shift and unit managers should ensure that the CNAs document to indicate that the care was provided to the residents. However, the LPN was unable to explain why the CNAs were unable to complete their documentations.

The surveyor conducted the interview with the DON on 1/20/23, 1/23/23, and 1/27/23. The DON stated that Resident #2's CP was updated for [redacted] management on return from the hospital on [redacted] However, the CP for Resident #2's behavior that happened on [redacted] was not created because the residents' behavior was related to the diagnosis of [redacted]. The DON also stated that if there was a change in medications, staff should monitor and document resident's behavior for [redacted] days, every shift, in the MR whether the resident's had a behavior or not. The DON was unable to provide a consistent monitoring documentation when the resident's medications were changed on [redacted].

During the tour, the surveyor conducted an interview with residents who were [redacted]. On [redacted] at 12:59 pm Resident #5 stated that Resident #2 was a [redacted] resident, he/she walked around the unit and entered other resident's room, Resident #2 would [redacted] on other [redacted] and staff would just redirect him/her. Resident #2 [redacted] staff and other residents

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 02/07/2023

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 600	Continued From page 26	F 600		

for no reason including him/her. Resident #5 further stated that Resident #2 also [redacted] at one point (unable to recall time and date). Resident #5 revealed that he/she did not report the incident to the facility because the staff were aware of the resident's behavior.

During an interview with the surveyor on [redacted] at 12:45 pm. Resident #6 stated that resident #2 walked around the unit, he/she would go into other residents' room and [redacted] on other residents [redacted], he/she "NJ EX Order. 264b1 staff and other residents when [he/she] does not get what [he/she] wants". Resident #6 stated, approximately 2-3 weeks ago between 2:30 pm to 3:30 pm, Resident #2 entered Resident #6's room, Resident #6 asked Resident #2 to leave the room, Resident #2 [redacted] Resident #6's [redacted] and walked out of the room. Resident #6 stated that he/she never reported the incident to the facility because this was a resident's [redacted] and that the staff were aware of his/her behavior.

During an interview with the surveyor on 1/20/23 at 9:00 am, UM/LPN #3 stated that the nurses are only to document residents' behavior in the residents MR when a behavior occurred. He further stated that nurses are not required to document in the MR if the resident had no behavior. He explained that they have no documentation indicating that the residents' behaviors were being monitored every shift consistently. However, on [redacted] at 11:36 am, the LPN stated that when there is a change in condition such as a change in medication or having [redacted] behaviors, the staff had to monitor the resident and document in the resident's MR. He further added that

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 02/07/2023

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 600	Continued From page 27	F 600		

documentation is important to see if a new intervention is effective or not and to show that the intervention is being implemented and it is part of communication. UM/LPN #3 was not able to explain why Resident #2's behavior documentation was not done.

During an interview with the surveyor on 1/27/23 at 9:15 am, UM/LPN #3 stated that the CP is a way of communication, as it summarizes the residents overall care, and should be individualized and patient centered. The CP had to be updated by the unit managers (UM), Supervisor, and DON within 48 hours for any change in condition including but not limited to, a fall, any incident, altercation, skin tear, or behavior. He further stated that it is important to update the CP to give proper care and to prevent from any recurrence. UM/LPN #3 explained that Resident #2's CP should have been updated for behaviors and medication change on return from the hospital on [redacted]. LPN was not able to provide an updated CP to address the resident behavior on [redacted]

2. During the survey on 1/23/23, the surveyor reviewed the facility's reportable event records for the past 3 months. The surveyor reviewed the RERR dated [redacted] involving Resident #7 and Resident #8. The RERR revealed that a [redacted] was reported to the NJDOH on [redacted]. The attached summary indicated that on [redacted] at approximately 2:00 pm, the staff witnessed Resident #7 not allowing Resident #8 to enter their room. Resident #7 [redacted] Resident #8 and in return, [redacted] Resident #7 in the [redacted] They were separated and neither resident sustained injury. Resident #8 was offered a room change, Resident #8 [redacted]

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 02/07/2023

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 600	Continued From page 28	F 600		

and the family did not like the room. It further indicated that "the facility would actively work on other room options that would be appropriate". The conclusion indicated, "this appears to be an isolated event. The residents have been roommates for a few months and have had no issues up until now. The room changes will be done as a precaution".

On [redacted], another [redacted] involving Resident #7 and Resident #8 was reported to the NJDOH. During the survey on [redacted], the surveyor reviewed the facility's RERR. Review of the RERR revealed that on [redacted] at approximately 11:00 am, staff at the nursing station heard Resident #7 [redacted]. When staff responded, Resident #7, while exiting the room, stated that Resident #8 [redacted] his/her [redacted]. The incident was unwitnessed. Resident #7 was unable to provide context, and Resident #8 asked the staff to leave the room. Neither resident had injury, redness, or bruise. The interventions implemented after the incident included: Resident #8's room will be changed. Both resident's behavior will be monitored and referred for [redacted] evaluation. It further indicated that this was the second minor incident between the resident. Both residents are ambulatory [redacted] and getting them out of each other's proximity should manage the behavior.

During the tour of the unit on 1[redacted] at 1:20 pm, the surveyor observed Resident #7 and Resident #8 lying in bed in the same room, [redacted] Both residents refused an interview with the surveyor.

Review of MR on 1/23/23, 1/27/23, 2/2/23, and

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 02/07/2023

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 600	Continued From page 29 2/7/23 revealed the following: 2a). Resident #7 was admitted to the facility on [redacted] with diagnoses that included but were not limited to NJ EX Order. 264b1 [redacted]. The MDS dated [redacted] 2 and [redacted] 3 revealed a BIMS score of [redacted], which indicated [redacted] status, and the Resident was independent and required minimal supervision with ADLs. The MDS indicated that Resident #7 exhibited NJ EX Order. 264b1 [redacted] directed toward others (e.g., [redacted] to [redacted] during the 7 days, counting back from [redacted]. The Medication Administration Record (MAR) revealed that Resident #7 received [redacted] for [redacted] from NJ EX Order. 264b1. Additionally, the medication [redacted] for [redacted] with NJ EX Order. 264b1 was started on [redacted] and the dosage was increased on [redacted] and [redacted]. Review of the PN revealed no documented evidence that the nurses consistently monitor Resident #7's behavior after the [redacted] was increased on NJ EX Order. 264b1 when it was indicated in the facility's policy that if a resident is being treated for NJ EX Order. 264b1 or [redacted] the staff will document ongoing reassessments of changes (positive or negative). Furthermore, the PN revealed documentation dated [redacted] at 2:15 pm about Resident #7 and Resident #8 NJ EX Order. 264b1. The residents were separated and assessed. The event was	F 600		

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 02/07/2023

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 600	Continued From page 30	F 600		

reported to the DON, Administrator, and Assistance Administrator. On that same date at 2:53 pm, the SW notified the RP and agreed to move Resident #8 to another room. The PN revealed no documented evidence that the nurses consistently monitored Resident #7's behavior after the physical altercation.

The revised care plan dated [redacted] revealed that Resident #7 is possessive of his/her room and does not want people to enter. Goals and interventions included but were not limited to: Resident will not [redacted]; resident will verbalize understanding of the [redacted] r; when the resident becomes [redacted], if the response is [redacted] staff to [redacted] and approach later.

The care plan indicated that Resident #7, who had [redacted] and a diagnosis of [redacted] would verbalize understanding of the [redacted]. However, there was no indication in the CP how Resident #7 would be monitored while in the room with the roommate (Resident #8) where the [redacted] occurred. The facility's policy for behavior management indicate that interventions and approaches will be based on detailed assessment of [redacted] and [redacted] symptoms as well as the potential situational and environmental reasons. Additionally, the policy included that the care plan will include but was not limited to targeted and individualized interventions for the [redacted] l symptoms, specific, measurable goals for the [redacted] and how the staff will monitor

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 02/07/2023

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 600	Continued From page 31	F 600		

for effectiveness of the interventions.

The PN revealed that on [redacted] at 10:55 am, the UM/LPN #3 documented that Resident #7 and Resident #8 had another NJ EX Order. 264b1 in the room and unwitnessed.

During an interview with the DON on 1/27/23 at 12:57 pm and UM/LPN #3 on 2/7/22 at 2:50 pm, they both confirmed that the NJ EX Order. 264b1 took place in the residents' room, and it was unwitnessed as the residents were not monitored in the room by the nursing staff at that time.

The DON further confirmed on that same date at 4:10 pm that the room change for Resident #8 was not attempted again until after the [redacted] recurred on [redacted] She stated that the NJ EX Order. 264b1 on [redacted] was considered a minor and isolated incident and Resident #8 refused to transfer to another room.

Review of the task form for the month of 11/2022 indicated that CNAs were to monitor for behavior symptoms every shift which included but were not limited to NJ EX Order. 264b1 [redacted] Resident #7's task form was not signed/initialed for the following dates and shifts: 7:00 am to 3:00 pm on 11/1/22, 11/3/22 to 11/6/22, 11/8/22, 11/9/22, 11/19/22, 11/20/22, and 11/23/22; 3:00 pm to 11:00 pm on 11/4/22, 11/12/22, 11/13/22, 11/21/22, 11/22/22, 11/24/22, and 11/26/22; and 11:00 pm to 7:00 am on 11/2/22 to 11/14/22, 11/16/22, 11/18/22, 11/20/22 to 11/22/22, 11/25/22, and 11/27/22 to 11/29/22.

For the month of 1/2023 for the following dates and shifts: 7:00 am to 3:00 pm on 1/3/23, 1/8/23,

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 02/07/2023

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 600	Continued From page 32	F 600		

1/12/23, 1/14/23, 1/15/23, and 1/21/23; 3:00 pm to 11:00 pm on 1/1/23, 1/7/23, 1/8/23, 1/15/23, 1/21/23, 1/23/23 and 1/26/23; 11:00 pm to 7:00 am on 1/2/23, 1/7/23 to 1/9/23, 1/13/23, 1/19/23, and 1/21/23 to 1/23/23.

During an interview with CNA #1 on 1/23/23 at 11:01 am, she stated that CNAs are expected to monitor residents' behavior and document in the kiosk, ADL records task for behavior monitoring. She further said that CNAs are responsible for completing the task at the end of the shift and if incomplete or blank, it did not happen.

During an interview with the DON on 1/27/23 at 12:57 pm, she stated that CNAs document resident's behavior in the kiosk or ADL record. She further stated that CNA observations and documentations are considered valuable they do not replace nurses observation and documentation.

2b. According to the AR, Resident #8 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted] and [redacted].

The MDS dated [redacted] and [redacted] revealed a BIMS score of [redacted] which indicated [redacted] status, and the Resident required supervision to minimal assistance with ADLs.

The nursing PN dated [redacted] at 1:04 pm indicated that Resident #8 "was [redacted] with staff and other residents. Resident [redacted] around the hallway and goes [redacted] of other residents' rooms. [redacted]." The nursing PN dated [redacted] at 8:30 pm indicated

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 02/07/2023

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 600	Continued From page 33	F 600		

that Resident #7 "was NJ EX Order. 264b1 to staff and residents". The Resident was not easily redirected but finally agreed to go to bed.

The CP initiated on [redacted] indicated that Resident #8 may present with a NJ EX Order. 264b1 related to his/her recent admission to the facility and his/her overall condition. Goals and interventions included but were not limited to: Resident #8 will have NJ EX Order. 264b1, such as being NJ EX Order. 264b1, and showing no signs and symptoms of NJ EX Order. 264b1 consults as needed. Monitor/document as needed risk for NJ EX Order. 264b1 NJ EX Order. 264b1, and NJ EX Order. 264b1 Monitor/record/report to MD (Medical Doctor) as needed risk for NJ EX Order. 264b1 someone

Review of the PN revealed documentation by the Social Worker (SW) on 10/31/22 at 10:32 am that Resident #8 was transferred to another room because of incompatibility with the roommate (Resident #7). The RP was made aware of the room change and staff to monitor the adjustment. However, the PN revealed no indication that the room change occurred or Resident #8 was monitored by the nurses for adjustment after the room change. Additionally, there was no documented evidence in the PN explaining what led to the room change.

Further review of the PN revealed documentation dated [redacted] at 2:15 pm that Resident #7 and

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 02/07/2023

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 600	Continued From page 34	F 600		

Resident #8 had a NJ EX Order. 264b1. They were separated and assessed. The event was reported to the DON, Administrator, and Assistance Administrator. On that same date at 2:53 pm, the SW notified the RP and agreed to move Resident #8 to another room.

Review of the MR on [redacted] revealed no documented evidence that the nurses consistently monitored Resident #8 for [redacted] fety after the NJ EX Order. 264b1 on [redacted]. In addition, there was no documented evidence that Resident #8 was offered another room change after the resident refused on [redacted] when it was indicated in the RERR summary that the facility staff would actively work on room change options.

