PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-0391

| | | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTR | | |
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| | 315214 | B. WING | | 08/11/2023 |
| | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080 | · |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE COMPLETION |
| A Life Safety Code S New Jersey Departm Survey and Field Op- 08/03/2023 and Arist found to be in noncor requirements for part Medicare/Medicaid a Safety from Fire, and National Fire Protect Life Safety Code (LS Health Care Occupal Aristacare at Cedar (was built in the Janual Type II Protected cor divided into 15 smok Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is with NFPA 96, Stand and Fire Protection of Operations, unless: * residential cooking | Survey was conducted by the pent of Health, Health Facility erations on 08/02/2023 and care at Cedar Oaks was impliance with the icipation in the 42 CFR 483.90(a), Life of the 2012 Edition of the ston Association (NFPA) 101, C), Chapter 19 EXISTING incies. Daks is a 3-story building that fary 1984. It is composed of instruction. The facility is expones. | | | 9/10/23 |
| cooking in accordance * cooking facilities op- compartments with 3 with the conditions up- or * cooking facilities in 30 or fewer patients of 18.3.2.5.4, 19.3.2.5.4 Cooking facilities pro per 9.2.3 are not requ | the with 18.3.2.5.2, 19.3.2.5.2 then to the corridor in smoke 0 or fewer patients comply ander 18.3.2.5.3, 19.3.2.5.3, smoke compartments with comply with conditions under 1. the tested according to NFPA 96 uired to be enclosed as | | | (X6) DATE |
| | INITIAL COMMENTS A Life Safety Code S New Jersey Departm Survey and Field Op- 08/03/2023 and Arist found to be in noncor requirements for part Medicare/Medicaid a Safety from Fire, and National Fire Protecti Life Safety Code (LS Health Care Occupant Aristacare at Cedar (was built in the Januat Type II Protected cord divided into 15 smoke Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is with NFPA 96, Stand and Fire Protection or Operations, unless: * residential cooking appliances such as in toasters) are used fo cooking in accordance * cooking facilities op compartments with 3 with the conditions un or * cooking facilities in 30 or fewer patients of 18.3.2.5.4, 19.3.2.5.4 Cooking facilities pro per 9.2.3 are not requi | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/02/2023 and 08/03/2023 and Aristcare at Cedar Oaks was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Aristacare at Cedar Oaks is a 3-story building that was built in the January 1984. It is composed of Type II Protected construction. The facility is divided into 15 smoke zones. Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/02/2023 and 08/03/2023 and Aristcare at Cedar Oaks was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Aristacare at Cedar Oaks is a 3-story building that was built in the January 1984. It is composed of Type II Protected construction. The facility is divided into 15 smoke zones. 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Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as | ROVIDER OR SUPPLIER ARE AT CEDAR OAKS SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: DENTIFYING INFORMATION) INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Filed Operations on 08/02/2023 and 08/03/2023 and Aristacre at Cedar Oaks was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Aristacare at Cedar Oaks is a 3-story building that was built in the January 1984. It is composed of Type II Protected construction. The facility is divided into 15 smoke zones. 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Electronically Signed 08/30/2023

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|-------------------------------|---|---|
| | | 315214 | B. WING | | 08/11/2023 |
| | ROVIDER OR SUPPLIER ARE AT CEDAR OAKS | , | | STREET ADDRESS, CITY, STATE, ZIP CODE 1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLÉTION |
| K 324 | corridor. | shall not be open to the 3.3.2.5.4, 19.3.2.5.1 through | K 324 | | |
| | by: Based on observation presence of facility modetermined that the facooking equipment wowith NFPA (National 196). This deficient practice six (6) burner natural evidenced by the following formula of the surveyor obtwo six (6) burner gas burner stove had the systems two nozzles right side of the stove 6 burner stove. The MD confirmed the observation. On 08/03/2023 during | acility failed to ensure that as protected in accordance Fire Protection Association) e was evidenced for 1 of 2 gas stoves and was owing, coroximately 12:20, in the ty Maintenance Director aserved in the main kitchen, as stoves. The right side 6 wet chemical's suppression a pointing away off to the e and not aiming towards the e finding at the time of the gas the survey exit at the first accordance of the survey exit at the survey | | F324- Cooking Facilities Immediate Action The right side 6 burner stove had the chemical's suppression systems two nozzles pointing away off to the right of the stove were re-aligned by the Maintenance Director on 8/3 to aim towards the 6 burner stove. The FSD/designee and Maintenance Director were verbally re-in-service proper direction of kitchen suppressivatem nozzles. The FSD/designee added to their maudit sheet proper direction of kitch suppression system nozzles to enscompliance. Identification of Others All residents have the potential to be affected by the deficient practice. The Maintenance Director/designer audited all other possible locations that have wet chemical's suppression systems with no other issues found. | to on the side on sion on the side on sion on the side on sion on the side on 8/3 on 8/3 on |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | PLE CONSTRUCTION IG 01 | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|-------------------------|---|-------------------------------|----------------------------|
| | | 315214 | B. WING _ | | 08/1 | 11/2023 |
| | ROVIDER OR SUPPLIER ARE AT CEDAR OAKS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 324 | Continued From page NFPA 101- 2012: -19 | | K 3 | Systemic Changes The Maintenance Director/designee will do a visual audit of the kitchen chemical suppression systems nozzles daily for week, then weekly x 1 month for 3 monto ensure the right side burner wet chemical's suppression systems nozzle are aiming towards the 6 burner stove using an audit tool. The audit tool will be reviewed with Administrator for 1 week, then weekly x month for 3 months. Quality Monitoring The Maintenance Director/designee will immedaetly inform the Amdinistrator of any negative findings specific to impropidirection of burner stove nozzles. The Maintenance Director/designee will bring results of the audits to Quality Assurance Performance Improvement Committee monthly x3 months. Quality Assurance Performance Improvement Committee, based on results of these audits, a decision will be made regardir the need for continued submission and reporting to the committee. | al's 1 ths ths | |
| K 345 SS=E | | esting and Maintenance | К3 | | ! | 9/10/23 |
| | A fire alarm system is accordance with an a with the requirements | Testing and Maintenance I tested and maintained in I pproved program complying I of NFPA 70, National I FPA 72, National Fire Alarm Records of system | | | | |