Review of the PN on [redacted] revealed documentation on [redacted] at 10:55 am about another NJ EX Order. 264b1 between Resident #7 and Resident #8. The PN indicated that Resident #7 and Resident #8 who had a [redacted] continued to share the same room until another r NJ EX Order. 264b1 NJ EX Order. 264b1 on [redacted]

During an interview with the SW on 2/7/23 at 11:30 am, she stated that Resident #8 was transferred to another room after the [redacted]. The resident's RP had agreed to the room change but the resident would not stay in the new room, so he/she remained in the same room with Resident #7. The SW confirmed that Resident #8 transferred again to another room after the [redacted] on [redacted], and Resident #8 had adjusted well to the new room. However, she could not explain why the room change was not attempted again as a precaution

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 02/07/2023

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 600	Continued From page 35	F 600		

when it was indicated in the RERR summary on [redacted] that the facility would actively work on other room options that would be appropriate. Additionally, she could not explain what led to the room change on [redacted]2 but stated that Resident #7 was very [redacted] and due to incompatibility

During an interview with the surveyor on [redacted] at 11:36 am, LPN #3, unit manager (UM) for Resident #7, could not remember a room transfer for Resident #8 on [redacted]

The revised care plan dated [redacted] for Resident #8 revealed that Resident #8 is at risk for potential NJ EX Order. 264b1 from or with a resident on the unit who has NJ EX Order. 264b1 [redacted]. Goals and interventions included but were not limited to: Resident #8 will be free from NJ EX Order. 264b1 [redacted] behavior documentation and [redacted] evaluation as needed; maintain a [redacted] from the other NJ EX Order. 264b1 residents; monitor Resident #8 whereabouts for safe interactions with peers.

A review of the MR on [redacted]3 revealed no documented evidence that the nursing staff consistently monitored Resident #8 behaviors, interactions with other residents, and whereabouts as indicated in the revised care plan on [redacted]

Review of the task form for the month of 11/2022 indicated that the following dates and shifts were not signed/initialed: 7:00 am to 3:00 pm 11/3/22 to 11/24/22 and 11/26/22 to 11/30/22; 3:00 pm to 11:00 pm on 11/1/22 to 11/3/22, 11/7/22, 11/11/22, 11/12/22, 11/13/22, 11/21/22, 11/24/22 and

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 36	F 600		

11/26/22, and 11:00 pm to 7:00 am on 11/1/22 to 11/5/22, 11/7/22 to 11/12/22, 11/14/22, 11/16/22, 11/18/22 to 11/25/22, and 11/27/22 to 11/30/22.

For the month of 1/2023 for the following dates and shifts: 7:00 am to 3:00 pm on 1/2/23, 1/3/23, 1/5/23 to 1/8/23, 1/10/23 to 1/12/23, and 1/15/23 to 1/26/23; 3:00 pm to 11:00 pm on 1/2/23, 1/4/23, 1/7/23 to 1/10/23, 1/13/23, 1/15/23, 1/17/23, 1/18/23, 1/21/23, 1/22/23, 1/24/23, and 1/26/23; and 11:00 pm to 7:00 am on 1/2/23, 1/7/23 to 1/9/23, 1/13/23, 1/19/23, and 1/21/23 to 1/23/23.

During an interview with CNA #1 on 1/23/23 at 11:01 am, she stated that Residents #7 and #8 were roommates. They would sometimes be f[NJ EX Orde] but [NJ EX Order: 26461] If the residents engage in an altercation, either one will [NJ EX Orde] CNA #1 explained that Resident #8 was transferred to another room sometime last year, but it was unsuccessful, so the residents' remained roommates. CNA #1 further explained that she did not witness the [NJ EX Order: 26461NJ EX Order: 26461] but heard about it. She added that nurses and CNAs monitor the residents' behavior, and CNAs report observed behaviors to the nurses.

During an interview with LPN #9 on 1/23/23 at 1:34 pm, she stated that residents' behavior should be monitored every shift for [NJ EXO] days for changes in medications for behavior and when an incident happened due to behavior. She explained that it is important to document resident's behavior in the PN even when there was no behavior because it shows that the observation happened. The surveyor asked if Residents #7 and #8 were monitored for behavior and whereabouts after the incident on [NJ EX Order: 26461]

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 02/07/2023

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 600	Continued From page 37	F 600		

LPN #9 was unsure but stated that nurses and CNAs supervise all residents. She agreed that if the behavior and whereabouts were not documented in the resident's MR, it did not happen.

During an interview with the UM/LPN #3, he stated that Resident #7 and Resident #8 do not get along sometimes. He explained that Resident #7 and Resident #8 never had an NJ EX Order: 26401 again after NJ EX Order: 26401 incident and could not confirm if another room change was attempted again. The surveyor asked when staff monitor residents for NJ EX Order: 26401 The UM/LPN #3 stated that residents must be monitored for behavior every shift for NJ EX days after an NJ EX Order: 26401 and changes in psychotropic medications, even if no behavior was observed. He agreed that if the observation was not documented in the MR, it did not happen.

During an interview with the surveyor on 1/23/23 at 2:24 pm, the Nursing Supervisor (NS) RN #2 stated that residents must be monitored for behavior every shift for NJ EX days after changes in NJ EX Order: 26401 medication to monitor the effectiveness of the medication.

During an interview with the DON on 1/23/23 at 12:57 pm and 3:50 pm, and 1/27/23 at 4:10 pm, she stated that nursing staff are expected to document observation of resident's behavior in the MR every shift for NJ EX days when there's new or changes in p NJ EX Order: 26401 medications and after an altercation. The nurses must document when residents are not displaying behaviors to show that residents are being monitored and to determine the effectiveness of the medication change. She added that behavior monitoring is a

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 02/07/2023

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 600	Continued From page 38	F 600		

protocol that requires no doctor's order. The DON could not explain why there was no consistent documentation in the MR that Resident #7 and Resident #8 were monitored after the [redacted] or after Resident #7 had a [redacted] c medication change on [redacted] and [redacted] However, she stated that the nurses should have documented behavior observations and confirmed that if it was not documented, it did not happen.

The surveyor asked the DON if Resident #8 was referred to the NJ EX Order. 264b1 for evaluation after the NJ EX Order. 264b1 on [redacted]. The DON stated that Resident #8 had adjusted well to the facility, and there was no need to refer every resident with a history of [redacted] r from the hospital. The surveyor asked if the care plan for Resident #7 and Resident #8 should address the NJ EX Order. 264b1 towards each other specifically since they were roommates and the [redacted] occurred inside the room. The DON stated, "I don't know how to answer that," care plans are discussed in the morning meeting with the team.

The surveyor asked the DON if Resident #7 was offered a room change after the [redacted] on [redacted] The DON stated that Resident #7 was not a candidate for a room change due to prior history. In addition, the DON stated that a room change was not attempted again for Resident #8 despite having it documented that the facility would actively work on room change options as a planned intervention when the resident had [redacted] on [redacted], because the residents' room was next to the nurse's station where they can be monitored, and the residents did not have an [redacted] since. However, it was not

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 02/07/2023

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 600	Continued From page 39	F 600		

confirmed during the interview that both residents were consistently monitored despite the room being next to the nurse's station since there was no consistent documentation in the PN to indicate that it was done. The DON confirmed if there was no documentation of behavior observation or monitoring in the PN, it did not occur.

During an interview with the surveyor on 1/27/23 at 1:55 pm, the Administrator stated that incidents, accidents, and abuse must be reported by the nursing staff immediately, and it goes through a chain of command. For emergencies, staff must inform the DON or the Administrator immediately. The Administration stated that the DON reports to him, but the DON would lead the investigation. The surveyor asked if he was informed of the abovementioned [redacted] incident on [redacted]. He stated he was unsure of the specifics of the actual event. The surveyor explained the details of the incident to the Administrator and then said he would have to look, but in general, room change would be attempted. The Administrator could not confirm if the room change occurred but stated that, in general, a room change should be offered after an [redacted]

Review of the facility policies titled:

"Abuse", dated 10/27/17, indicated under "...Prevention...The facility leadership will assess the needs of the residents in the facility to be able identify concerns in order to prevent potential abuse...RESIDENT ASSESSMENT The population of the facility includes individuals who meet the criteria for skilled care under the Medicaid and Medicare guidelines including specialty programs provided by the facility...Every

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 02/07/2023

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 600	Continued From page 40	F 600		

resident is unique and may be subject to 'abuse' based on a variety of circumstances, including facility physical plant, environment, the resident's health, behavior or cognitive level...Staff supervision and ongoing monitoring are used to identify resident with a risk behavior...The interdisciplinary team will identify the vulnerabilities and interventions on the resident care plan...POPULATION...The facility will ensure a comprehensive dementia management program to prevent resdient [resident] abuse if applicable..."

"Acute Condition Changes - Clinical Protocol", undated, revealed "...MONITORING AND FOLLOW-UP 1. The staff will monitor and document the resident's progress and response to treatment, and the Physician will adjust treatment accordingly. 2. The Physician will help the staff monitor a resident with a recent acute change of condition until the problem or condition has resolved or stabilized..."

"Behavior Assessment and Monitoring" undated, indicated "Problematic behavior will be identified and managed appropriately...Monitoring 1. If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function..."

"Behavioral Assessment, Intervention and Monitoring" undated, indicated "POLICY STATEMENT 1. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. 2. Residents who do not display symptoms of, or have not been diagnosed with, a

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 02/07/2023

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 600	Continued From page 41	F 600		

mental, psychiatric psychosocial adjustment or post-traumatic stress disorder will not develop a patter of decreases social interaction or increased withdrawn, angry or depressive behaviors that cannot be explained or attributed to a specific clinical condition that makes the pattern unavoidable. Residents will have minimal complications associated with the management of altered or impaired behavior...Assessment 4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others...Management...Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying cases, as well as the potential situational and environmental reason for the behavior. The care plan will include, as a minimum: a. A Description of the behavioral symptoms including...Monitoring 1. If the resident is being treated for altered behavior or mood, the IDT [Interdisciplinary Team] will seek and document any improvements or worsening in the individual's behavior, mood, and function. 2. The IDT will monitor the progress of individuals with impaired cognition and behavior until stable...Interventions will be adjusted based on the impact on behavior..."

"Care Plans-Comprehensive", undated, indicated "An individualized, patient centered Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs in developed for each resident consistent with the Resident Rights...Care plans are revised as changes in the resident's condition dictate..."

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 02/07/2023

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 600	Continued From page 42 "Charting and Documentation", undated, indicated "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record...All observations...services performed...must be documented in the resident's medical record..." "RESIDENT ABUSE NEGLECT AND MISTREATMENT "THE LAW"", undated, indicated under "...Prevention...Aggressive care planning of all residents who have needs and/or behaviors that may trigger a negative reaction...psychiatric conditions with history of aggressive behaviors...Identification: Immediate incident reporting (refer to Accident/Incident Policy & Procedure) and investigation of all falls, bruising, skin-tears, increase in depressive, isolative fearful behavior, and occurrences that may constitute abuse..." NJAC 8:39-4.1 (a)5 NJAC 8:39-27.1(a)	F 600		
F 689 SS=D	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: Complaint #:	F 689	F689 Free of Accident	3/28/23

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 43 NJ00160765, NJ00160776 NJ00160791, NJ00161051 Based on interview, medical records (MR) review, and review of pertinent facility documents on 1/20/23, 1/23/23, 1/27/23, 2/2/3, and 2/7/23, it was determined that the facility failed to ensure that a.) a resident with known history of [redacted] and repeatedly attempted to open the medication cart was adequately supervised and had appropriate care plan in place and b.) an incident or accident was reported immediately to the nursing supervisor (NS) or the Director of Nursing (DON) in accordance to the facility's reporting policy for incidents and accidents for 1 of 3 residents (Resident #7) reviewed for incident and accident. The deficient practice was evidenced by the following: 1.According to the Admission Record (AR), Resident #7 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: NJ EX Order. 264b1 [redacted]. The Minimum Data Set (MDS), an assessment tool dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated a severely impaired cognitive status and the resident required minimal supervision with Activities of Daily Living (ADL). The MDS indicated that Resident #7 exhibited [redacted] symptoms directed toward others (e.g., NJ EX Order. 264b1 [redacted] days during the [redacted] days, counting back from [redacted]	F 689	Hazards/Supervision/Devices Immediate Action On [redacted] resident #7 investigation was initiated and completed, behavior care plan was reviewed and updated, and responsible party/medical practitioner notified of medication found at bedside. Audit of medication at beside was done by social worker/designee of residents rooms immediately and completed on [redacted] with no other medications found. LPN #5 and #6 were in-serviced on reporting/notifications/updating the care plan post incident on [redacted] Re-in servicing for nursing department began by nurse educator/designee on [redacted] on reporting/notifications/updating the care plans post incident/storing medication safely/securely and was completed. Staff re-in servicing began on abuse/neglect, incident/accident reports, and behavioral assessment/monitoring/care plans/reporting/medication storage and was completed. Interdisciplinary Care Plan Team was assembled on [redacted] and were re-in serviced by Administrator on facility policy for abuse/accidents/incidents/individualized behavior care plans. Review of behavioral assessment and	

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 44 The Physician's Order Summary Report (OSR) reflected that Resident #7 was receiving the following supplements: NJ EX Order. 264b1 [redacted] A review of the nursing progress notes (PN) revealed the following documentation: On 10/7/22 at 10:10 PM, Licensed Practical Nurse (LPN) #6 documented that Resident #7 tried opening the nurse's medication cart. On [redacted] 3:32 PM, LPN #8 documented that Resident #7 was [redacted], trying to [redacted] from the medication cart several times. On [redacted] at 11:01 PM, LPN #5, documented "despite all due medications given, the Resident kept asking for more and tried to open the medication cart." Additionally, the PN revealed the Resident attempted to open the medication cart on [redacted], and tried to enter the medication room on [redacted]. There was no indication in the MR that the abovementioned recurring behavior of Resident #7 was addressed in the care plan. On 12/6/22 at 10:32 PM, LPN #6 documented the following in the PN: Resident #7 was in bed sleeping, [redacted] " Licensed practical nurse (LPN) #6 and LPN #5 "found [redacted] bottles of supplements, supplements were removed" and educated the Resident who had a [redacted] not to keep medication in his/her room for safety. LPN #6 took the Resident's vital sign (VS) and recorded them in VS section of the MR.	F 689	monitoring policy was completed by administration with no changes made. All current resident responsible parties were notified of the facility policy on bringing medications into the facility by Director of Quality Experience/designee on 2/9/2023. Identification of Others All residents with known history of wandering behavior and repeated attempts to open medication cart have the potential to be affected. Systemic Changes Additional staff were re-educated with multiple re-in-services beginning on [redacted] on reporting/notification/care planning by nurse educator/designee. The Director of Quality Experience/designee will notify new/re-admissions policy on of bringing medication into facility within one week by Director of Quality Experience/designee. The nursing unit manager/designee will do a random audit of 6 rooms on unit weekly x 6 months to ensure medication/supplements are not found at bedside using audit tool. Quality Monitoring The Quality Assurance Performance Improvement Committee meetings have been moved from quarterly to monthly. The administrator/designee will review new/re-admissions and/or their	

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 02/07/2023

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 45 There was no documented evidence in the PN that the medication cart was locked at the time of the incident, that an investigation was initiated to ensure that all medication carts and medication room on the unit were secured and locked and determine how the unknown supplements were obtained, that an RN conducted a comprehensive assessment, that the NS or the DON was notified, that the PP or RP was notified, or the care plan was updated. Furthermore, there was no indication in the PN that the LPN provided continued observation of Resident #7 after the incident. A review of the care plan (CP) with a revision date NJ EX Order. 264b1 indicated the resident "may do one the following, if it is not a problem for the resident, do not be concerned with: wandering...kicking and hitting med cart." Goals and interventions included but were not limited to: Resident will display NJ EX Order. 264b1 and have NJ EX Order. 264b1 ; Assess potential and NJ EX Order. 264b1 ; Leave alone in a safe environment such as his/her room; Have NJ EX Order. 264b1 evaluate as needed and routinely". The CP did not reflect interventions of Resident #7's recurring behavior of attempting to open the medication cart or enter the medication room when it was initially documented on NJ EX Order. 264b1 The PN reflected that a quarterly interdisciplinary care plan meeting (IDCP) was held on NJ EX Order. 264b1 , and it was documented that the "care plans have been reviewed and are up to date." However, the behavior was not addressed in the care plan until NJ EX Order. 264b1	F 689	responsible parties are educated on not having any stored medications at the residents bedside weekly x 6 months, then monthly. The administrator/designee will review that new/re-admissions and/or their responsible parties are educated on not having any stored medications at the residents bedside weekly x 6 months, then monthly. The results of these reviews will be submitted to the Quality Assurance Performance Improvement Committee monthly for 6 months. Based on results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 46 Review of the summary on the incident dated NJ EX Order: 264 with the DON's name stamp, unsigned, provided to the surveyor via email on NJ EX Order: 264 indicated the following: On NJ EX Order: 264 this writer was made aware that on NJNG EX Order: 7 a nurse, LPN #6 NJ EX Order: 264b1 bottles of supplements in a drawer of Resident #7. On NJ EX Order: 264 Resident #7's belongings were immediately checked, and no supplements of any kind were found. LPN #6 was interviewed and confirmed that she looked at the resident's drawer because the resident seemed NJ EX Order: y and found the supplements, one was NJ EX Order: 264b1 NJ EX Order: 264b1 and could not recall the others. Review of the resident's chart confirm that the vital signs were normal. The NS confirmed that she was not notified of the incident. The DON made the RP aware of the incident and the RP was not aware where the supplements came from. The DON asked Resident #7 who could not recall where the supplements came from. There was no documented conclusion, but it was indicated that it was unclear how the supplements arrived in Resident #7's drawer on NJ EX Order: 264. The surveyor reviewed the document "Full QA Report" Incident date/time: NJ EX Order: 264b1, 5:00 PM forwarded by the DON post survey on 2/10/23. It was indicated on the form that LPN #6 was the assigned care giver and LPN #5 was the witness. The location of the incident was at the resident's room. There was no injury noted. Additionally, the form indicated that there was no staff interview, and the details of the incident was not documented. The form indicated that the Administrator and DON were not notified of the incident until NJ EX Order: 264	F 689		

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 47	F 689		

The surveyor reviewed LPN #6 signed written witness statement dated [redacted] forwarded by the DON post survey on 2/10/23. LPN #6 indicated that Resident #7 was sleeping around 5PM but the resident usually [redacted] e unit. Due to this, she [redacted]" the resident and took his/her VS because Resident #7 was [redacted] LPN #6 indicated that she "checked the resident's drawer and found supplements such as [redacted]". "She could not recall. She removed them and put them in the cart."

The surveyor reviewed LPN #5's signed and undated written witness statement, forwarded by the DON post survey on 2/10/23. LPN #5 wrote that LPN #6 asked her to check Resident #7's room because "she thinks Resident #7 took something from the med carts." LPN #5 indicated "nurse searched the room and found bottles of supplements in the drawer." The Resident was [redacted] and [redacted] the unit. There was documentation in the MR indicating the Resident #7 was [redacted] in the unit. The document did not indicate that an RN assessed Resident #7, that the LPNs started an incident report, and the RP and PP were notified.

On 1/23/22 at 1:20 PM, Resident #7 refused an interview with the surveyor.

During a telephone interview with the surveyor on 1/23/23 at 2:01 PM, LPN #6 stated that on [redacted], during her medication pass at approximately 5:00 PM, Resident #7 was not wandering out of the room, which she stated was unusual. Because of that, she decided to check on the resident with LPN #5. Resident #7 was

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 48	F 689		

found in bed [redacted] owsy" when awakened, not [redacted] e, and [redacted] alm, and for that reason, she searched the room. While searching, LPN #6 found "three bottles of supplements" in the resident's nightstand drawer. LPN #6 explained that she took the Resident's VS, which she stated was normal, and placed the supplements in the medication cart. She said that Resident #7 was not assessed by a RN. She further explained that she left the supplements in the medication cart for the night shift but was unable to confirm that incident was reported to the oncoming nurse. LPN #6 could not confirm if she reported the incident to the NS or the DON and could not answer when the surveyor asked why the supplements were not given to the supervisor at the time when she reported the incident. Additionally, LPN #6 stated that she could not recall the name of the supplements. LPN #6 further stated that Resident #7 had tried opening the medication cart before, but it was locked. It was confirmed during interview that she did not initiate an investigation to determined how Resident #7 obtained the medications or if all the medication carts on the unit were secured and notify the PP or RP. However, she stated that nurses are responsible for informing the PP or RP of changes in condition, incident, accident, and initiating an incident report. LPN #6 acknowledged that she should have called the PP and started an incident report.

During a telephone interview with the surveyor on 1/30/23 at 1:10 PM, LPN #5 stated that she was in the room when LPN #6 found bottles of supplements or medications in the nightstand drawer. LPN #5 could not recall how many bottles or the names of the medications, was unaware where LPN #6 placed them and was unsure if

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 49	F 689		

LPN #6's medication cart was locked at the time of incident. She was unsure if the incident was reported to the oncoming nurse but confirmed that she did not report the incident to the NS or the DON, notify the PP or RP or initiate an investigation as she was busy with her residents. LPN #5 stated that the incident should have been reported to the NS immediately to ensure the resident's safety.

During a telephone interview with the surveyor on 2/6/23 at 11:28 AM, the PP stated that she was unaware of the incident on [redacted] when Resident #7 was found [redacted] when [redacted] and at the same time bottles of unknown supplements/medications were found in the resident's nightstand drawer. She explained that some residents can self-administer medications with the PP's order, but not Resident #7, due to his/her cognitive status. She further explained that she expects nurses to call her for any incident or accidents and changes in resident's condition so that she can make appropriate clinical decisions. She added that Resident #7's nurse should have notified her about the drowsiness and the medications found in the resident's room, regardless of the type of medication.

During an interview with the surveyor on 1/23/23 at 2:24 PM, RN #2, NS on 12/6/22 confirmed the abovementioned incident was not reported to her. She explained that nurses are responsible for notifying the NS or DON when incidents or accidents occur, calling the PP and RP for changes in condition, and initiating an incident report or investigation and stated that LPN #6 should have immediately reported the abovementioned incident to her.

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 02/07/2023

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 50	F 689		

During an interview with the surveyor on 1/23/23 at 11:36 AM and telephone interview on 2/10/23 at 10:24 AM, LPN #3 who was the unit manager (UM) for Resident #7, stated that he was unaware about the incident on 1[NJ EX Order 2]; or Resident #7's abovementioned recurrent behavior. He explained that nurses are responsible for initiating or updating care plans. However, not all nurses know how to create or update CP.

During an interview with the surveyor on 1/23/23 at 3:50 PM, the DON stated that nurses did not notify her or the NS about the abovementioned incident that occurred on[NJ EX Order 2]. She explained that nurses are expected to report any incident/accident to the NS and initiate an incident report immediately. Also, nurses are expected to notify the RP and PP of changes in condition and when an incident or accident occurs. The DON acknowledged that LPN #6 should have immediately reported the incident to the nursing supervisor and started an incident report/investigation.

During an interview with the surveyor on 1/27/23 at 1:55 PM, the Administrator stated that nursing staff must report incidents and accidents immediately to the supervisor unless it's an emergency then the DON or the Administrator must be notified immediately. The Administrator stated that he was unaware of the abovementioned incident. The surveyor asked if the incident was reported to him since the DON began the investigation on[NJ EX Order 2]. The surveyor explained the details of the incident to the Administrator then he stated that he would have to look because he was not sure of the specifics. The Administrator confirmed the nurse should

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 51	F 689		

have followed the protocol for incident and accidents which include reporting to the NS, and notification of PP and RP.

Review of an undated facility policy titled "Accidents and Incidents"; under "Policy Interpretation and Implementation" indicated 1. The Nurse Supervisor/Charge Nurse...shall promptly initiate and document investigation of the accident or incident. 2. shall be included in the report...a. the date and time...b. the nature of the injury...g. the date/time attending physician was notified as well as the time the physician responded...h. the date/time the family was notified and by whom...3. The Nurse Supervisor/Charge Nurse...shall complete a Report of Incident/Accident form and submit to the Director of Nursing Services within 24 hours...

Review of the facility policy titled, "Behavior Assessment and Monitoring" undated, under "Policy Statement" indicated 1. Problematic behavior will be identified and managed appropriately...under "Assessment" 2. The nursing staff will identify, document, and inform the physician about an individual's mental status, behavior, and cognition, including a. onset, duration, and frequency...or changes in behavior, cognition, and mood..."

Review of the facility policy titled, "Acute Condition Changes-Clinical Protocol" undated, under "Assessment and Recognition" indicated that nursing staff will contact the Physician...for emergencies, they will call or page the Physician and request a prompt response. Under "Monitoring and Follow-Up" it indicated that staff will monitor and document the resident's progress and responses to treatment..."