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| * * | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI | | ULTIPLE CONSTRUCTION LDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|--|-------|-------------------------------|--|
| | | 315214 | B. WING _ | | | 08 | 3/11/2023 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | · | | |
| | | | | 13 | 311 DURHAM AVENUE | | | |
| ARISTACA | ARE AT CEDAR OAKS | | | S | OUTH PLAINFIELD, NJ 07080 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE | |
| K 345 | Continued From pag | e 3 | K 3 | 345 | | | | |
| | acceptance, mainten available. 9.6.1.3, 9.6.1.5, NFP | ance and testing are readily A 70, NFPA 72 | | | | | | |
| | | Γ is not met as evidenced | | | | | | |
| | | and review of facility provided 3/02/2023 and 08/03/2023, it | | | K345 - Fire Alarm System | | | |
| | was determined that | | | Immediate Action | | | | |
| | | sitivity was checked every | | | The Maintenance Director/designee | | | |
| | - | facility smoke detectors in | | | immediately communicated with the | | | |
| | accordance with NFPA 72 National Fire Alarm facilities alarm vendor and added to and Signaling Code (2010 Edition Section mandatory inspections preformed by | | | | | | | |
| | and Signaling Code (14.4.5.3.2. | 2010 Edition Section | | | mandatory inspections preformed by alarm vendor - that smoke detection sensitivity was checked every alternat | ۵ | | |
| | This deficiency was e | evidenced by the following: | | | year of the facility smoke detectors in accordance with NFPA 72 National Fir | | | |
| | During the the survey | y entrance on 08/02/2023 at | | | Alarm and Signaling Code (2010 Edition | on | | |
| | approximately 9:17 A | M, a request was made to | | | Section 14.4.5.3.2). The smoke detec | tor | | |
| | | ance Director (MD) to provide | | | sensitivity testing was completed on | | | |
| | | tions from January 1, 2022 | | | August 17th by alarm vendor. | | | |
| | | 23 and provide a copy of the | | | | | | |
| | last Smoke Detector | Sensitivity testing. | | | Identification of Others | | | |
| | Later that day at app review of the facility | roximately 12:09 PM, a | | | All residents have the potential to be affected. | | | |
| | inspections was perfe | | | | Systemic Changes | | | |
| | mopodione was pon | omou. | | | The Maintenance Director/designee w | rill | | |
| | The survevor reviewe | ed the following Fire Alarm | | | ensure the fire alarm system is tested | | | |
| | and Detection systen | | | | maintained in accordance with an | | | |
| | - 06/16/2023 Semi- | | | | approved program complying with the | | | |
| | - 12/08/2022 Annua | l inspection. | | | requirements of NFPA 70, National | | | |
| | - 06/21/2022 Semi- | | | | Electric Code, and NFPA 72, National | | | |
| | - 02/08/2022 Annua | ll inspection. | | | Alarm and Signaling Code. Records of | | | |
| | | | | | system acceptance, maintenance and | | | |
| | | sting reports revealed no | | | testing are readily available for inspec | tion. | | |
| | reterence to a smoke | e detection sensitivity testing. | | | To another make detection on 10.00 | | | |
| | At approximately 4.5 | O DM a request was made to | | | To ensure smoke detection sensitivity | | | |
| | | 0 PM a request was made to Il to the facility fire alarm and | | | checked every alternate year of the fa smoke detectors in accordance with N | - | | |

Facility ID: NJ61216

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|-----|---|-------------------------------|----------------------------|
| | | 315214 | B. WING _ | | | 08/ | 11/2023 |
| | ROVIDER OR SUPPLIER | | | 13 | TREET ADDRESS, CITY, STATE, ZIP CODE B11 DURHAM AVENUE OUTH PLAINFIELD, NJ 07080 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 345 | the last Sensitivity Teadetectors. On 08/03/2023 at 9:22 the vendor had not pet the smoke detectors. A review of an e-mail provided by the MD in scheduled to do the stest Thursday August the day before to confirmed the testing had not been pondone on 08/03/2023 during | rendor and request a copy of sting of the smoke 2 AM, the MD stated that erformed a sensitivity test of from the alarm vendor adicated, "We have you moke detector sensitivity 17th We will be in touch firm." e smoke detector sensitivity performed. g the survey exit at M, the surveyor informed ac deficiency. | K | 345 | 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. the Maintenance Director/designee will include documentation in the facilities inspection log book to ensure records of system acceptance, maintenance and testing are readily available. The facilites inspection log book will be reviewed with Administrator after currer inspection has been preformed, then every other year to ensue compliance. Quality Monitoring The Maintenance Director/designee will immediately inform the Administrator of any negative findings specific to smoke detection sensitivity testing. The Maintenance Director/designee will bring results of the smoke detection sensitivity testing to the Quality Assurance Performance Improvement Committee month after testing was preformed even other year. Quality Assurance Performance Improvement Committee, based on results, a decision will be maintegarding the need for continued submission and reporting to the | of nt | |
| K 351 SS=E | Sprinkler System - Ins CFR(s): NFPA 101 | stallation | K | 351 | committee. | | 9/25/23 |
| | | tallation nospitals where required by protected throughout by an | | | | | |