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 02/07/2023

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 52 Review of the facility policy titled, "Care Plans-Comprehensive" undated, under "Policy Statement" indicated that an individualized, patient centered, comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, mental, and psychological needs is developed for each resident consistent with the Resident's rights. Under "Policy Interpretation and Implementation" indicated 1. Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident...3. Each resident's comprehensive care plan has been designed to: a. incorporate identified problem areas...d. reflect treatment goals and objective and measurable outcomes...5. Care plans are revised as changes in the resident's condition dictate, care plans are reviewed at least quarterly..." NJAC 8:39-27.1(a)	F 689		
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00160765, NJ00160776 NJ00160791, NJ00161051 Based on observation, interviews, medical record	F 835	F835 Administration Immediate Action Administrator was re-educated on the Administrators job description and facility	3/28/23

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835	Continued From page 53 (MR) review, and review of other pertinent facility documentation during the on-site investigation on 1/20/23, 1/23/23, 1/27/23, 2/2/23, and 2/7/23, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to follow the facility's "Administrator" job description and failed to ensure that policies and procedures were implemented by staff under "Behavior Assessment and Monitoring", "RESIDENT ABUSE NEGLECT AND MISTREATMENT "THE LAW"", "Abuse", "Charting and Documentation", "Care Plans-Comprehensive", and "Behavioral Assessment, Intervention and Monitoring", "Accidents and Incidents", and "Acute Condition Changes - Clinical Protocol". 1. On 1/11/23, Resident #2, who had NJ EX Order. 264b1 staff with a NJ EX Order. and NJ EX Order. 264b1 them. Resident #2 was evaluated at the hospital on NJ EX Order. 264b1 and returned on NJ EX Order. 264b1 On NJ EX Order. 264b1 the NJ EX Order. 264b1 medication (given for NJ EX Order. 264b1 with NJ EX Order. 264b1) was changed when Resident # 2 returned to the facility from the Acute Care Hospital (ACH). The LNHA unable to explain that the facility did not initiate a formal behavior monitoring process, develop a CP, and/or start interventions for this NJ EX Order. 264b1 r. Resident #2's care plan (CP) and progress notes (PN) lacked documentation that the resident was being supervised or monitored to address his/her NJ EX Order. 264b1 displayed on NJ EX Order. 264b1 . This deficient practice resulted a resident-to-resident physical abuse/altercation	F 835	policy/procedures/responsibilities to ensure they are followed/implemented by staff. Policies reviewed including but not limited to the following: administrative functions, behavior assessment and monitoring, resident abuse/neglect/ mistreatment, staff charting and documentation, comprehensive care plans, behavioral assessment and monitoring, accidents and incidents, and acute condition changes protocols. The investigation/updated care plans/medical practitioner/responsible party notification was completed for residents #7 and #8 and was reviewed by Administrator for accuracy/completion. Interdisciplinary Care Plan Team was convened on 1/30/2023 and were re-in serviced by Administrator on facilities policy for abuse/accidents/incidents/individualized behavior care plans. Resident # 1 and #2 no longer reside at the facility. Administrator met with DON/ NJ EX Order. 264b1 practitioner to assure that residents with behavioral care plans were reviewed and updated. Administrator ensured that staff were educated on behavior care plan policy/behavioral monitoring policy/reporting incidents to DON/medical practitioner. Administrator reviewed behavioral audits initiated by DON on 1/20/2023 in	

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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F 835	Continued From page 54 when on NJ EX Order. 26 at 3:05 pm, a staff member witnessed Resident #1 NJ EX Order. 264b1 in the hallway past Resident #2's doorway. Resident #2 was coming out of his/her room and NJ EX Order. Resident #1 in the NJ EX Order, causing Resident #1 to NJ EX. Resident #1 was observed NJ EX Order. 264b1 and noted with NJ EX Order. 264b1 to the NJ EX Order. 264b1 and NJ EX Order e. Resident #1 was hospitalized with an NJ EX Order. 264b1 and NJ EX Order. 264b1. This resulted in an Immediate Jeopardy (IJ) which began NJ EX Order. 264b 2.) On NJ EX Order. 264b at 2:00 pm, Resident #7 and #8 who are roommates, both NJ EX Order. 264b1 with a NJ EX Order. 264b1 of NJ EX Order. 264b1 and NJ EX Order. 264b1 n had a witnessed NJ EX Order. 264b1 Resident #7 NJ EX Order. 26 Resident #8 and Resident #8 NJ EX Resident #7 on his/her NJ EX Order. Resident #8 was offered a room change which the family agreed but Resident #8 NJ EX Order. 264b. Resident #7 was not offered a room change because he/she for was not a candidate. Consequently, on 1/25/23 at approximately 11:00 am, another NJ EX Order. 264b1 NJ EX Order. 264b involving Resident #7 and Resident #8. When staff responded to the room, Resident #7 reported that Resident #8 NJ EX her/his NJ EX Order. The incident was unwitnessed. Resident #8 was moved to another room. This resulted in an IJ which began on NJ EX Order. 26 2 and the facility was notified of the IJ on NJ EX Order. 26. The LNHA failed to ensure that adequate supervision, and consistently document/monitor resident behavior in the Medical Record (MR) in accordance with their policy and ensure that the physical altercation did not recur. Additionally,	F 835	conjunction with psychiatric services to ensure that residents with behavior care plans were reviewed and updated. Administrator assured the licensed nurses and certified nursing assistants were educated on the charting and documentation policies related to completing task form. Administrator reviewed daily audits with DON/designee to ensure behavioral monitoring documentation is occurring. Interdisciplinary Care Plan Team was convened on 1/30/2023 and were re-in serviced by Administrator on facilities policy for abuse/ accidents/incidents/individualized behavior care plans/monitoring. On 1/25/2023 the facility abuse policy and incident/accident policy was re-reviewed by administrative team consisting of Administrator, DON, and the Medical Director. Identification of Others All residents have the potential to be affected by this practice. Systematic Changes Chief Clinical Officer has scheduled monthly meetings x6 months with Administrator to ensure oversight process related to administrative job description and related policies. Policies reviewed including but not limited to the following: administrative functions, behavior assessment and monitoring, resident	

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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 835	Continued From page 55 there was no indication that Resident #8's revised care plan was implemented. 3.) On 12/6/22 approximately 5:00 pm, Resident #7 was found in bed NJ EX Order. 264b1" when NJ EX Order. 264b1, and NJ EX Order. 264b1 LPN #6 found NJ EX Ord bottles of supplements" in the resident's nightstand drawer. LPN #6 placed the three supplements in her medication cart. Resident #7 was not assessed by a RN. The incident was not communicated to the oncoming nurse, nursing supervisor (NS), DON, primary physician (PP) and/or Resident's responsible party (RP). LPN #6 did not initiate an investigation. The LNHA failed to ensure that: a resident with known history of NJ EX Order. 264b1 and frequently attempting to open the medication cart was monitored/supervised and failed to ensure the care plan was in place to address these behaviors, an incident or accident was reported immediately to the NS or the DON in accordance to the facility's reporting policy for incidents and accidents, a resident who was found NJ EX Order. 264b1 y NJ EX Order. 264b1 when NJ EX Order. 264b1 was assessed by a RN and the PP was notified about the resident's change in condition, a comprehensive incident investigation was initiated to ensure that all medications were secured and locked, and the Responsible Party (RP) was notified. The LNHA's also failed to ensure that adequate supervision was provided, consistently document/monitor resident behavior in the MR, implement the plan of care, to initiate an investigation to determine how Resident #7 obtained the NJ EX Order bottles of unknown supplements, posed a serious and immediate risk to the safety and well-being of all the residents in	F 835	abuse/neglect/ mistreatment, staff charting and documentation, comprehensive care plans, behavioral assessment and monitoring, accidents and incidents, and acute condition changes protocols to ensure they are being followed/implemented by staff. Quality Monitoring Chief Clinical Officer will review audit findings with Administrator monthly x6 months to assure completion and compliance. Administrator/Chief Clinical Officer/designee will bring results of their monthly meeting/audit reviews to the monthly Quality Assurance Performance Improvement meetings x6 months. Based on results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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F 835	Continued From page 56 the facility. This resulted in immediate jeopardy (IJ) situation which began on [NJ EX Order 264] The facility was notified of the IJ on [NJDLTSS Order #] This deficient practice has the potential to affect all 57 residents on the memory care unit/third floor/Maple unit as evidenced by the following: The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Clinical Nurse of Operation (CNO) were notified of the IJ and provided with the IJ template on [NJ EX Order 264] at 4:44 pm. The facility provided an acceptable removal plan which was verified on-site on [NJ EX Order #] during the survey. The facility implemented the Removal Plan which included but was not limited to; review of the policies and procedures for abuse, incidents/accidents and individualized behavior care plans, behavior monitoring for the Administrator and Administrative team. This deficient practice was identified for 4 of 11 residents (Resident #1, Resident #2, Resident #7, and Resident #8) and evidenced by the following: Ref Ftag 600 IJ Review of the "REPORTABLE EVENT RECORD/REPORT" (RERR), dated [NJ EX Order 264b1] at 3:05 pm, revealed a Resident-to-Resident Abuse incident involving Resident #1 and Resident #2 was reported to the New Jersey Department of Health (NJDOH) on [NJ EX Order 26] at 5:00 pm. Attached with the RERR was the investigation summary report (ISR). The ISR indicated that Resident #1 was ambulating when Resident #2 came toward Resident #1 and [NJ EX Order 264b] Resident #1's [NJ EX Order] [NJ EX Order 264b1], causing him/her to [NJ EX O] First aid was provided to Resident #1. The Nurse	F 835		

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

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 835	Continued From page 57	F 835		

practitioner (NP #1) immediately assessed Resident #1. Resident #1 was transferred to an ACH via 911 and admitted with an [redacted]. The ISR further indicated that Resident #2 remained NJ EX Order. 264b1 staff, and was kept away from other residents. Resident #2 was transferred to the ACH via 911 at approximately 4:15 pm.

1.) According to Admission Report (AR), Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: NJ EX Order. 264b1 .

The Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #1's [redacted] and the resident required supervision for Activities of Daily Living (ADLs).

A PN, dated [redacted] 3:51 pm, documented by Nurse Practitioner (NP #1) indicated that she responded to a call from [redacted] unit. When she arrived in the unit, Resident #1 was found on the floor in a [redacted], the resident [redacted] and [redacted] her/his [redacted]. She further indicated that the staff reported that Resident #1 was [redacted] in the hallway when Resident #2 randomly [redacted] Resident #1 causing Resident #1 to [redacted] to the floor. Resident #1 was observed to have NJ EX Order. 264b1 to the [redacted] NJ EX Order. 264b1 [redacted]r. Staff was able to stop the [redacted] and [redacted] Resident #1 to a [redacted] position. Staff applied NJ EX Order. 264b1 per minute ([redacted]), vital signs were: Pulse of [redacted] beats per minute (bpm), respiration of [redacted] bpm, blood pressure of [redacted] and oxygen saturation

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 02/07/2023

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 835	Continued From page 58	F 835		

was NJ EX Or percent. NP #1 further indicated that Resident #1 had an NJ EX Order. 264b1 after the NJ EX to the floor and a brief NJ EX Order. 26 NJ EX Order. 264b1.

1a.) According to AR, Resident #2 was admitted to the facility on NJ EX Order., with diagnoses which included but were not limited to: NJ EX Order. 264b1 .

The MDS dated NJ EX Order. 264b, revealed that Resident #2 had a BIMS score of NJ EX Or, indicating Resident #2's cognition was NJ EX Order. 264b1 and the resident required supervision for ADLs.

The CP, dated NJ EX Order. 26 revealed that Resident #2 presented with a NJ EX Order. 264b1 to recent NJ EX Order. 264b n to the facility as well as overall condition. Interventions included but not limited to: Monitor and record NJ EX Order. to determine if problems seem to be related to NJ EX Order. 264b1. The CP further revealed that Resident #2 had potential for side effects related to NJ EX Order. 264b1 drug use of NJ EX Order and NJ EX Order. 264b1 for NJ EX Order. 264b1 and NJ EX Order. 264b1. NJ EX (EX Order. 264b1 NJ EX (EX Order. Resident #2's CP was initiated for NJ EX Order. 264b1. Interventions were to "Administer antibiotics as ordered...Educate (patient/family) on handwashing...On going communication with infection control nurse...strict handwashing ..."

Review of a facility PN, dated NJ EX Order. 3 at 7:25 pm, by the Telehealth Nurse Practitioner (TNP #1) revealed the following: Resident #2 had "Change in Condition...Resident became NJ EX Order. 264b1 NJ EX Order. 264b1 and others...Onset: few minutes ago. NJ EX Order. 264b1 in

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 02/07/2023

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 835	Continued From page 59	F 835		

other pt's [patient's] room, became [redacted] at everybody and other residents, [redacted] and [redacted] and not able to contain [Resident #2]. Nurse says sometimes [redacted] but 'never like this'. Nurse says [Resident #2] tried to hurt others physically...ASSESSMENT/DIAGNOSIS: [redacted] ...General Assessment/Diagnosis Plan Notes:-[redacted] eval in ER [emergency room]; 1:1 monitoring until EMS arrives for transport..."

Review of a facility PN, dated [redacted] at 8:00 pm, Registered Nurse (RN #1) documented "&;20pm [7:20] call from [redacted] floor for an emergency. When I arrived pt [patient] was [redacted]. We attempted to calm pt [patient] down. Hit this writer in head with a full water bottle. All residents placed in their room with doors closed. pt [patient] attempting to get into rooms and screaming [redacted] Call placed to 911, telehealth made aware we were sending [gender for a[redacted] eval at [hospital emergency room]. [Family members] came and [family members] were placed in the day room with the doors closed. Pt [Patient] calmed down with them here. Call placed to [hospital emergency room]. Police and ambulance transported [gender] to [hospital]".

Review of the CP did not include any indication that interventions were implemented to address the [redacted] behavior displayed on [redacted]

Review of the HR, psychiatry consult, dated [redacted] at 2:54 pm, revealed that Resident #2 "was brought in the ED [emergency department]

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 02/07/2023

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 835		F 835		

Continued From page 60

for NJ EX Order. 264b1, [gender] has been a resident at [facility] since NJ EX Order. 26 , reportedly [gender] has been having NJ EX Order. 264b1 t, according to staffs [gender] has frequent NJ EX Order. 264b1 ."

The "Order Summary Report (OSR), dated NJ EX Order. 26 , reflected that the NJ EX Order. 264b1 milligram (mg), give NJ E milliliter (ml) was increased from every NJ EX hours to every NJ hours for NJ EX Order. 264b1 NJ EX Order. 264b1 .

There was no indication in the MR that NJ EX Order. 264b1 monitoring was initiated when the medication was changed on NJ EX Order. 26 .

Review of the "TASK" form for the month of NJ EX Order. 2 indicated that CNAs were to monitor Resident #2's NJ EX Order. 264b1 every shift. The TASK form for monitoring was not signed/initialed as completed on the following dates and shifts after Resident #2 returned from the hospital: 1/13/23, 1/14/23, 1/15/23 during the shift of 7:00 am to 3:00 pm on, 1/13/23, 1/14/23, and 1/15/23 during the shift 3:00 pm to 11:00 pm, and 1/13/23 during 11:00 pm to 7:00 am which was not according to the "Charting and Documentation" policy.

On NJ EX Order. 26 at 3:15, unit manager LPN (UM/LPN #3), who was the nurse for Resident #2 on NJ EX Order. 26 documented that at 2:30 pm Resident #2 was in his/her room, at 3:05 pm, another resident was walking down the hallway when Resident #2 NJ EX Order. 264 the resident causing Resident #1 NJ EX to the ground and sustained an NJ EX Order. 264b1 the NJ EX Order. 264b1 NJ EX Order. 264b1 .

On NJ EX Order. 26 at 4:53 pm, Nurse Practitioner (NP #1) documented "Called to NJ EX Order floor stat.

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 02/07/2023

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 835	Continued From page 61	F 835		

Patient seen on bed with 2-3 staff members monitoring and maintaining [redacted] position and location in the room after [redacted] randomly [redacted] another resident. [Resident #2] appears [redacted] and restless but otherwise appears medically stable. Of note, patient just returned from the hospital on [redacted] s/p [status post] [redacted] eval for similar [redacted] behaviors. [Resident #2] was treated for UTI and completes oral [redacted] therapy] tomorrow". NP #1 further documented that her "Impression/Plan: Patient with [redacted] towards staff and another resident. Day #4/5 [redacted] in progress. ER [emergency room] for [redacted] and medical evaluation and treatment."

Further review of Resident #2's medical record (MR) revealed there was no documented evidence that Resident #2's behavior was being monitored consistently after the incident on [redacted] when there was a change in condition or when the medication, [redacted] was changed on [redacted] 3.

During the tour, the surveyor conducted an interview with residents who were [redacted] On [redacted] at 12:59 pm Resident #5 stated that Resident #2 was a [redacted], he/she walked around the unit and entered other resident's room, Resident #2 would [redacted] on other residents' [redacted] and staff would just redirect him/her. Resident #2 [redacted] staff and other residents for no reason including him/her. Resident #5 further stated that Resident #2 also [redacted] at one point (unable to recall time and date). Resident #5 revealed that he/she did not report the incident to the facility because the staff were aware of the resident's behavior.

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 02/07/2023

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 835	Continued From page 62 During an interview with the surveyor on 1/20/23 at 12:45 pm. Resident #6 stated that resident #2 walked around the unit, he/she would go into other residents' room and [redacted] on other residents' [redacted], he/she "NJ EX Order. 264b1 staff and other residents when [he/she] does not get what [he/she] wants". Resident #6 stated, approximately 2-3 weeks ago between 2:30 pm to 3:30 pm, Resident #2 entered Resident #6's room, Resident #6 asked Resident #2 to leave the room, Resident #2 [redacted] Resident #6's [redacted] and walked out of the room. Resident #6 stated that he/she never reported the incident to the facility because this was a resident's [redacted] and that the staff were aware of his/her behavior. The surveyor conducted an interview with CNA #1 on 1/20/23 at 9:27 am. The CNA stated that she documented the residents' behavior in the Kiosks (kiosk or mobile devices that enables care staff to document activities of daily living at or near the point of care to help improve accuracy and timeliness of documentation). She stated that not all residents were being monitored, only those residents that appear in the Kiosks. She explained that a questionnaire would appear, and CNAs had to indicate if behavior occurred by answering "Y for yes and N for no". She also explained that the Kiosks had to be answered and cannot be left blank to indicate that the behavior was being monitored. The surveyor conducted an interview with CNA #2 on 1/20/23 at 2:00 pm. The CNA stated that she documents residents' behavior in the Kiosks but not for all residents, only when being asked in the Kiosks. She explained that a questionnaire will	F 835		

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 02/07/2023

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 835	Continued From page 63	F 835		

appear, and the CNA had to indicate if behavior occurred by answering "Y for yes and N for no". She stated that sometimes she documents in the Kiosks and at times she forgets or had no time to sign the Kiosks.

The surveyor conducted an interview with the UM/LPN #3 on 2/7/23 at 11:07 am. The LPN stated that CNAs should document the task provided at the end of the shift and unit managers should ensure that the CNAs document to indicate that the care was provided to the residents. However, the LPN was unable to explain why the CNAs were unable to complete their documentations.

The surveyor conducted the interview with the DON on 1/20/23, 1/23/23, and 1/27/23. The DON stated that Resident #2's CP was updated for [redacted] management on return from the hospital on [redacted]. However, the CP for Resident #2's behavior that happened on [redacted] was not created because the residents' behavior was related to the diagnosis of [redacted]. The DON also stated that if there was a change in medications, staff should monitor and document resident's behavior for [redacted] days, every shift, in the MR whether the resident's had a behavior or not. The DON was unable to provide a consistent monitoring documentation when the resident's medications were changed on [redacted].

During an interview with the surveyor on 1/20/23 at 9:00 am, UM/LPN #3 stated that the nurses are only to document residents' behavior in the residents MR when a behavior occurred. He further stated that nurses are not required to document in the MR if the resident had no behavior. He explained that they have no

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 02/07/2023

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 835	Continued From page 64	F 835		

documentation indicating that the residents' behaviors were being monitored every shift consistently. However, on [redacted] at 11:36 am, the LPN stated that when there is a change in condition such as a change in medication or having [redacted] behaviors, the staff had to monitor the resident and document in the resident's MR. He further added that documentation is important to see if a new intervention is effective or not and to show that the intervention is being implemented and it is part of communication. UM/LPN #3 was not able to explain why Resident #2's behavior documentation was not done.

During an interview with the surveyor on 1/27/23 at 9:15 am, UM/LPN #3 stated that the CP is a way of communication, as it summarizes the residents overall care, and should be individualized and patient centered. The CP had to be updated by the unit managers (UM), Supervisor, and DON within 48 hours for any change in condition including but not limited to, a fall, any incident, altercation, skin tear, or behavior. He further stated that it is important to update the CP to give proper care and to prevent from any recurrence. UM/LPN #3 explained that Resident #2's CP should have been updated for behaviors and medication change on return from the hospital on [redacted] LPN was not able to provide an updated CP to address the resident behavior on [redacted].

2.) During the survey on 1/23/23, the surveyor reviewed the facility's reportable event records for the past 3 months. The surveyor reviewed the RERR dated [redacted] involving Resident #7 and Resident #8. The RERR revealed that a [redacted] was reported to 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 02/07/2023

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 835	Continued From page 65	F 835		

NJDOH on [redacted]. The attached summary indicated that on [redacted] at approximately 2:00 pm, the staff witnessed Resident #7 not allowing Resident #8 to enter their room. Resident #7 pushed Resident #8 and in return, [redacted]t Resident #7 in the [redacted] They were separated and neither resident sustained injury. Resident #8 was offered a room change, Resident #8 declined, and the family did not like the room. It further indicated that "the facility would actively work on other room options that would be appropriate". The conclusion indicated, "this appears to be an isolated event. The residents have been roommates for a few months and have had no issues up until now. The room changes will be done as a precaution".

On 1/25/23, another resident-to-resident abuse/physical altercation involving Resident #7 and Resident #8 was reported to the NJDOH. During the survey on 1/27/23, the surveyor reviewed the facility's RERR. Review of the RERR revealed that on [redacted] at approximately 11:00 am, staff at the nursing station heard Resident #7 [redacted]. When staff responded, Resident #7, while exiting the room, stated that Resident #8 hit his/her [redacted]. The incident was unwitnessed. Resident #7 was unable to provide context, and Resident #8 asked the staff to leave the room. Neither resident had injury, redness, or bruise. The interventions implemented after the incident included: Resident #8's room will be changed. Both resident's behavior will be monitored and referred for [redacted] evaluation. It further indicated that this was the second minor incident between the resident. Both residents are ambulatory with [redacted] and getting them out of each other's proximity should manage the behavior.

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 02/07/2023

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 835	Continued From page 66 2a). Resident #7 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: NJ EX Order. 264b1 [redacted]. The MDS dated [redacted] and [redacted] revealed a BIMS score of [redacted] which indicated [redacted] status, and the Resident was independent and required minimal supervision with ADLs. The MDS indicated that Resident #7 exhibited NJ EX Order. 264b1 symptoms directed toward others (e.g. [redacted] to [redacted] days during the [redacted] days, counting back from [redacted]. The Medication Administration Record (MAR) revealed that Resident #7 received [redacted] for [redacted] from NJ EX Order. 264b1. Additionally, the medication [redacted] for [redacted] ia with NJ EX Order. 264b1 was started on [redacted] and the dosage was increased on [redacted] and [redacted]. Review of the PN revealed no documented evidence that the nurses consistently monitor Resident #7's behavior after the [redacted] was increased on [redacted] and [redacted] when it was indicated in the facility's policy that if a resident is being treated for NJ EX Order. 264b1 or [redacted] the staff will document ongoing reassessments of changes (positive or negative). Furthermore, the PN revealed documentation dated [redacted] at 2:15 pm about Resident #7 and Resident #8 [redacted] ercation. The residents were separated and assessed. The event was reported to the DON, Administrator, and	F 835		

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 02/07/2023

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 835	Continued From page 67	F 835		

Assistance Administrator. On that same date at 2:53 pm, the SW notified the RP and agreed to move Resident #8 to another room. The PN revealed no documented evidence that the nurses consistently monitored Resident #7's behavior after the NJ EX Order. 264b1

The revised care plan dated NJ EX Order. 264b1 revealed that Resident #7 is possessive of his/her room and does not want people to enter. Goals and interventions included but were not limited to: Resident will not NJ EX Order. 264b1 s; resident will verbalize understanding of the NJ EX Order. 264b1 when the resident becomes NJ EX Order. 264b1, intervene before NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1, if the response is NJ EX Order. 264b1, staff to walk calmly away and approach later.

The care plan indicated that Resident #7, who had NJ EX Order. 264b1 and a diagnosis of NJ EX Order. 264b1 would verbalize understanding of the need to NJ EX Order. 264b1 . However, there was no indication in the CP how Resident #7 would be monitored while in the room with the roommate (Resident #8) where the NJ EX Order. 264b1 occurred. The facility's policy for behavior management indicate that interventions and approaches will be based on detailed assessment of physical, psychological and behavioral symptoms as well as the potential situational and environmental reasons. Additionally, the policy included that the care plan will include but was not limited to targeted and individualized interventions for the behavioral symptoms, specific, measurable goals for the targeted behavior and how the staff will monitor for effectiveness of the interventions.

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 02/07/2023

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 835		F 835		

Continued From page 68

The PN revealed that on NJ EX Order. 264b at 10:55 am, the UM/LPN #3 documented that Resident #7 and Resident #8 had another NJ EX Order. 264b1 in the room and unwitnessed.

During an interview with the DON on 1/27/23 at NJ EX Order. 264b1

NJ EX Order. 264b was considered a minor and isolated incident and Resident #8 refused to transfer to another room.