| IDENTIFICATION NAMER: 315214 B. WING STREET-ADDRESS. CITY. STATE, 2IP CODE 1311 DURHAM AYENUE SOUTH PLANFIELD, NJ 07880 B. SUMMARY STATEMENT OF DEFICIENCIES (FACH LEFFICIENCY MUST 18 PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREDULATORY OR LSC IDENTIFYING INFORMATION) K 351 Continued From page 5 A BUILDING 91 CONSERETE PROPOSEST PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPARTMENT TAG CONTINUED AND THE AND THE ARROWS THE APPROPRIATE DEPARTMENT TAG Continued From page 5 A BUILDING 91 STREET-ADDRESS, CITY. STATE, 2IP CODE 1311 DURHAM AYENUE SOUTH PLANFIELD, NJ 07880 FREGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONSERETE PROPOSEST PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPARTMENT TAG PROPOSEST PLAN OF CONTINUED AND TAGE (FACH CORRECTION SHOULD BE COMPRESS) FREGULATORY OR LSC IDENTIFYING INFORMATION) K 351 CONTINUED AND THE APPROPRIATE A BUILDING 91 STREET-ADDRESS, CITY. STATE, 2IP CODE 1311 DURHAM AYENUE SOUTH PLANFIELD, NJ 07880 FREGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION TAG CONSERETE PROPOSED TO THE APPROPRIATE (FACH CORRECTION SHOULD BE COMPRESS AND TAGE CROSS-REFERENCED TO THE APPROPRIATE (FACH CORRECTION SHOULD BE COMPRESS AND TAGE FREGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION TAG CONTINUED TO THE APPROPRIATE FREGULATORY OR LSC IDENTIFYING INFORMATION FREGULATORY OR LSC IDENTIFY OR LAND IN THE APPROPRIATE FREGULATORY OR LSC IDENTIF | CTATEMENT OF DEFICIENCIES (VA) PROVIDED (CURRING LA | | (X2) MULTIPLE CONSTRUCTION | | | (Y2) DATE CUDVEY | | |
|---|---|---------------------------------------|--|---------|-----|---------------------------------------|-------------------------------|---------|
| ARISTACARE AT CEDAR OAKS ARISTACARE AT CEDAR OAKS SUTH PLIANIFELD, NJ 07680 EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR I.S.C.IDENTIFYING INFORMATION) K 351 Continued From page 5 approved automatic sprinkler system in accordance with NFPA 13, Islandard for the installation of Sprinkler systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinkler sare not required in clothes closest of patient sleeping rooms where the area of the closest does not exceed 6 square feet and sprinkler overage covers the closet footprint as required by NFPA 13, Islandard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 97, 97.1.1(1) This REOUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/02/2023 and 08/03/2023, in the presence of facility management it was determined that: 1) The Facility failed to property install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 97.9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice was evidenced by the following, On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and make | ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | | (X3) DATE SURVEY COMPLETED | |
| ARISTACARE AT CEDAR OAKS SINEET ADDRESS, CITY, STATE, JP CODE 1311 DURANA WARLE SUDTH PLANTIFELD, NJ 07680 | | | 245244 | B WING | | | | |
| ARISTACARE AT CEDAR OAKS SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX PAGE PROPRIET ALTON SHOULD BY COMPACTION | | | 315214 | D. WING | | | 08/ | 11/2023 |
| ARISTACARE AT CEDAR CAKS SOUTH PLANFIELD, NJ 07080 SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K 351 Continued From page 5 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler overage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.2, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as required by CMS regulation \$483, 9.0(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 installation of Sprinkler Systems 2012 Edition. The deficient practice was evidenced by the following, On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke | NAME OF PI | ROVIDER OR SUPPLIER | | | | | | |
| No. December Summary Statement of Deficiencies PREFIX TAG | ARISTACA | ARE AT CEDAR OAKS | | | 13 | 311 DURHAM AVENUE | | |
| K 351 Continued From page 5 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This RECUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/02/2023 and 08/03/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as required by CMS regulation \$483.93.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition. Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility part out which identified the various rooms and smoke | | | | | S | OUTH PLAINFIELD, NJ 07080 | | |
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| Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice was evidenced by the following, On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke immediately communicated with Sprinkler contractor requesting estimate to ensure, adjust sprinkler coverage, and/or install new fire sprinkler inside the basement level West stairwell landing area to cover the 21 feet by 7 feet 9 inch lower landing area, the Willow wing shower room inside a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | 08/03/2023, in the pre | esence of facility | | | Immediate Action | | |
| required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice was evidenced by the following, On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke contractor requesting estimate to ensure, adjust sprinkler coverage, and/or install new fire sprinkler inside the basement level West stairwell landing area to cover the 21 feet by 7 feet 9 inch lower landing area, the Willow wing shower room inside a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | | , | | | Maintenance Director/designee | | |
| environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice was evidenced by the following, On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke adjust sprinkler coverage, and/or install new fire sprinkler inside the basement level West stairwell landing area to cover the 21 feet by 7 feet 9 inch lower landing area, the Willow wing shower room inside a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | | | | | · · · · · · · · · · · · · · · · · · · | | |
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| Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. the 21 feet by 7 feet 9 inch lower landing area, the Willow wing shower room inside a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep following, by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke the 21 feet by 7 feet 9 inch lower landing area, the Willow wing shower room inside a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | • | · | | | | | |
| Systems 2012 Edition. area, the Willow wing shower room inside a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep following, On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke area, the Willow wing shower room inside a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside a 3 feet by 3 feet shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | | | | | _ | | |
| a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | | | | | - | - | |
| The deficient practice was evidenced by the following, Wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke Wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | Systems 2012 Edition | ٦. | | | _ | | |
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| CMS regulation 483.90(a) physical On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | · · | e was evidenced by the | | | _ | | |
| On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | ionowing, | | | | - | IUI | |
| approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | On 08/02/2023 during | the survey entrance at | | | . , , , | | |
| the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | | - | | | | | |
| to provide a copy of the facility lay-out which identified the various rooms and smoke National Fire Protection Association (NFPA) 13 Installation of Sprinkler | | | | | | | | |
| identified the various rooms and smoke (NFPA) 13 Installation of Sprinkler | | | • • | | | | | |
| | | | | | | | | |
| Ouripartinents in the facility. | | compartments in the | | | | Systems 2012 Edition. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIF A. BUILDING | PLE CONSTRUCTION G 01 | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------------------|--|-------------------------------|
| | | 315214 | B. WING | | 08/11/2023 |
| NAME OF P | ROVIDER OR SUPPLIER | • | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | , |
| ADISTAC | ARE AT CEDAR OAKS | | | 1311 DURHAM AVENUE | |
| AKISTAC | ARE AT CEDAR OARS | | | SOUTH PLAINFIELD, NJ 07080 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE COMPLETION |
| K 351 | Continued From pag | e 6 | K 35 | 51 | |
| | the facility was a thre hundred and fifty one rooms and common | | | The Maintenance Director/design audited/checked all other areas o facility for proper sprinkler covera 8/4 determining that all other area provided proper fire sprinkler coveral. | f the ge on as erage |
| | | ately 9:50 AM on 08/02/2023 /03/2023 in the presence of ur of the facility was | | according to CMS regulation 483. physical environment to all areas accordance with the requirements NFPA 101 2012 Edition, Section 9.7, 9.7.1.1 and National Fire Pro | in s of 19.3.5.1, |
| | | surveyor observed the at failed to provide proper e: | | Association (NFPA) 13 Installation Sprinkler Systems 2012 Edition. | n of |
| | basement level West surveyor observed n | on 08/02/2023: .) At approximately 9:56 AM, inside the assement level West Stairwell landing area, the urveyor observed no evidence of a fire sprinkler system to cover the 21 feet by 7 feet 9 inch lower anding area. At that time the surveyor asked the ID, "Do you see and fire sprinklers here." The ID looked up and around and said, "No." | | Identification of Others All residents and staff have the potential to be affected. Systemic Changes The Maintenance Director/design | |
| | landing area. At that MD, "Do you see and | | | add automatic fire sprinkler protect their Preventative Maintenance M Round Log to ensure compliance | ction to lonthly |
| | On 08/03/2023: 2.) At approximately 9:52 AM, inside the 2nd. floor Willow Wing shower room, the surveyor observed no evidence of fire sprinkler coverage inside a 3 feet by 3 feet shower stall. The | | | The Sprinkler contractor installed /adjusted exsiting sprinkler heads provided proper fire sprinkler cover areas noted. | to |
| | room would not reac stall. | prinklers inside the shower h into the 3 feet by 3 feet | | Quality Monitoring The Maintenance Director/design inform the Administrator immediate any negative findings immediately | tely of |
| | floor Oak Wing show observed no evidence | 11:40 AM, inside the 1st er room, the surveyor e of fire sprinkler coverage | | regarding sprinkler protection to e identification/corrections are made | e timely. |
| | The locations of the | o by 3 feet wide shower stall. Fire sprinklers inside the not reach into the 6 feet by 3 | | The Maintenance Director/design bring results of the Preventative Maintenance Monthly Round Log Sprinkler contractor completion processing the second section of the process of the proces | and the |