Review of the task form for the month of 11/2022 indicated that CNAs were to monitor for behavior symptoms every shift which included but were not limited to NJ EX Order. 264b1 Resident #7's task form was not signed/initialed for the following dates and shifts: 7:00 am to 3:00 pm on 11/1/22, 11/3/22 to 11/6/22, 11/8/22, 11/9/22, 11/19/22, 11/20/22, and 11/23/22; 3:00 pm to 11:00 pm on 11/4/22, 11/12/22, 11/13/22, 11/21/22, 11/22/22, 11/24/22, and 11/26/22; and 11:00 pm to 7:00 am on 11/2/22 to 11/14/22, 11/16/22, 11/18/22, 11/20/22 to 11/22/22, 11/25/22, and 11/27/22 to 11/29/22.

For the month of 1/2023 for the following dates and shifts: 7:00 am to 3:00 pm on 1/3/23, 1/8/23, 1/12/23, 1/14/23, 1/15/23, and 1/21/23; 3:00 pm

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 02/07/2023

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 835	Continued From page 69	F 835		

to 11:00 pm on 1/1/23, 1/7/23, 1/8/23, 1/15/23, 1/21/23, 1/23/23 and 1/26/23; 11:00 pm to 7:00 am on 1/2/23, 1/7/23 to 1/9/23, 1/13/23, 1/19/23, and 1/21/23 to 1/23/23.

During an interview with CNA #1 on 1/23/23 at 11:01 am, she stated that CNAs are expected to monitor residents' behavior and document in the kiosk, ADL records task for behavior monitoring. She further said that CNAs are responsible for completing the task at the end of the shift and if incomplete or blank, it did not happen.

During an interview with the DON on 1/27/23 at 12:57 pm, she stated that CNAs document resident's behavior in the kiosk or ADL record. She further stated that CNA observations and documentations are considered valuable they do not replace nurses observation and documentation.

2b. According to the AR, Resident #8 was admitted to the facility on [redacted] 2 with diagnoses that included but were not limited to: [redacted] NJ EX Order. 264b1.

The MDS dated [redacted] and [redacted] revealed a BIMS score of [redacted], which indicated [redacted] status, and the Resident required supervision to minimal assistance with ADLs.

The nursing PN dated [redacted] at 1:04 pm indicated that Resident #8 "was [redacted] s. Resident [redacted] around the [redacted] and [redacted] of other residents' rooms. NJ EX Order. 264b1." The nursing PN dated [redacted] at 8:30 pm indicated that Resident #7 "was NJ EX Order. 264b1

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 02/07/2023

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 835		F 835		

Continued From page 70

NJ EX Order. 264 to staff and residents". The Resident was not easily redirected but finally agreed to go to bed.

The CP initiated on NJ EX Order. 264b indicated that Resident #8 may present with a NJ EX Order. 264b1 related to his/her recent admission to the facility and his/her overall condition. Goals and interventions included but were not limited to: Resident #8 will have improved NJ EX Order. 264b1, such as being happier, having a NJ EX Order. 264b1, and showing no signs and symptoms of NJ EX Order. 264b1. Behavioral Health consults as needed. Monitor/document as needed risk for NJ EX Order. 264b1: NJ EX Order. 264b1 or NJ EX Order. 264b1

Monitor/record/report to MD (Medical Doctor) as needed risk for NJ EX Order. 264b1, increased NJ EX Order. 2 others or NJ EX Order. 264b1

Review of the PN revealed documentation by the Social Worker (SW) on NJ EX Order. 26 2 at 10:32 am that Resident #8 was transferred to another room because of incompatibility with the roommate (Resident #7). The RP was made aware of the room change and staff to monitor the adjustment. However, the PN revealed no indication that the room change occurred or Resident #8 was monitored by the nurses for adjustment after the room change. Additionally, there was no documented evidence in the PN explaining what led to the room change.

Further review of the PN revealed documentation dated NJ EX Order. 264b at 2:15 pm that Resident #7 and Resident #8 had a NJ EX Order. 264b1. They were

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 02/07/2023

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 835	Continued From page 71	F 835		

separated and assessed. The event was reported to the DON, Administrator, and Assistance Administrator. On that same date at 2:53 pm, the SW notified the RP and agreed to move Resident #8 to another room.

Review of the MR on [redacted] revealed no documented evidence that the nurses consistently monitored Resident #8 for safety after the NJ EX Order. 264b1 on [redacted]. In addition, there was no documented evidence that Resident #8 was offered another room change after the resident refused on [redacted] when it was indicated in the RERR summary that the facility staff would actively work on room change options.

Review of the PN on [redacted] revealed documentation on [redacted] at 10:55 am about another physical altercation between Resident #7 and Resident #8. The PN indicated that Resident #7 and Resident #8 who had a [redacted] continued to share the same room until another NJ EX Order. 264b1 [redacted] on [redacted]

During an interview with the SW on 2/7/23 at 11:30 am, she stated that Resident #8 was transferred to another room after the [redacted] The resident's RP had agreed to the room change but the resident would not stay in the new room, so he/she remained in the same room with Resident #7. The SW confirmed that Resident #8 transferred again to another room after the NJ EX Order. 264b1, and Resident #8 had adjusted well to the new room. However, she could not explain why the room change was not attempted again as a precaution when it was indicated in the RERR summary on

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 02/07/2023

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 835	Continued From page 72	F 835		

NJ EX Order. 264b2 that the facility would actively work on other room options that would be appropriate. Additionally, she could not explain what led to the room change on NJ EX Order. 264b2 but stated that Resident #7 was very territorial and due to incompatibility

During an interview with the surveyor on 1/23/23 at 11:36 am, LPN #3, unit manager (UM) for Resident #7, could not remember a room transfer for Resident #8 on NJ EX Order. 264b2.

The revised care plan dated NJ EX Order. 264b for Resident #8 revealed that Resident #8 is at risk for NJ EX Order. 264b1 from or with a resident on the unit who has demonstrated NJ EX Ord [redacted]. Goals and interventions included but were not limited to: Resident #8 will be free from NJ EX Order. 264b1 [redacted] behavior documentation and NJ EX Order. 264b1 evaluation as needed; maintain a safe distance from the other NJ EX Order. 264b1 residents; monitor Resident #8 whereabouts for safe interactions with peers.

A review of the MR on 1/23/23 revealed no documented evidence that the nursing staff consistently monitored Resident #8 behaviors, interactions with other residents, and whereabouts as indicated in the revised care plan on 11/11/23.

Review of the task form for the month of 11/2022 indicated that the following dates and shifts were not signed/initialed: 7:00 am to 3:00 pm 11/3/22 to 11/24/22 and 11/26/22 to 11/30/22; 3:00 pm to 11:00 pm on 11/1/22 to 11/3/22, 11/7/22, 11/11/22, 11/12/22, 11/13/22, 11/21/22, 11/24/22 and 11/26/22, and 11:00 pm to 7:00 am on 11/1/22 to

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 02/07/2023

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 835	Continued From page 73	F 835		

11/5/22, 11/7/22 to 11/12/22, 11/14/22, 11/16/22, 11/18/22 to 11/25/22, and 11/27/22 to 11/30/22.

For the month of 1/2023 for the following dates and shifts: 7:00 am to 3:00 pm on 1/2/23, 1/3/23, 1/5/23 to 1/8/23, 1/10/23 to 1/12/23, and 1/15/23 to 1/26/23; 3:00 pm to 11:00 pm on 1/2/23, 1/4/23, 1/7/23 to 1/10/23, 1/13/23, 1/15/23, 1/17/23, 1/18/23, 1/21/23, 1/22/23, 1/24/23, and 1/26/23; and 11:00 pm to 7:00 am on 1/2/23, 1/7/23 to 1/9/23, 1/13/23, 1/19/23, and 1/21/23 to 1/23/23.

During an interview with CNA #1 on 1/23/23 at 11:01 am, she stated that Residents #7 and #8 were roommates. They would sometimes be [redacted] but usually [redacted]. If the residents engage in an altercation, either one will [redacted]. CNA #1 explained that Resident #8 was transferred to another room sometime last year, but it was unsuccessful, so the residents' remained roommates. CNA #1 further explained that she did not witness the [redacted] on [redacted] but heard about it. She added that nurses and CNAs monitor the residents' behavior, and CNAs report observed behaviors to the nurses.

During an interview with LPN #9 on 1/23/23 at 1:34 pm, she stated that residents' behavior should be monitored every shift for [redacted] days for changes in medications for behavior and when an incident happened due to behavior. She explained that it is important to document resident's behavior in the PN even when there was no behavior because it shows that the observation happened. The surveyor asked if Residents #7 and #8 were monitored for behavior and whereabouts after the incident on [redacted]. LPN #9 was unsure but stated that nurses and

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 02/07/2023

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 835	Continued From page 74	F 835		

CNAs supervise all residents. She agreed that if the behavior and whereabouts were not documented in the resident's MR, it did not happen.

During an interview with the UM/LPN #3, he stated that Resident #7 and Resident #8 do not get along sometimes. He explained that Resident #7 and Resident #8 never had an altercation again after [redacted] incident and could not confirm if another room change was attempted again. The surveyor asked when staff monitor residents for behavior. The UM/LPN #3 stated that residents must be monitored for behavior every shift for [redacted] days after an altercation and changes in psychotropic medications, even if no behavior was observed. He agreed that if the observation was not documented in the MR, it did not happen.

During an interview with the surveyor on 1/23/23 at 2:24 pm, the Nursing Supervisor (NS) RN #2 stated that residents must be monitored for behavior every shift for [redacted] days after changes in psychotropic medication to monitor the effectiveness of the medication.

During an interview with the DON on 1/23/23 at 12:57 pm and 3:50 pm, and 1/27/23 at 4:10 pm, she stated that nursing staff are expected to document observation of resident's behavior in the MR every shift for [redacted] days when there's new or changes in psychotropic medications and after an altercation. The nurses must document when residents are not displaying behaviors to show that residents are being monitored and to determine the effectiveness of the medication change. She added that behavior monitoring is a protocol that requires no doctor's order. The DON

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 02/07/2023

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 835	Continued From page 75	F 835		

could not explain why there was no consistent documentation in the MR that Resident #7 and Resident #8 were monitored after the NJ EX Order. 264b1 2 or after Resident #7 had a NJ EX Order. 264b1 medication change on 10/14 and NJ EX Order. 264b1. However, she stated that the nurses should have documented behavior observations and confirmed that if it was not documented, it did not happen.

The surveyor asked the DON if Resident #8 was referred to the NJ EX Order. 264b1 for evaluation after the NJ EX Order. 264b1 altercation on NJ EX Order. 264b1. The DON stated that Resident #8 had adjusted well to the facility, and there was no need to refer every resident with a history of NJ EX Order. 264b1 from the hospital. The surveyor asked if the care plan for Resident #7 and Resident #8 should address the a NJ EX Order. 264b1 specifically since they were roommates and the altercation occurred inside the room. The DON stated, "I don't know how to answer that," care plans are discussed in the morning meeting with the team.

The surveyor asked the DON if Resident #7 was offered a room change after the altercation on NJ EX Order. 264b1. The DON stated that Resident #7 was not a candidate for a room change due to prior history. In addition, the DON stated that a room change was not attempted again for Resident #8 despite having it documented that the facility would actively work on room change options as a planned intervention when the resident had NJ EX Order. 264b1 on NJ EX Order. 264b1, because the residents' room was next to the nurse's station where they can be monitored, and the residents did not have an altercation since. However, it was not confirmed during the interview that both residents

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 02/07/2023

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 835	Continued From page 76	F 835		

were consistently monitored despite the room being next to the nurse's station since there was no consistent documentation in the PN to indicate that it was done. The DON confirmed if there was no documentation of behavior observation or monitoring in the PN, it did not occur.

During an interview with the surveyor on 1/27/23 at 1:55 pm, the Administrator stated that incidents, accidents, and abuse must be reported by the nursing staff immediately, and it goes through a chain of command. For emergencies, staff must inform the DON or the Administrator immediately. The Administration stated that the DON reports to him, but the DON would lead the investigation. The surveyor asked if he was informed of the abovementioned physical altercation incident on [redacted]. He stated he was unsure of the specifics of the actual event. The surveyor explained the details of the incident to the Administrator and then said he would have to look, but in general, room change would be attempted. The Administrator could not confirm if the room change occurred but stated that, in general, a room change should be offered after an altercation.

Ref Ftag 689

3.) According to the Admission Record (AR), Resident #7 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted].

The Minimum Data Set (MDS), an assessment tool dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated

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 02/07/2023

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 835		F 835		

Continued From page 77

a NJ EX Order. 264b1 status and the resident required minimal supervision with Activities of Daily Living (ADL). The MDS indicated that Resident #7 exhibited NJ EX Order. 264b1 directed toward others (e.g., NJ EX Order. 264b1 days during the NJ E days, counting back from NJ EX Order. 264b

A review of the nursing progress notes (PN) revealed the following documentation: on NJ EX Ex Order. at 10:10 PM, Licensed Practical Nurse (LPN) #6 documented that Resident #7 tried opening the nurse's medication cart. On 1 NJ EX Order. 26 at 3:32 PM, LPN #8 documented that Resident #7 was very NJ EX Order. 264b1, trying to pull medications from the medication cart several times. On NJ EX Order. 264b1 at 11:01 PM, LPN #5, documented "despite all due medications given, the Resident kept asking for more and tried to open the medication cart." Additionally, the PN revealed the Resident attempted to open the medication cart on NJ EX Order. 264b1, NJNJ EX Order. 26, and tried to enter the medication room on NJ EX Order. 264b1. There was no indication in the MR that the abovementioned recurring behavior of Resident #7 was addressed in the care plan.