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 315214 B. WING 08/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1311 DURHAM AVENUE** ARISTACARE AT CEDAR OAKS SOUTH PLAINFIELD, NJ 07080 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 351 Continued From page 7 K 351 the Quality Assurance Performance The MD confirmed the findings at the time of Improvement Committee monthly for 3 observations. months. The Quality Assurance Performance Improvement Committee, On 08/03/2023 during the survey exit at based on results, a decision will be made approximately 1:20 PM, the surveyor informed regarding the need for continued the Administrator of the deficiency. submission and reporting to the committee. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13 Portable Fire Extinguishers K 355 9/10/23 K 355 CFR(s): NFPA 101 SS=D Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced Based on observation and review of facility K355 -Portable Fire Extinguishers documentation on 08/02/2023 and 08/03/2023 in Immediate Action the presence of facility management, it was determined that the facility failed to: Maintenance Director/designee 1.) Perform a monthly examination for 3 of 32 immediately completed on 8/3 the monthly visual examinations on 1 "ABC-Type" fire portable fire extinguishers, extinguisher inside the 2nd floor day room 2.) Replace 1 of 32 portable fire extinguishers when discharged. . 1 Willow unit pantry on the 1st floor. 1 2.) Install portable fire extinguishers with-in the "Class K" wet chemical fire extinguisher required height for 1 of 32 fire extinguishers inside the main kitchen, and replaced observed, as required by National Fire Protection inside the first floor stairwell next to the Association as required by NFPA 101, 2012 recreation office- 1 "ABC-Type" fire Edition, Section 19.3.5.12, 9.7.4.1 and National extinguisher to comply with NFPA 10 Fire Protection Association (NFPA) 10, 2010 Edition 2010 Standard. Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. 8/3 the installation height of same "Class

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|---|---|------------------------------|-------------------------------|--|
| | | 315214 | B. WING _ | | | 08/ | /11/2023 | |
| NAME OF PE | ROVIDER OR SUPPLIER | | , | S1 | FREET ADDRESS, CITY, STATE, ZIP CODE | • | | |
| ARISTACA | RE AT CEDAR OAKS | | | | 311 DURHAM AVENUE OUTH PLAINFIELD, NJ 07080 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| K 355 | for portable fire exting - 4- 3 Inspection Ma - 4- 3.1 Frequency. Inspected when initial thereafter at approxin extinguishers shall be intervals when circum - 4- 3.3 Corrective A of any fire extinguished conditions listed in 4-immediate corrective - 4-3.4 At least month was performed and the performing the inspect least monthly and that tag or label attached - 7.3.1.1.1 Fire exting to maintenance at into years at the time of his specifically indicated electronic notification. Reference #2 NFPA for portable fire exting - 6.1.3.8 Installation - 6.1.3.8.1 Fire exting weight not exceeding that the top of type fire than 5 feet above the - 6.1.3.8.3 In no case between the bottom of extinguisher and the following: | 10 Edition 2010 Standard guishers reads, intenance. Fire extinguishers shall be ally placed in service and mately 30-day intervals. Fire extinspected at more frequent enstances require. Intervals a deficiency in any 3.2 (a), (b), (h), and (i), action shall be taken. In the date the inspection reinitials of the person extinguishers shall be kept on a sto the fire extinguishers. It records shall be subjected revals of not more than 1 ydrostatic test, or when by an inspection or 10 Edition 2010 Standard guishers reads, a Height. Inguishers having a gross 40 lb shall be installed so re extinguisher is not more | K | 355 | K" wet chemical fire extinguisher inside the main kitchen was adjusted by the Maintenace Diectort/designee to be not more than 5 feet above the floor and clearance between the bottom of the hiportable fire extinguisher and the floor less than 4 inches. 8/3 the Maintenance Director/designee examined all other areas of the facility portable fire extinguishers are selected installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. No other issues found. 8/17 Maintenance Director/designee re-educated staff on standard for portafire extinguishers. 8/17 Maintenance Director was re-educated by Administrator on NFPA Edition 2010 Standard for portable fire extinguishers. Identification of Others All residents and staff have the potentiato be affected. Systemic Changes Maintenance Director/designee revised/will use portable fire extinguish locations map during monthly inspection intervals and as needed, to ensure accuracy of inspection with NFPA 10 Edition 2010 Standard for portable fire extinguishers. A copy of the portable fire extinguishers. A copy of the portable fire extinguishers. A copy of the portable fire extinguisher locations map will be retain monthly for referance and validation in | t and be that h or ble 10 al | | |

Facility ID: NJ61216

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | | (X3) DATE SURVEY COMPLETED |
|--|---|--|--|---|
| | 315214 | B. WING | | 08/11/2023 |
| ROVIDER OR SUPPLIER | - | | | |
| ARE AT CEDAR OAKS | | | | |
| (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE COMPLETION |
| Continued From pag | ne 9 | K 355 | | |
| survey entrance at a request was made to Maintenance Director the facility lay-out who rooms and smoke construction of the facility lay-out who rooms and smoke construction of the facility's MD a total conducted. During the two day be observed and inspective extinguishers in a portable fire extinguishers in the surveyor observit were identified: On 08/02/2023: 1.) At approximately fire extinguisher inside was last annually insome the surveyor observit was last annually insome examinations perform February, March, Apono 08/03/2023: 2.) At approximately fire extinguisher, inside the 1st. floor was last November 2022. There was no evider | pproximately 9:17 AM, a to the Administrator and or (MD) to provide a copy of hich identified the various of partments in the facility. ately 9:50 AM on 08/02/2023 a a a a a a a a a a a a a a a a a a a | K 355 | maintenace log book. Quality Monitoring The Maintenace Director/designee inform the Administrator immediate any negative findings regarding compliance with portable fire exstict to ensure corrections are made tim The Maintenance Director/designe bring results/copy of portable fire extinguisher locations map to the Quality Assurance Performa Improvement Committee monthly fmonths. The Quality Assurance Performance Improvement Commit based on results, a decision will be regarding the need for continued submission and reporting to the committee. | ely of gishers elely. e will nce or 3 |
| | CORRECTION ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENT REGULATORY OR Continued From pag survey entrance at a request was made to Maintenance Director the facility lay-out whoms and smoke consumer of the facility's MD at the facility fire extinguishers in portable fire extinguishers in portable fire extinguishers in the surveyor observit were identified: On 08/02/2023: 1.) At approximately fire extinguisher inside was last annually insome the surveyor observit were identified: On 08/02/2023: 2.) At approximately fire extinguisher, inside the 1st. floor was last November 2022. There was no evider | CORRECTION 315214 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. Starting at approximately 9:50 AM on 08/02/2023 and continued on 08/03/2023 in the presence of the facility's MD a tour of the facility was conducted. During the two day building tour the surveyor observed and inspected thirty two (32) portable fire extinguishers in various locations. These 32 portable fire extinguishers were last annually inspected in September and November 2022 with the surveyor observing the following issues that were identified: On 08/02/2023: 1.) At approximately 11:10 AM, One "ABC-Type" fire extinguisher inside the 2nd. floor Day room was last annually inspected September 2022. There was no evidence of monthly visual examinations performed and documented for February, March, April, May, June and July 2023. On 08/03/2023: 2.) At approximately 11:30 AM, One "ABC-Type" fire extinguisher, inside the Willow Unit Pantry on the 1st. floor was last annually inspected | A BUILDING I B. WING ROVIDER OR SUPPLIER RE AT CEDAR OAKS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. Starting at approximately 9:50 AM on 08/02/2023 and continued on 08/03/2023 in the presence of the facility's MD a tour of the facility was conducted. During the two day building tour the surveyor observed and inspected thirty two (32) portable fire extinguishers in various locations. These 32 portable fire extinguishers were last annually inspected in September and November 2022 with the surveyor observing the following issues that were identified: On 08/02/2023: 1.) At approximately 11:10 AM, One "ABC-Type" fire extinguisher inside the 2nd. floor Day room was last annually inspected September 2022. There was no evidence of monthly visual examinations performed and documented for February, March, April, May, June and July 2023. On 08/03/2023: 2.) At approximately 11:30 AM, One "ABC-Type" fire extinguisher, inside the Willow Unit Pantry on the 1st. floor was last annually inspected November 2022. There was no evidence of monthly visual | A BUILDING 01 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1311 DURNAM AVENUE SOUTH PLAINFIELD, NJ 07080 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 9 survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. Starting at approximately 9:50 AM on 08/02/2023 and continued on 08/03/2023 in the presence of the facility's MD a tour of the facility was conducted. During the two day building tour the surveyor observed and inspected thirfy two (32) portable fire extinguishers in various locations. These 32 portable fire extinguishers were last annually inspected in September and November 2022 with the surveyor observing the following issues that were identified: On 08/02/2023: 1.) At approximately 11:10 AM, One "ABC-Type" fire extinguisher inside the 2nd. floor Day room was last annually inspected September 2022. There was no evidence of monthly visual examinations performed and documented for February, March, April, May, June and July 2023. On 08/03/2023: 2.) At approximately 11:30 AM, One "ABC-Type" fire extinguisher, inside the Willow Unit Pantry on the 1st. floor was last annually inspected November 2022. There was no evidence of monthly visual |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | FIPLE CONSTRUCTION NG 01 | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-------------------------|---|------------------------------------|-------------------------------|----------------------------|
| | | 315214 | B. WING _ | | | 08/ | 11/2023 |
| | ROVIDER OR SUPPLIER ARE AT CEDAR OAKS | | | STREET ADDRESS, CITY, STATE, ZIF 1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 0708 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | CTION SHOULD BE O THE APPROPRIA | | (X5) COMPLETION DATE |
| K 355 | extinguisher with the the RED discharge zo indicating gauge. At the made to the MD to reach the MD complied with t | pressure indicating needle in one of the pressure hat time, a request was place the fire extinguisher. h the request. 12:25 PM, One "Class K" tinguisher inside the main ually inspected September e of of a monthly erformed and documented ber 2022. ed that the extinguisher was elevation on the wall. At that easured and recorded the | K | 355 | | | |
| | observations. On 08/03/2023 during approximately 1:20 P the Administrator of the NFPA 10 NJAC 8:39 -31.1 (c), HVAC CFR(s): NFPA 101 HVAC | M, the surveyor informed ne deficiency. 31.2 (e). and air conditioning shall shall be installed in manufacturer's | K s | 521 | | | 9/10/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIF | PLE CONSTRUCTION G 01 | | ATE SURVEY OMPLETED | |
|---|---|--|---------------------------------|--|---|----------------------------|
| | | 315214 | B. WING | | | 08/11/2023 |
| | ROVIDER OR SUPPLIER ARE AT CEDAR OAKS | , | | STREET ADDRESS, CITY, STATE, ZIP CODE 1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080 | • | |
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| K 521 | Continued From page | e 11 | K 52 | 21 | | |
| | by: Based on observation 08/03/2023 in the present management, it was failed to ensure that it systems were being 13 Resident bathroom the National Fire Prospon. This deficient praction following: On 08/02/2023 (day a survey entrance at a prequest was made to Maintenance Directo the facility lay-out who rooms and smoke conducted. Starting at approximation and continued on 08/04/2015 the facility's MD a tou conducted. | determined that the facility the facility's ventilation properly maintained for 8 of m exhaust systems as per tection Association (NFPA) e was evidenced by the one of survey) during the oproximately 9:17 AM, a the Administrator and m (MD) to provide a copy of ich identified the various mpartments in the facility. y provided lay-out identified the story building with 151 toms and various common ately 9:50 AM on 08/02/2023 (03/2023 in the presence of ur of the facility was our the surveyor inspected (13) Resident sleeping rooms | | Immediate Action Maintenance Director immediatel communicated with HVAC contra 8/3 who identified Resident room #249, #255, 2nd floor unisex bath #257, #264, #107, and #172 whe the exhaust system did not functi properly. Contractor identified ar the issue on 8/10. 8 of 13 identifi facility area exhaust systems wer and verified working in accordance the manufacturer's specifications the National Fire Protection Asso (NFPA) 90A, 18.5.2.1, 19.5.2.1, 9 The Maintenance Director/design 8/3 audited, using the single ply t paper method, all other Resident rooms, bathrooms, and various of areas in the facility to ensure that facility's ventilation system was b properly maintained. No other is: were found. The Maintenance Director/design re-tested on 8/10, using the single tissue paper method, and verified exhaust systems were functioned for identified Resident rooms #24 #255, 2nd floor unisex bathroom, #264, #107, and #172. | actor on is #247, horoom, en tested ion and fixed fied are fixed as per ociation 2.2. There on tissue a sleeping common at the being sues There is a sue a sleeping common at the diproperly at that the diproperly 17, #249, | |

| 1 ' | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI | | LE CONSTRUCTION 6 01 | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|--|---|-------------------------------|--|
| | | 315214 | B. WING | ····· | | 8/11/2023 | |
| | ROVIDER OR SUPPLIER ARE AT CEDAR OAKS | | • | STREET ADDRESS, CITY, STATE, ZIP CODE 1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| K 521 | exhaust systems wer of single ply tissue participation with a confirm ventilation was not function properly bathrooms in the follows of the confirm ventilation. On 08/03/2023: 1.) At approximately room #247 bathrooms system did not function the inspection, the substitute inspection, the substitute exhaust system obstathroom had no win open. This bathrooms ventilation. 2.) At approximately room #249 bathrooms system did not functionad no window with a This bathroom would ventilation. 3.) At approximately room #255 bathrooms system did not functionad no window with a This bathroom would ventilation. 4.) At approximately Resident Unisex bathrooms was system did not functional rooms. | ified when the bathroom re tested (by placing a piece aper across the grills to as present), the exhaust did in 8 of 13 resident owing locations: 9:32 AM, inside Resident on properly. At the time of urveyor informed the MD that did not function properly. The adow with an area that would would rely on mechanical 9:37 AM, inside Resident on properly. The bathroom an area that would open. I rely on mechanical 9:50 AM, inside Resident on properly. The bathroom an area that would open. I rely on mechanical | K 52 | Identification of Others Residents in rooms #247, #24 2nd floor unisex bathroom, #2 #107, and #172 have the pote affected. Systemic Changes The Maintenance Director/des highlight facility's ventilation sy their Preventative Maintenance Round Log to ensure complian Resident bathroom exhaust sy per the National Fire Protection Association (NFPA) 90A, 18.5 19.5.2.1, 9.2. Resident sleeping room exhaus bathroom exhaust systems ar common areas with facility exi systems will be randomly teste by the Maintenance Director/of placing a piece of single ply tis across the grills to confirm fact ventilation systems were being maintained. The Preventative Maintenance Round Log will be reviewed w Administrator monthly for 3 me Quality Monitoring The Maintenance Director/des inform the Administrator imme any negative findings on the F | signee will signee will systems on see Monthly nee with systems as on see i.2.1, sust systems, and various haust ed monthly designee, by ssue paper sility's g properly e Monthly with onths. | | |
| | open. This bathroom ventilation. | would rely on mechanical 10:10 AM, inside Resident | | Maintenance Monthly Round I identify/ensure corrections are timely. | Log to | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G 01 | | TE SURVEY MPLETED |
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| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| ARISTACA | ARE AT CEDAR OAKS | | | 1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR | SHOULD BE | (X5) COMPLETION DATE |
| K 521 | system did not function had no window with a This bathroom would ventilation. 6.) At approximately room #264 bathroom system did not function had no window with a This bathroom would ventilation. 7.) At approximately room #107 bathroom system did not function had no window with a This bathroom would ventilation. 8.) At approximately room #172 bathroom system did not function had no window with a This bathroom would ventilation. The MD confirmed the On 08/03/2023 during approximately 1:20 Pthe Administrator of the NFPA 90A. NJAC 8:39-31.2 (e). | n, when tested the exhaust on properly. The bathroom an area that would open. rely on mechanical 10:19 AM, inside Resident when tested the exhaust on properly. The bathroom an area that would open. rely on mechanical 11:22 AM, inside Resident when tested the exhaust on properly. The bathroom an area that would open. rely on mechanical 11:39 AM, inside Resident when tested the exhaust on properly. The bathroom an area that would open. rely on mechanical 11:39 AM, inside Resident when tested the exhaust on properly. The bathroom an area that would open. rely on mechanical | K 5. | The Maintenance Director/des bring results of the Preventativ Maintenance Monthly Round L contractor completion dates to Assurance Performance Impro Committee monthly for 3 mont Quality Assurance Performance Improvement Committee, base results, a decision will be made the need for continued submis reporting to the committee. | e on the Quality overment on the Quality overment on the ee on the ee of the | |
| K 531 SS=E | Elevators CFR(s): NFPA 101 | | K 5 | 31 | | 9/10/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING | | | CONSTRUCTION 1 | (X3) DATE SURVEY COMPLETED | |
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| | | 315214 | B. WING | | | 08/ | 11/2023 |
| | ROVIDER OR SUPPLIER ARE AT CEDAR OAKS | | · | 1: | TREET ADDRESS, CITY, STATE, ZIP CODE 311 DURHAM AVENUE OUTH PLAINFIELD, NJ 07080 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| K 531 | ASME A17.1, Safety Escalators. Firefighter monthly with a writter Existing elevators con Safety Code for Exist Escalators. All existing distance of 25 feet or level that best serves personnel for firefight Firefighter's Service FA17.3. (Includes firefighter's service Properation, machine receivator lobby smoke 19.5.3, 9.4.2, 9.4.3. This REQUIREMENT by: Based on observation 08/02/2023 and 08/03 facility management if facility failed to maint communications for 2 accordance with ASM. This deficient practice following: On 08/02/2023 during AM, a request was management management of the properation of the practice following: | and the provision of 9.4. ed and tested as specified in Code for Elevators and r's Service is operated in record. Inform to ASME/ANSI A17.3, ing Elevators and g elevators, having a travel more above or below the the needs of emergency ing purposes, conform with Requirements of ASME/ANSI ghter's service Phase I key ector automatic recall, hase II emergency in-car key form smoke detectors, and edetectors.) The is not met as evidenced in and interview on 3/2023, in the presence of the was determined that the fain elevator emergency of 4 elevators tested, in ME/ANSI A17.3. The was evidenced by the graph of the survey entrance at 9:17 and to the Administrator and form of ME/ANSI have been saving how many building? The MD told the | K | 531 | Immediate Action - NFPA 101 Elevator Maintenance Director immediately communicated with Elevator Contractor and Phone Contractor on 8/2 to fix elevator #1 and #2 emergency communication phones in accordance with ASME/ANSI A17.3. Elevator phore were fixed on 8/4. On 8/2 staff were educated and increase hallway supervision was initiated on both elevators #1 and #2 to ensure increase staff awareness and that emergency communication was present. On 8/4 safety team held an ad-hoc | r nes sed oth | |

| NAME OF PROVIDER OR SUPPLIER ARISTACARE AT CEDAR OAKS (XA) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 531 Continued From page 15 presence of the facility MD at approximately 10:14 AM, a test of elevator #1 emergency communication phone rang and no one answered. This test was repeated a two additional times with the same result. At approximately 10:18 AM, a test of elevator #2 emergency telephone was performed. When the surveyor tested the emergency communication phone was performed. When the same result. At approximately 10:18 AM, a test of elevator #2 emergency telephone was performed. When the surveyor tested the emergency communication phone was performed. When the surveyor tested the emergency communication phone was performed. When the surveyor tested the emergency communication phone was performed. When the surveyor tested the emergency communication phone was performed. When the surveyor tested the emergency communication phone was performed. When the surveyor tested the emergency communication phone was performed. When the surveyor tested the emergency communication phone was performed. When the surveyor tested the emergency communication phone rang and no | | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | | CONSTRUCTION 1 | | (X3) DATE SURVEY COMPLETED | | |
|--|--------|---|---|-------------|---|--|------------------------------|-------------------------------|--|--|
| ARISTACARE AT CEDAR OAKS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCE TO SHOU | | | 315214 | B. WING _ | | | 08 | /11/2023 | | |
| REFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 531 Continued From page 15 presence of the facility MD at approximately 10:14 AM, a test of elevator #1 emergency telephone was performed. When the surveyor tested the emergency communication phone rang and no one answered. This test was repeated a two additional times with the same result. At approximately 10:18 AM, a test of elevator # 2 emergency telephone was performed. When the surveyor tested the emergency communication phone, it did not function properly. The The Maintenance Director/designee on | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1311 DURHAM AVENUE | | | | | |
| presence of the facility MD at approximately 10:14 AM, a test of elevator #1 emergency telephone was performed. When the surveyor tested the emergency communication phone, it did not function properly. The emergency communication phone rang and no one answered. This test was repeated a two additional times with the same result. At approximately 10:18 AM, a test of elevator # 2 emergency telephone was performed. When the surveyor tested the emergency communication phone, it did not function properly. The meeting and reviewed elevator contractors inspection and test monthly log to ensure compliance and safety. Elevator contratacted management/designee inserviced elevator contracted technician on preventitive mainteance procedure, emergency communication phones function, and notification to facility of any negative findings monthly. The Maintenance Director/designee on | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | × | (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR | 3E | COMPLETION | | |
| one answered. This test was repeated an additional two times with the same result. The MD confirmed the findings at the times of observations. On 08/03/2023 at approximately 1:05 PM, an interview with an elevator mechanic (who was called in by the facility) was conducted. The Elevator mechanic told the MD and surveyor that elevator #1 had no emergency communication phone line. On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e) ASME/ANSI A17.3 communication phones. No other issues were found. Identification of Others All residents have the potential to be affected. Systemic Changes The Maintenance Director/designee will verify elevator #1 and #2 emergency communication phones are in good working order, monthly with the elevator contractor present. Quality Monitoring The Maintenance Director/designee will inform the Administrator immediately of any negative findings of the elevator emergency communication phones to ensure identification and corrections are made timely. The Maintenance Director/designee will bring results of verifing elevator #1 and #2 emergency communication phones are in | K 531 | presence of the facilit 10:14 AM, a test of el telephone was perfor tested the emergency did not function prope communication phone answered. This test wadditional times with At approximately 10: emergency telephone surveyor tested the ephone, it did not functemergency communione answered. This additional two times was the Additional two times was additional two times | levator #1 emergency med. When the surveyor y communication phone, it erly. The emergency e rang and no one was repeated a two the same result. 18 AM, a test of elevator # 2 e was performed. When the mergency communication tion properly. The cation phone rang and no test was repeated an with the same result. 18 In the cation phone rang and no test was repeated an with the same result. 19 In the cation phone result. 20 In the cation phone rang and no test was repeated an with the same result. 21 In the cation phone rang and no test was repeated an with the same result. 22 In the cation phone rang and no test was repeated an with the same result. 23 In the cation phone rang and no test was repeated an with the same result. 24 In the same result repeated an with the same result. 25 In the cation phone rang and no test was repeated an with the same result. | K | 531 | contractors inspection and test monthlog to ensure compliance and safety. Elevator contratacted management/designee inserviced elevator contracted technician on preventitive mainteance procedure, emergency communication phones function, and notification to facility of a negative findings monthly. The Maintenance Director/designee o 8/3 audited elevator #3 and #4 emergicommunication phones. No other issuit were found. Identification of Others All residents have the potential to be affected. Systemic Changes The Maintenance Director/designee with verify elevator #1 and #2 emergency communication phones are in good working order, monthly with the elevation contractor present. Quality Monitoring The Maintenance Director/designee with inform the Administrator immediately cany negative findings of the elevator emergency communication phones to ensure identification and corrections a made timely. The Maintenance Director/designee with presents of verifing elevator #1 and #2 emergency communication phones to ensure identification and corrections a made timely. | n ency es ill of re ill d #2 | | | |