On 12/6/22 at 10:32 PM, LPN #6 documented the following in the PN: Resident #7 was in bed sleeping, NJ EX Order. 264b1 Licensed practical nurse (LPN) #6 and LPN #5 "found NJ EX Order bottles of supplements, supplements were removed" and educated the Resident who had a NJ EX Order. 2 not to keep medication in his/her room for safety. LPN #6 took the Resident's vital sign (VS) and recorded them in VS section of the MR. There was no documented

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 02/07/2023

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 835	Continued From page 78	F 835		

evidence in the PN that the medication cart was locked at the time of the incident, that an investigation was initiated to ensure that all medication carts and medication room on the unit were secured and locked and determine how the unknown supplements were obtained, that an RN conducted a comprehensive assessment, that the NS or the DON was notified, that the PP or RP was notified, or the care plan was updated. Furthermore, there was no indication in the PN that the LPN provided continued observation of Resident #7 after the incident.

The Physician's Order Summary Report (OSR) reflected that Resident #7 was receiving the following supplements: NJ EX Order. 264b1 NJ EX Order. 264b1 [redacted]

A review of the care plan (CP) with a revision date [redacted] indicated the resident "may do one the following, if it is not a problem for the resident, do not be concerned with: NJ EX Order. 264b1 [redacted]" Goals and interventions included but were not limited to: Resident will display positive behaviors and have decreased episodes of NJ EX Order. 264b1; Assess [redacted] and NJ EX Order. 264b1; Leave alone in a safe environment such as his/her room; Have NJ EX Order. 264b1 evaluate as needed and routinely". The CP did not reflect interventions of Resident #7's recurring behavior of attempting to open the medication cart or enter the medication room when it was initially documented on [redacted]

The PN reflected that a quarterly interdisciplinary care plan meeting (IDCP) was held on [redacted] and it was documented that the "care plans have

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 02/07/2023

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 835	Continued From page 79	F 835		

been reviewed and are up to date." However, the abovementioned behavior was not addressed in the care plan until [redacted].

Review of the summary on the incident dated [redacted] with the DON's name stamp, unsigned, provided to the surveyor via email on [redacted] indicated the following: On 1[redacted] this writer was made aware that on [redacted] nurse, LPN #6 discovered [redacted] bottles of supplements in a drawer of Resident #7. On [redacted], Resident #7's belongings were immediately checked, and no supplements of any kind were found. LPN #6 was interviewed and confirmed that she looked at the resident's drawer because the resident seemed [redacted] and found the supplements, one was NJ EX Order. 264b1 and could not recall the others. Review of the resident's chart confirm that the vital signs were normal. The NS confirmed that she was not notified of the incident. The DON made the RP aware of the incident and the RP was not aware where the supplements came from. The DON asked Resident #7 who could not recall where the supplements came from. There was no documented conclusion, but it was indicated that it was unclear how the supplements arrived in Resident #7's drawer on [redacted].

The surveyor reviewed the document "Full QA Report" Incident date/time: NJ EX Order. 264b1 5:00 PM forwarded by the DON post survey on 2/10/23. It was indicated on the form that LPN #6 was the assigned care giver and LPN #5 was the witness. The location of the incident was at the resident's room. There was no injury noted. Additionally, the form indicated that there was no staff interview and detail of the incident was not documented. The form indicated that 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 02/07/2023

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 835	Continued From page 80	F 835		

Administrator and DON were not notified of the incident until 1[redacted]

The surveyor reviewed LPN #6 signed written witness statement dated [redacted] forwarded by the DON post survey on 2/10/23. LPN #6 indicated that Resident #7 was [redacted] around 5PM but the resident usually [redacted] on the unit. Due to this, she "awoke" the resident and took his/her VS because Resident #7 was [redacted]. LPN #6 indicated that she "checked the resident's drawer and found supplements such as NJ EX Order. 264b1 and two others". "She could not recall. She removed them and put them in the cart."

The surveyor reviewed LPN #5's signed and undated written witness statement, forwarded by the DON post survey on 2/10/23. LPN #5 wrote that LPN #6 asked her to check Resident #7's room because "she thinks Resident #7 took something from the med carts." LPN #5 indicated "nurse searched the room and found bottles of supplements in the drawer." The Resident was NJ EX Order. 264b1 and [redacted] on the unit. There was documentation in the MR indicating the Resident #7 was NJ EX Order. 264b1 in the unit. The document did not indicate that an RN assessed Resident #7, that the LPNs started an incident report, and the RP and PP were notified.

There was no statement documented from the 11-7 shift assigned nurse on [redacted]

The surveyor was unable to interview the 11-7 shift assigned nurse on 1[redacted]

On 1/23/22 at 1:20 PM, Resident #7 refused an interview with the surveyor.

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 02/07/2023

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 835	Continued From page 81 During a telephone interview with the surveyor on 1/23/23 at 2:01 PM, LPN #6 stated that on [redacted], during her medication pass at approximately 5:00 PM, Resident #7 was not wandering out of the room, which she stated was unusual. Because of that, she decided to check on the resident with LPN #5. Resident #7 was found in bed[redacted], [redacted], and [redacted], and for that reason, she searched the room. While searching, LPN #6 found [redacted] bottles of supplements" in the resident's nightstand drawer. LPN #6 explained that she took the Resident's VS, which she stated was normal, and placed the supplements in the medication cart. She said that Resident #7 was not assessed by a RN. She further explained that she left the supplements in the medication cart for the night shift but was unable to confirm that incident was reported to the oncoming nurse. LPN #6 could not confirm if she reported the incident to the NS or the DON and could not answer when the surveyor asked why the supplements were not given to the supervisor at the time when she reported the incident. Additionally, LPN #6 stated that she could not recall the name of the supplements. LPN #6 further stated that Resident #7 had tried opening the medication cart before, but it was locked. It was confirmed during the interview that she did not initiate an investigation to determined how Resident #7 obtained the medications or if all the medication carts on the unit were secured and notify the PP or RP. However, she stated that nurses are responsible for informing the PP or RP of changes in condition, incident, accident, and initiating an incident report. LPN #6 acknowledged that she should have called the PP and started an incident report.	F 835		

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 02/07/2023

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 835	Continued From page 82	F 835		

During a telephone interview with the surveyor on 1/30/23 at 1:10 PM, LPN #5 stated that she was in the room when LPN #6 found bottles of supplements or medications in the nightstand drawer. LPN #5 could not recall how many bottles or the names of the medications, was unaware where LPN #6 placed them and was unsure if LPN #6's medication cart was locked at the time of incident. She was unsure if the incident was reported to the oncoming nurse but confirmed that she did not report the incident to the NS or the DON, notify the PP or RP or initiate an investigation as she was busy with her residents. LPN #5 stated that the incident should have been reported to the NS immediately to ensure the resident's safety.

During a telephone interview with the surveyor on 2/6/23 at 11:28 AM, the PP stated that she was unaware of the incident on [redacted] when Resident #7 was found [redacted] when [redacted] and at the same time bottles of unknown supplements/ medications were found in the resident's nightstand drawer. She explained that some residents can self-administer medications with the PP's order, but not Resident #7, due to his/her [redacted] status. She further explained that she expects nurses to call her for any incident or accidents and changes in resident's condition so that she can make appropriate clinical decisions. She added that Resident #7's nurse should have notified her about the [redacted] and the medications found in the resident's room, regardless of the type of medication.

During a telephone interview with the surveyor on 1/23/23 at 1:44 PM, Resident #7's RP stated that

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 02/07/2023

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 835	Continued From page 83	F 835		

he/she was not informed about the bottles of supplements or medication found in the Resident's nightstand drawer when the Resident was found [redacted] on [redacted]. The RP confirmed that he never brought any medications to the facility as it would be unsafe for Resident #7 to self-administer medications.

During an interview with the surveyor on 1/23/23 at 2:24 PM, RN #2, NS on [redacted] confirmed the abovementioned incident was not reported to her. She explained that nurses are responsible for notifying the NS or DON when incidents or accidents occur, calling the PP and RP for changes in condition, and initiating an incident report or investigation and stated that LPN #6 should have immediately reported the abovementioned incident to her.

During an interview with the surveyor on 1/23/23 at 11:36 AM and telephone interview on 2/10/23 at 10:24 AM, LPN #3 who was the unit manager (UM) for Resident #7, stated that he was unaware about the incident on [redacted] or Resident #7's abovementioned [redacted] behavior. He explained that nurses are responsible for initiating or updating care plans. However, not all nurses know how to create or update CP. Therefore, the UM is responsible for updating the care plans to ensure accuracy and appropriate interventions are in place. LPN #3 was unable to explain why the residents' behavior was not addressed in the CP but acknowledged that interventions should have been in place for the resident's safety.

During an interview with the surveyor on 1/23/23 at 3:50 PM, the DON stated that nurses did not notify her or the NS about the abovementioned incident that occurred on [redacted]. She explained

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 02/07/2023

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 835	Continued From page 84	F 835		

that nurses are expected to report any incident/accident to the NS and initiate an incident report immediately. Also, nurses are expected to notify the RP and PP of changes in condition and when an incident or accident occurs. The DON acknowledged that LPN #6 should have immediately reported the incident to the nursing supervisor and started an incident report/investigation.

During an interview with the surveyor on 1/27/23 at 1:55 PM, the Administrator stated that nursing staff must report incidents and accidents immediately to the supervisor unless it's an emergency then the DON or the Administrator must be notified immediately. The Administrator stated that he was unaware of the abovementioned incident. The surveyor asked if the incident was reported to him since the DON began the investigation on [redacted]. The surveyor explained the details of the incident to the Administrator then he stated that he would have to look because he was not sure of the specifics. The Administrator confirmed the nurse should have followed the protocol for incident and accidents which include reporting to the NS, and notification of PP and RP.

The job description for "Administrator", undated, indicated "The primary purpose of your job position is to direct the day-to-day functions at the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long term-care facilities to ensure that the highest degree of quality care can be provided to our residents at all times...As the Administrator, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your

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 02/07/2023

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 835	Continued From page 85	F 835		

assigned duties...Duties and Responsibilities Administrative Functions Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities. Develop and maintain written policies and procedure that govern the operation of the facility. Assist department directors in the development and use of departmental policies and procedures, establish a rapport in and among departments so that each can realize the importance of teamwork. Reviewed the facility's policies and procedures periodically, at least annually and make changes as necessary to assure continued compliance with current regulations...Interpret the facility's policies and procedures to employees, residents, family members, visitors, government agencies...as necessary. Assume that administrative authority, responsibility, and accountability of directing the activities and programs of the facility. Make routine inspections of the facility to ensure assure that stablished policies and procedures are being implemented and followed. Delegate administrative authority, responsibility, and accountability to other staff personnel as deemed necessary to perform their assigned duties. Consult with department directors concerning the operation of their departments to assist in eliminating/correcting problem areas, and /or improvement of services...Ensure that all residents receive care in a manner and in an environment, that maintains or enhances their quality of life without abridging the safety and rights of other residents. Ensure that each resident receives the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan..."

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	315214	A. BUILDING _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835	Continued From page 86	F 835		

Review of the facility policies titled:

"Abuse", dated 10/27/17, indicated under "...Prevention...The facility leadership will assess the needs of the residents in the facility to be able identify concerns in order to prevent potential abuse...RESIDENT ASSESSMENT The population of the facility includes individuals who meet the criteria for skilled care under the Medicaid and Medicare guidelines including specialty programs provided by the facility...Every resident is unique and may be subject to 'abuse' based on a variety of circumstances, including facility physical plant, environment, the resident's health, behavior or cognitive level...Staff supervision and ongoing monitoring are used to identify resident with a risk behavior...The interdisciplinary team will identify the vulnerabilities and interventions on the resident care plan...POPULATION...The facility will ensure a comprehensive dementia management program to prevent resdient [resident] abuse if applicable..."

"Accidents and Incidents" undated, under "Policy Interpretation and Implementation" indicated that 1. The Nurse Supervisor/Charge Nurse...shall promptly initiate and document investigation of the accident or incident. 2. shall be included in the report...a. the date and time...b. the nature of the injury...g. the date/time attending physician was notified as well as the time the physician responded...h. the date/time the family was notified and by whom...3. The Nurse Supervisor/Charge Nurse...shall complete a Report of Incident/Accident form and submit to the Director of Nursing Services within 24 hours...