PRINTED: 03/01/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 315214 B. WING 08/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1311 DURHAM AVENUE** ARISTACARE AT CEDAR OAKS SOUTH PLAINFIELD, NJ 07080 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ΙD (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 531 Continued From page 16 K 531 good working order, monthly with the elevator contractor present to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee, based on results, a decision will be made regarding the need for continued submission and reporting to the committee. K 911 Electrical Systems - Other K 911 9/10/23 SS=E CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations on 08/02/2023 and K911 -Electrical Systems Other 08/03/2023, in the presence of facility Immediate Action management, it was determined that the facility failed to ensure that 4 of 13 electrical outlets The Maintenance Director/designee located next to a water source (with-in 6 feet) immediately contacted the Electrical contractor on 8/2 to ensure that 4 of 13 were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. electrical outlets located next to a water source (with-in 6 feet) were equipped with This deficient practice was evidenced by the Ground-Fault Circuit Interrupter (GFCI) protection. Electrical contractor replaced following: duplex outlets with Ground-Fault Circuit On 08/02/2023 during the survey entrance at 9:17 Interrupter (GFCI) protected outlets on 8/4 AM, a request was made to the Administrator and inside the 3rd floor Soiled Linen Room, Maintenance Director (MD) to provide a copy of inside the 2nd floor Soiled Utility Room, the facility lay-out which identified the various inside the 2nd floor Willow Unit Unisex rooms and smoke compartments in the facility. Bathroom, and inside the 1st floor Oak

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | I DENTIFICATION NITIMBED: | | PLE CONSTRUCTION G 01 | ' ' | (X3) DATE SURVEY COMPLETED | | |
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| | | 315214 | B. WING | ····· | 0 | 8/11/2023 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | | | |
| | | | | 1311 DURHAM AVENUE | | | | |
| ARISTACA | ARE AT CEDAR OAKS | | | SOUTH PLAINFIELD, NJ 07080 | | | | |
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| K 911 | Continued From page | e 17 | K 9 | 11 | | | | |
| | | | | Wing Unisex Bathroom next to | the Pantry. | | | |
| | Continued From page 17 A review of the facility provided lay-out identified there were three floors in the facility. Starting at 9:50 AM on 08/02/2023 and continued on 08/03/2023, in the presence of the facility's MD a tour of the building was performed. During the two (2) day tour of the facility, the surveyor observed and tested thirteen (13) electrical outlets in wet (with-in 6 feet of a sink) locations that failed to de-nergize when tested in the following locations, On 08/02/2023: 1.) At approximately 10:44 AM, inside the 3rd floor Soiled Linen Room, one Duplex electrical outlet located two (2) feet to the right of the sink when tested with a GFCI tester to de-energize as required by code. 2.) At approximately 11:24 AM, inside the 2nd floor Soiled Utility Room one Duplex electrical outlet located twenty (20) inches to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. On 08/03/2023: 3.) At approximately 9:54 AM, inside the 2nd floor Willow Unit Unisex Bathroom one Duplex electrical outlet located twenty two (22) inches to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize, the Duplex electrical outlet located twenty two (22) inches to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize, the Duplex electrical outlet did not de-energize as required by code. | | | The Maintenance Director/desi audited all other possible locate electrical outlets located next to source (with-in 6 feet) were equal Ground-Fault Circuit Interrupte protection. No other issues four lidentification of Others All electrical outlets located new water source (with-in 6 feet) has potential to be affected. Systemic Changes The Maintenance Director/desi do a visual audit monthly for 3 ensure all electrical outlets located a water source (with-in 6 feet) equipped with Ground-Fault Cillnterrupter (GFCI) protection. The audit tool will be reviewed Administrator for monthly for 3 Quality Monitoring The Maintenance Director/desi bring results of the audits to Quality Monitoring The Maintenance Director/desi bring results of the audits to Quality Monitoring Committee monthly x3 months Assurance Performance Impro Committee, based on results of audits, a decision will be made the need for continued submiss reporting to the committee. | ions on 8/4 o a water uipped with or (GFCI) and. Ind. Ind. | | | |
| | 4.) At approximately Oak Wing Unisex Ba | 11:29 AM, inside the 1st floor throom next to the Pantry, trical outlet located twenty | | I | JOH ANA | | | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G 01 | | (X3) DATE SURVEY COMPLETED | | |
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| | | 315214 | B. WING _ | | 80 | 3/11/2023 | | |
| NAME OF PROVIDER OR SUPPLIER ARISTACARE AT CEDAR OAKS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| K 911 K 916 SS=E | tested with a GFCI te Duplex electrical outle required by code. The MD confirmed the observations. On 08/03/2023 during approximately 1:20 P the Administrator of the NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NElectrical Systems - ECFR(s): NFPA 101 Electrical Systems - EAlarm Annunciator A remote annunciator A remote annunciator powered is provided to generating personnel. hard-wired to indicate emergency power so system (e.g., building to be substituted for to 6.4.1.1.17, 6.4.1.1.17 | the right of the sink when ster to de-energize, the Red et did not de-energize as e findings at the time of the survey exit at M, the surveyor informed ne deficiency. FPA 70: -210.8 Essential Electric System I that is storage battery to operate outside of the location readily observed by The annunciator is alarm conditions of the surce. A centralized computer information system) is not the alarm annunciator. | K 9 | 11 | | 9/25/23 | | |
| | facility management, facility failed to provio annunciator panel for generator's electrical | 8/2023 in the presence of it was determined that the le a working remote 1 of 1 emergency system to alert staff of the accordance with National | | K916 - Electrical Systems -Esser Immediate Action The Maintenance Director/design- immediately communicated with t facilities Generator vendor to con- working remote annunciator pane 1 emergency generator's electrical | ee he nect a l for 1 of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | 2) MULTIPLE CONSTRUCTION BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF PI | ROVIDER OR SUPPLIER | 1 | | STREET ADDRE | SS, CITY, STATE, ZIP CODE | | | | |
| | | | | 1311 DURHAM | AVENUE | | | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EA | PROVIDER'S PLAN OF CORRECTI ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE | | |
| K 916 | This deficient practi | ge 19 ce was evidenced by the | K 9 | to alert st accordan | taff of the system's condition | | | | |
| | approximately 9:17 the Administrator ar "Does the facility ha and where is the loc annunciator panel fe told the surveyor, ye emergency generate annunciator panel w Oak Wing Nursing s On day 08/03/2023 tour of the building w approximately 11:11 floor Oak Wing Nurs The surveyor obser Generator annuncia pressed the test but indicator lights, no li surveyor asked the panel work?" The M facility had a tempo connected and the fi | or the generator?" The MD ses the facility had one (1) or and that the generator vas located on the 1st floor station. (day two of survey) during a with the facility MD at AM, an inspection at the 1st. sing station was performed. ved one Emergency tor panel. When the surveyor ton to activate all of the ghts illuminated. The MD, "Does this annunciator MD told the surveyor that the rary emergency generator facility was waiting for the new meeted. The annunciator | | Identificat All reside affected. Systemic Generato remote ar 1st floor of facility en system. indicate a emergend the annur activate a Maintena annunciat annunciat all of the will be ke inspection | tion of Others ents have the potential to be changes or vendor connected the ex nnunciator panel located or Oak wing nursing station to mergency generator's electr The system is hard-wired to alarm conditions of the cy power source. When pr nciator panel test button wi all of the indicator lights. Ince Director/designee will ator panel weekly by pressinator panel test button, to act indicator lights. Document ept in the facilities maintenator in log book for review. Ince Director/designee create | cisting on the or the rical to ressed till check ng the tivate tation ace | | | |
| | observations. On 08/03/2023 during approximately 1:20 the Administrator of Reference: | he findings at the times of ng the survey exit at PM, the surveyor informed the deficiency. 7 Alarm Annunciator. A | | review wi months, t test log fo The Main bring resu | Monitoring Intenance Director/designee Intenance Director/designee Intenance Administrator weekly Intenance Compliance. Intenance Director/designee | y for 3 panel e will or | | | |

| | | X1) PROVIDER/SUPPLIER/CLIA (X2) MUL [*] IDENTIFICATION NUMBER: A. BUILDI | | | CONSTRUCTION 1 | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|-----------|-----|---|-------------------------------|----------------------------|--|
| | | 315214 | B. WING _ | | | 08 | /11/2023 | |
| NAME OF PROVIDER OR SUPPLIER ARISTACARE AT CEDAR OAKS | | | | 13 | TREET ADDRESS, CITY, STATE, ZIP CODE 311 DURHAM AVENUE OUTH PLAINFIELD, NJ 07080 | • | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| K 916 | remote annunciator the powered shall be provided the generating room is observed by operating work station (see 700 Electrical Code). The hard-wired to indicate emergency or auxiliar (1) individual visual sistemation following: (a) When the emer source is operating to (b) When the batte (2) Individual visual saudible signal to warralarm condition shall (a) Low lubricating (b) Low water temprequirement in 6.4.1. (c) Excessive wate (d) Low fuel when it | nat is storage battery vided to operate outside of n a location readily g personnel at a regular 1.12 of NFPA 70, National annunciator shall be a alarm conditions of the ry power source as follows: ignals shall indicate the gency or auxiliary power o supply power to load. ry charger is malfunctioning. ignals plus a common of an engine-generator include the following: oil pressure perature (below that 1.11) r temperature the main fuel storage tank -hour operating supply | KS | 916 | Assurance Performance Improvement Committee monthly for 3 months. Qua Assurance Performance Improvement Committee, based on results, a decisic will be made regarding the need for continued submission and reporting to committee. | ality on | | |

POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / | MULTIPLE CONSTRUCTION | | DATE OF REVISIT | |
|------------------------------|-----------------------------------|---------------------------------------|-----------------|----|
| IDENTIFICATION NUMBER | A. Building 01 - MAIN BUILDING 01 | | | |
| 315214 _{Y1} | B. Wing | Y2 | 9/28/2023 | Y3 |
| NAME OF FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| ARISTACARE AT CEDAR OAKS | | 1311 DURHAM AVENUE | | |
| | | SOUTH PLAINFIELD, NJ 07080 | | |
| | | | | |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITE | M | DATE | ITEM | | | DATE | ITEM | | | DATE |
|---|-----------------------|--|-----------|------------|--------------|----------------------|---------------|-----------------------|-----|-----------------------|
| Y4 | | Y5 | Y4 | | | Y5 | Y4 | | | Y5 |
| ID Prefix | NFPA 101 | Correction | ID Prefix | NFPA 1 | 01 | Completed | ID Prefix | NFPA 101 | | Correction |
| LSC | K0324 | 09/10/2023 | LSC | K0345 | | 09/10/2023 | LSC | K0351 | | 09/25/2023 |
| ID Prefix | | Correction | ID Prefix | | | Correction | ID Prefix | | | Correction |
| Reg. # LSC | NFPA 101 K0355 | Completed 09/10/2023 | Reg. # | NFPA 1 | 01 | Completed 09/10/2023 | Reg.# | NFPA 101 K0531 | | Completed 09/10/2023 |
| ID Prefix | | Correction | ID Prefix | | | Correction | ID Prefix | | | Correction |
| Reg. # | NFPA 101 | Completed | Reg. # | NFPA 1 | 01 | Completed | Reg.# | | | Completed |
| LSC | K0911 | 09/10/2023 | LSC | K0916 | | 09/25/2023 | LSC | - | | |
| ID Prefix | | Correction | ID Prefix | | | Correction | ID Prefix | | | Correction |
| Reg. # LSC | | Completed | Reg. # | | | Completed | Reg. # LSC | | | Completed |
| ID Prefix Reg. # | | Correction | ID Prefix | | | Correction | ID Prefix | | | Correction Completed |
| LSC | | Completed | LSC | | | | LSC | | | Completed |
| REVIEWE STATE AC | | REVIEWED BY (INITIALS) | DATE | | SIGNATURE OF | SURVEYOR | 1 | D | ATE | |
| REVIEWE CMS RO | ED BY | REVIEWED BY (INITIALS) | DATE | | TITLE | | | D | ATE | |
| FOLLOWUP TO SURVEY COMPLETED ON 8/11/2023 | | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? | | | | | YES | s 🔲 no | | |