"Acute Condition Changes - Clinical Protocol",

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 02/07/2023

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 835	Continued From page 87	F 835		

undated, revealed "ASSESSMENT AND RECOGNITION ...5 ... The nursing staff will contact the Physician...for emergencies, they will call or page the Physician and request a prompt response ...MONITORING AND FOLLOW-UP 1. The staff will monitor and document the resident's progress and response to treatment ..."

"Behavior Assessment and Monitoring" undated, indicated "POLICY STATEMENT Problematic behavior will be identified and managed appropriately ... Assessment ...2. The nursing staff will identify, document, and inform the physician about an individual's mental status, behavior, and cognition, including a. onset, duration, and frequency ... or changes in behavior, cognition, and mood...Monitoring 1. If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function..."

"Behavioral Assessment, Intervention and Monitoring" undated, indicated "POLICY STATEMENT 1. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment...Assessment 4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others...Management...Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying cases, as well as the potential situational and environmental reason for the behavior. The care plan will include, as a minimum: a. A Description of the behavioral symptoms including...Monitoring

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 02/07/2023

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 835	Continued From page 88	F 835		

1. If the resident is being treated for altered behavior or mood, the IDT [Interdisciplinary Team] will seek and document any improvements or worsening in the individual's behavior, mood, and function. 2. The IDT will monitor the progress of individuals with impaired cognition and behavior until stable...Interventions will be adjusted based on the impact on behavior..."

"Care Plans-Comprehensive", undated, indicated "An individualized, patient centered Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs in developed for each resident consistent with the Resident Rights ...Policy Interpretation and Implementation ...Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident...3. Each resident's comprehensive care plan has been designed to: a. Incorporate identified problem areas...d. Reflect treatment goals and objective and measurable outcomes...5. Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly...

"Charting and Documentation", undated, indicated "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record...All observations...services performed...must be documented in the resident's medical record..."

"RESIDENT ABUSE NEGLECT AND MISTREATMENT "THE LAW"", undated,

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 02/07/2023

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 835	Continued From page 89 indicated under "...Prevention...Aggressive care planning of all residents who have needs and/or behaviors that may trigger a negative reaction...psychiatric conditions with history of aggressive behaviors..."	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061216	A. BUILDING: _____ B. WING _____	C 02/07/2023

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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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00158022, NJ00160765 NJ00160791, NJ00160776 NJ00161009, NJ00161051 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was evidence by the following. shifts reviewed. 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 10 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	S 560	S560 Mandatory Access to Care Immediate Action Staffing coordinator was educated on New Jersey state certified nursing assistant staffing requirements. Recruitment and retention efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will use staffing agencies and offer additional shifts to current staff. Identification of Others Residents residing in the facility have the potential to be affected by this practice. Systemic changes Hiring/recruitment/engagement/retention efforts including pay for experience, online job listings, job fairs, shift differentials, incentives, and referral bonuses are being utilized to continue to be competitive in the marketplace. Focus on retention efforts include, but are not limited to incentive program, engagement program, retention program, career growth, educational training opportunities, and employee morale	3/28/23

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

Electronically Signed | 03/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061216	A. BUILDING: _____ B. WING _____	C 02/07/2023

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) COMPLETE DATE
S 560	Continued From page 1 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. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 5/8/22 to 5/14/22, 10/30/2022 to 11/12/2022, and 11/27/2022 to 22/04/2023, revealed the staffing to resident ratios did not meet the minimum requirement. The facility was deficient in CNA staffing for residents as follows: For the 2 weeks of 05/08/2022 to 05/14/2022, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -05/01/22 had 20 CNAs for 205 residents on the day shift, required 26 CNAs. -05/02/22 had 22 CNAs for 205 residents on the das shift, required 26 CNAs. -05/03/22 had 23 CNAs for 204 residents on the day shift, required 25 CNAs. -05/07/22 had 20 CNAs for 206 residents on the day shift, required 26 CNAs. -05/10/22 had 23 CNAs for 202 residents on the day shift, required 25 CNAs. -05/14/22 had 24 CNAs for 201 residents on the day shift, required 25 CNAs. For the 2 weeks of 10/30/2022 to 11/12/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/30/22 had 18 CNAs for 212 residents on the day shift, required 26 CNAs. -10/31/22 had 18 CNAs for 212 residents on the day shift, required 26 CNAs.	S 560	programs. The facility Administrator/designee will continue to document all recruitment and retention efforts weekly. Quality monitoring The Administrator/designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results of these reviews will be submitted to the Quality Assurance Performance Improvement Committee monthly x6 months. Based on the audit results, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061216	A. BUILDING: _____ B. WING _____	C 02/07/2023

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) COMPLETE DATE
S 560	Continued From page 2	S 560		

-11/01/22 had 18 CNAs for 212 residents on the day shift, required 26 CNAs.
-11/02/22 had 17 CNAs for 212 residents on the day shift, required 26 CNAs.
-11/03/22 had 20 CNAs for 215 residents on the day shift, required 27 CNAs.
-11/04/22 had 15 CNAs for 211 residents on the day shift, required 26 CNAs.
-11/05/22 had 15 CNAs for 211 residents on the day shift, required 26 CNAs.
-11/06/22 had 14 CNAs for 211 residents on the day shift, required 26 CNAs.
-11/07/22 had 20 CNAs for 211 residents on the day shift, required 26 CNAs.
-11/08/22 had 16 CNAs for 213 residents on the day shift, required 27 CNAs.
-11/09/22 had 20 CNAs for 213 residents on the day shift, required 27 CNAs.
-11/10/22 had 20 CNAs for 213 residents on the day shift, required 27 CNAs.
-11/11/22 had 20 CNAs for 213 residents on the day shift, required 27 CNAs.
-11/12/22 had 18 CNAs for 215 residents on the day shift, required 27 CNAs.

For the weeks of 11/27/2022 to 2/04/2023, the facility was deficient in CNA staffing for residents on 69 of 70 day shifts and deficient in total staff for residents on 3 of 70 overnight shifts as follows:
-11/27/22 had 17 CNAs for 214 residents on the day shift, required 27 CNAs.
-11/28/22 had 20 CNAs for 211 residents on the day shift, required 26 CNAs.
-11/29/22 had 20 CNAs for 208 residents on the day shift, required 26 CNAs.
-11/30/22 had 21 CNAs for 205 residents on the day shift, required 26 CNAs.
-12/01/22 had 18 CNAs for 205 residents on the day shift, required 26 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061216	A. BUILDING: _____ B. WING _____	C 02/07/2023

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) COMPLETE DATE
S 560	Continued From page 3	S 560		

-12/02/22 had 19 CNAs for 204 residents on the day shift, required 25 CNAs.
-12/03/22 had 18 CNAs for 204 residents on the day shift, required 25 CNAs.
-12/04/22 had 17 CNAs for 204 residents on the day shift, required 26 CNAs.
-12/05/22 had 20 CNAs for 204 residents on the day shift, required 26 CNAs.
-12/06/22 had 18 CNAs for 207 residents on the day shift, required 26 CNAs.
-12/07/22 had 23 CNAs for 207 residents on the day shift, required 26 CNAs.
-12/08/22 had 20 CNAs for 207 residents on the day shift, required 26 CNAs.
-12/09/22 had 22 CNAs for 217 residents on the day shift, required 27 CNAs.
-12/10/22 had 20 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/11/22 had 19 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/12/22 had 22 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/13/22 had 21 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/14/22 had 24 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/15/22 had 16 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/16/22 had 21 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/17/22 had 21 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/18/22 had 18 CNAs for 219 residents on the day shift, required 27 CNAs.
-12/19/22 had 26 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/20/22 had 20 CNAs for 216 residents on the day shift, required 27 CNAs.
-12/21/22 had 23 CNAs for 216 residents on the day shift, required 27 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061216	A. BUILDING: _____ B. WING _____	C 02/07/2023

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) COMPLETE DATE
S 560	Continued From page 4 -12/22/22 had 19 CNAs for 216 residents on the day shift, required 27 CNAs. -12/23/22 had 23 CNAs for 214 residents on the day shift, required 27 CNAs. -12/24/22 had 22 CNAs for 214 residents on the day shift, required 27 CNAs. -12/24/22 had 13 total staff for 214 residents on the overnight shift, required 15 total staff. -12/25/22 had 21 CNAs for 213 residents on the day shift, required 27 CNAs. -12/25/22 had 13 total staff for 213 residents on the overnight shift, required 15 total staff. -12/26/22 had 21 CNAs for 213 residents on the day shift, required 27 CNAs. -12/27/22 had 24 CNAs for 212 residents on the day shift, required 26 CNAs. -12/28/22 had 24 CNAs for 212 residents on the day shift, required 26 CNAs. -12/29/22 had 19 CNAs for 212 residents on the day shift, required 26 CNAs. -12/30/22 had 22 CNAs for 212 residents on the day shift, required 26 CNAs. -12/31/22 had 19 CNAs for 213 residents on the day shift, required 27 CNAs. -01/01/23 had 23 CNAs for 212 residents on the day shift, required 26 CNAs. -01/02/23 had 22 CNAs for 211 residents on the day shift, required 26 CNAs. -01/03/23 had 19 CNAs for 211 residents on the day shift, required 26 CNAs. -01/05/23 had 23 CNAs for 211 residents on the day shift, required 26 CNAs. -01/06/23 had 24 CNAs for 211 residents on the day shift, required 26 CNAs. -01/07/23 had 24 CNAs for 214 residents on the day shift, required 27 CNAs. -01/08/23 had 24 CNAs for 214 residents on the day shift, required 27 CNAs. -01/09/23 had 22 CNAs for 214 residents on the day shift, required 27 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061216	A. BUILDING: _____ B. WING _____	C 02/07/2023

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) COMPLETE DATE
S 560	Continued From page 5 -01/10/23 had 19 CNAs for 219 residents on the day shift, required 27 CNAs. -01/11/23 had 24 CNAs for 219 residents on the day shift, required 27 CNAs. -01/12/23 had 20 CNAs for 219 residents on the day shift, required 27 CNAs. -01/13/23 had 21 CNAs for 220 residents on the day shift, required 27 CNAs. -01/14/23 had 19 CNAs for 220 residents on the day shift, required 27 CNAs. -01/15/23 had 16 CNAs for 220 residents on the day shift, required 27 CNAs. -01/16/23 had 23 CNAs for 218 residents on the day shift, required 27 CNAs. -01/17/23 had 21 CNAs for 212 residents on the day shift, required 26 CNAs. -01/18/23 had 24 CNAs for 212 residents on the day shift, required 26 CNAs. -01/19/23 had 20 CNAs for 210 residents on the day shift, required 26 CNAs. -01/20/23 had 22 CNAs for 209 residents on the day shift, required 26 CNAs. -01/21/23 had 20 CNAs for 209 residents on the day shift, required 26 CNAs. -01/21/23 had 14 total staff for 209 residents on the overnight shift, required 15 total staff. -01/22/23 had 20 CNAs for 208 residents on the day shift, required 26 CNAs. -01/23/23 had 22 CNAs for 207 residents on the day shift, required 26 CNAs. -01/24/23 had 22 CNAs for 207 residents on the day shift, required 26 CNAs. -01/25/23 had 22 CNAs for 205 residents on the day shift, required 26 CNAs. -01/26/23 had 19 CNAs for 205 residents on the day shift, required 26 CNAs. -01/27/23 had 19 CNAs for 205 residents on the day shift, required 26 CNAs. -01/28/23 had 14 CNAs for 205 residents on the day shift, required 26 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061216	A. BUILDING: _____ B. WING _____	C 02/07/2023

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) COMPLETE DATE
S 560	Continued From page 6 -01/29/23 had 15 CNAs for 205 residents on the day shift, required 26 CNAs. -01/30/23 had 24 CNAs for 202 residents on the day shift, required 25 CNAs. -01/31/23 had 18 CNAs for 201 residents on the day shift, required 25 CNAs. -02/01/23 had 21 CNAs for 201 residents on the day shift, required 25 CNAs. -02/02/23 had 22 CNAs for 201 residents on the day shift, required 25 CNAs. -02/03/23 had 18 CNAs for 201 residents on the day shift, required 25 CNAs. -02/04/23 had 18 CNAs for 208 residents on the day shift, required 26 CNAs. -02/04/23 had 14 total staff for 208 residents on the overnight shift, required 15 total staff. The surveyor conducted an interview with the Staffing Coordinator (SC) on 02/7/23 at 3:17 pm, the SC stated that she started in the position as SC on 4/2022. The SC stated that the facility uses agency to fill the staffing needs of the CNAs. She added that they offered incentive for those who work extra hours. The SC also stated that she was aware of the new minimum staffing ratio requirements for nursing homes. The SC stated that she reports to the Facility Administrator (FA) and the DON when having difficulty with staffing. The SC added that the facility is currently hiring for CNAs. NJAC 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061216		3/31/2023

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/28/2023	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	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	
2/7/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO