STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 1/18/2023. The facility was found to be in compliance with 42 CFR 483.73	E 000		
F 000	INITIAL COMMENTS Survey Date: 2/22/23 Census:107 Sample: 22 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to accurately assess two residents' status in the Minimum Data Set (MDS), an assessment tool used to evaluate resident's care needs. This deficient practice was observed for 2 of 22 residents reviewed, Resident #21 and #31 and was evidenced by the following: 1. Review of the Admission Record indicated that	F 641	Resident #31 and Resident #21 had no adverse effects. Both Residents had their MDS modified and corrected. All those who smoke and have a catheter are potentially affected. Re-education performed with MDS coordinator on the importance of adhering to accuracy of assessments performed	2/3/23

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

Electronically Signed | 02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(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 641	Continued From page 1 Resident #31 was admitted to the facility on EX Order 26.4B1. Review of the most recent quarterly MDS dated EX Order 26.4B1 indicated that Resident #31 had a Brief Interview of Mental Status of NJ EX meaning the resident had EX Order 26.4B1 EX Order 26.4B1 Medical Diagnosis for Resident #31 included, but not limited to EX Order 26.4B1 [redacted] On 01/27/2023 at 09:45 AM, the surveyor reviewed the most recent quarterly MDS dated EX Order 26.4B1. Under section H, titled EX Order 26.4B and EX Order 26.4B1 "no" was marked for EX Order 26.4B1. Earlier review of the progress notes indicated the EX Order 26.4B1 was initially inserted on EX Order 26.4B1 and was present on the day of the review. On 02/01/2023 at 12:53 PM, the surveyor interviewed the Minimum Data Set Coordinator (MDSC) regarding the answer "no" under section H for EX Order 26.4B1 and why EX Order 26.4B1 EX Order 26.4B1 was marked no. The MDSC said the resident had the EX Order 26.4B1 and then it was removed and then reinserted. The surveyor was told the EX Order 26.4B1 was reinserted on EX Order 26.4B1. The surveyor asked the MDSC when the quarterly MDS, section H, that was completed on EX Order 26.4B1 was updated and the MDSC replied, "when it was brought to my attention on January 30th". This was after the surveyor's inquiry. 2. On 01/27/2023 at 2:05 PM, the surveyor	F 641	and evaluating residents Care needs. A bi-weekly audit of smokers and catheter residents MDS will be performed MDS/Designee. MDS/designee will coordinate the results of the bi-weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks then monthly for 3 more months. MDS/designee will provide a report of findings to the QA committee for action as appropriate. Date of Compliance 2/3/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(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 641	Continued From page 2 observed resident #21 outside in the smoking area, smoking a cigarette. There was a staff member present and the resident could also be seen through the glass door by the front desk receptionist. There was a cigarette disposal receptacle that the resident was utilizing as well. On 01/30/2023 at 10:59 AM, the surveyor interviewed Resident #21 and he/she stated that he/she smokes and the facility holds their cigarettes at the front desk and Resident #21 retrieves the cigarettes when he/she was ready to smoke during the designated smoking times. At that same date and time, review of the admission MDS that was completed on EX Order 26.4B1 by the MDS Coordinator (MDSC) showed that Resident #21 was admitted on EX Order 26.4B1, and has a BIMS of EX Order has limited assistance with ADL's, and under section J1300, Resident #21 was listed as 0 for (No) under current tobacco use. Resident #21 should have been coded number 1 for (Yes) as being a smoker on the admission MDS. Medical diagnosis for Resident 21 included, but not limited to EX Order 26.4B1 On 02/01/2023 at 12:53 PM, MDSC was interviewed by surveyors and asked about the process for a new admission and how the MDSC	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 641	Continued From page 3	F 641		

would know that a newly admitted resident was a smoker. The MDSC stated the info usually comes in and is available on the paperwork that presents with the resident and if not, then the MDSC would have to rely on staff to let her know that info and sometimes it is not given to her.

On 02/01/2023 at 12:58 PM, the Administrator was interviewed and confirmed that the MDS should be documented and coded correctly to identify whether the resident was a smoker and there should be a smoking assessment done for smokers as well.

On 02/01/2023 at 1:35 PM, the surveyor reviewed the care plan (CP) and Resident #21's care plan area revealed that resident has EX Order 26.4B1 related to smoking which was initiated on EX Order 26.4B1 and revised on EX Order 26.4B1. The CP did not address any safety measures for the resident to adhere to, no mention of smoking times, where cigarettes/matches are to be stored, or the process for staff or the resident to follow to ensure Resident #21's safety.

Upon further review, there were no smoking assessments available for Resident #21. The Administrator was asked for MDS, CP, and smoking assessments. MDS and CP were provided but no smoking assessment was received.

There also was nothing specific that shows that the resident agrees to adhere to the facility's smoking policy up to or through the review date. Surveyor was provided a blank smoking policy that was not signed by Resident #21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 641	Continued From page 4 On 02/01/2023 at 02:08 PM, the surveyor reviewed the policy provided by the facility titled, "Smoking Policy", an undated policy. The policy revealed, "AristaCare at Norwood Terrace shall establish and maintain safe smoking practices. All smokers are supervised at AristaCare at Norwood Terrace. 4. The staff will review as needed and quarterly the status of a resident's smoking privileges periodically and consult as needed with the Director of Nursing and attending physician." The last line stated, "I have been informed of the AristaCare at Norwood Terrace Smoking policy and agree to abide by it." with a line for a signature. This policy was presented to the surveyor unsigned by Resident #21. On 02/02/2023 at 11:20 AM, the surveyor reviewed the policy provided by the facility titled, "MDS Completion and Submission Timeframes", an undated policy. The policy revealed "our facility will conduct and submit resident asssessments in accordance with current federal and state submission timeframes." The policy did not speak to the accuracy of MDS assessments, only to submitting the MDS within the required timeframes.	F 641		
F 658 SS=D	NJAC 33.2 (d) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		2/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 658	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain profession standards of clinical practice for 2 of 22 residents (Resident #8 and #66) reviewed by a.) documenting on the Treatment Administration Record (TAR) that preventative EX Order 26.4B1 were applied to a resident when they were not and not following the physicians most recent order for EX Order 26.4B1 and b.) correctly transcribe an order to the Medication Administration Record (MAR) to remove a EX Order 26.4B1. This deficient practice was evidenced by the following: a.) On 01/23/23 at 10:53 AM, during the initial tour of the facility Resident #8 was observed in bed. The surveyor observed that there were NJ Exec. Order [redacted] on the resident's nightstand. Resident #8 told the surveyor they get put on at night. The surveyor asked the resident if he/she could move legs and the resident said, NJ Exec. Order 26:4.b.1 Review of the Admission Record indicated that Resident #8 was admitted to the facility on NJ Exec. Order 26:4.b. [redacted]. Review of the most recent annual Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 showed Resident #8 had a Brief Interview of Mental Status (BIMS) of EX Ord [redacted], meaning the resident was EX Order 26.4B1 Section G of the MDS, functional status indicated the resident was a NJ Exec. Order 26:4.b.1 [redacted]. Medical diagnoses included, but not limited to	F 658	Residents #8 and #66 did not have any adverse effects. Resident #8 had her orders updated right away to remove the old order of having EX Order 26.4B1 at all times. Resident #66 had order for EX Order 26.4B1 updated to reflect on the MAR. All residents with heel booties or lidocaine patch orders have the potential to be affected. Education/In-service performed with Nurses on following physician orders and on reflecting the orders on the MAR. Nursing administration/ designee performed an audit on all residents with orders for Heel booties and Lidocaine patches to ensure orders are entered correctly and being followed. A weekly written audit will be conducted by the DON/Designee for Heel booties and Lidocaine patches to ensure orders are entered correctly and being followed. DON/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. DON/designee will provide a report of her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(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 658	Continued From page 6 EX Order 26.4B1 [redacted] On 01/25/23 at 09:53 AM, the surveyor reviewed the physician orders and there was an active order for 'EX Order 26.4B1 on at all times" The order date was EX Order 26.4B1 and remained an active order. There was also an older order for EX Order 26.4B1 while in bed every shift for EX Order 26.4B1 prevention with a start date of EX Order 26.4B1 On 01/25/23 at 10:35 AM, the surveyor went to see the resident. A housekeeper in the room told the surveyor the resident was "in activities on the EX Order 26.4B1". The surveyor observed the resident's EX Order 26.4B1 on the nightstand next to the bed. On 01/25/23 at 10:48 AM, the surveyor observed Resident #8 in the EX Order 26.4B1 dining room participating in activities while sitting in a wheelchair. The resident did not have any EX Order 2 EX Order 26.4 on during the observation. On 01/26/23 on 10:38 AM, the surveyor observed the resident in bed. The resident had EX Order 26.4B1 to EX Order 26.4B1. The surveyor asked the resident if he/she wore them all the time and the resident said "no, I wear them in bed, when I'm in the wheelchair, I don't need to wear anything on my EX Order 26 . On 01/26/23 at 11:15 AM, the surveyor reviewed the Treatment Administration Record (TAR) and it showed the nurses were signing the resident's EX Order 26.4 as applied on day shift, evening shift, and night shift, meaning the resident was wearing the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 658	Continued From page 7 [redacted] each day. On 1/27/23 at 11:20 AM, the surveyor observed Resident #8 in the day room sitting in a wheelchair for activities. The resident did not have the [redacted] in place. On 01/27/23 at 11:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding Resident #8[redacted]. The surveyor asked how they were ordered by the physician and the LPN said, "all the time", but the resident usually just wears them in bed. "Sometimes she/he doesn't want to wear them". On 01/27/23 at 12:02 PM, the surveyor reviewed the progress notes for December 2022 and January 2023. There was no documentation that Resident #8 was refusing to wear the [redacted] On 01/27/23 at 12:56 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) regarding Resident #8 and the [redacted]. The UM/LPN told the surveyor the resident is supposed to always wear them but has been refusing lately. The surveyor asked why the nursing staff were documenting the boots as being on the resident during the day, evening and night shifts and the UM/LPN said, "they should not document that if the [redacted] are not on". The surveyor asked if the physician was aware of the resident's [redacted] and the UM/LPN said, "we will have to document he/she is refusing and let the doctor know". On 02/01/23 at 10:12 AM, The Licensed Nursing Home Administrator (LNHA) met with surveyor and explained that Resident #8 had two orders	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(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 658	Continued From page 8	F 658		

for EX Order 26.4B1, one order said at all times and one order said while in bed. The LNHA said the staff were following the most up to date order of while in bed. The surveyor asked why the Treatment Administration Record was signed as if the resident was wearing the EX Order 26.4 on days, evenings, and nights and the LNHA said, "no your right they shouldn't have signed as if they were on, I can't argue with that".

b. On 01/26/23 at 11:10 AM the surveyor observed Resident #66 completing a puzzle with the assistance of a staff member.

According to the Admission Record, Resident #66 was admitted to the facility with a diagnosis including but not limited to EX Order 26.4B1, unspecified. A review of his EX Order 26.4B1 quarterly minimum data set reflects that he has EX Order 2 and EX Order 26.4B1 deficits

Review of the EX Order 26.4B1 EX Order 26 medication administration record (MAR) and EX Order 26.4B1 MAR of Resident #66 reflected an order for EX Order 26.4B1 apply to EX Order 26.2 EX Order 26 topically one time a day for EX Order 26.4B1. There was no order observed to remove the NJ Exec. Order 26

Review of the Order Summary Report with Active Orders as of EX Order 26.4B1 reveals under the heading "other" to remove EX Order 26.4B1 at bedtime per schedule with a date of EX Order 26.4B1. The order was not transcribed to the MAR for the nurse to remove the EX Order 26.4B

During an interview on 1/27/2023 at 12:10PM, the Director of Nursing stated that the order to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 658	Continued From page 9 remove the EX Order 26.4B1 was ordered and designated in the "other" category and was not designated to the (MAR). Review of the Facility's policy "Physicians' Medication Orders", revealed 7. Order will be electronically shown on the MAR or TAR	F 658		
F 690 SS=D	NJAC 8:39-27.1 (a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		2/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 690	Continued From page 10 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation it was determined that the facility failed to obtain physician orders for EX Order 26.4B1 EX Order 26.4B1 care for Resident #31, 1 of 2 resident reviewed for EX Order 26.4B1 and was evidenced by the following: On 01/23/23 at 10:40 AM, during the initial tour of the facility Resident #31 was in the bed. The surveyor observed a EX Order 26.4B1 with EX Order 26.4B1 hanging at the bedside. The EX Order 26.4B1 collection bag was in a privacy bag. Review of the Admission Record indicated that Resident #31 was admitted to the facility on EX Order 26.4B1 Review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 indicated that Resident #31 had a Brief Interview of Mental Status of EX Order meaning the resident had EX Order 26.4B1 . Review of section G, functional status, of the MDS indicated the resident was a NJ Exec. Order 26:4.b.1 for transfers, mobility, dressing, and personal hygiene. Medical Diagnosis for Resident #31 included, but not limited to EX Order 26.4B1	F 690	Resident #31 did not have any adverse effects. Received a physician order to remove EX Order 26.4B1 and updated in residents chart. Audit performed on all residents with EX Order 26.4B1 to ensure there are physician orders. All residents with catheters who do not have an order have potential to be at risk. Education performed with nursing to ensure there are physician orders for residents with catheters. A weekly written audit will be conducted on all residents with catheters by DON/Designee to ensure that they have an appropriate physician order. The DON/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. DON/designee will provide a report of her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(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 690	Continued From page 11	F 690		

EX Order 26.4B1

On 01/27/23 at 09:32 AM, the surveyor reviewed the Physician Orders (POS) which showed an order for the following: EX Order 26.4B1 EX Order 26.4B1) every shift for EX Order 26.4B1 document output, it was an active order dated EX Order 26.4B1 Further review of the orders did not show any orders for changing the EX Order 26.4B1

On 01/27/23 at 10:06 AM, the surveyor reviewed the progress notes which showed the EX Order 26.4B1 EX Order 26.4B1 was inserted on EX Order 26.4B1

The following was documented in the progress notes: Order given by Nurse Practitioner for EX Order 26.4B1. Order carried out scan shows EX Order 26.4B1 EX Order 26.4B1 inserted, output EX Order 26.4B .

On 01/27/23 at 10:10 AM, the surveyor reviewed the Treatment Administration Record (TAR) for EX Order 26.4B1 The EX Order 26.4B1 TAR included the following order: EX Order 26.4B1 every shift for EX Order 26.4B1 retention document output. The order had a start date of EX Order 26.4B1. The TAR was blank from EX Order 26.4B1 meaning not signed as done by any nurses, and the progress notes indicated the EX Order 26.4B1 was inserted EX Order 26.4B1. The EX Order 26.4B1 TAR included an EX Order 26.4B1 EX Order 26.4B1 every shift for EX Order 26.4B1 retention and document amounts every shift.

On 01/27/23 at 12:45 PM, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 690	Continued From page 12 interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) regarding EX Order 26.4B1 and EX Order 26.4B1. The surveyor asked the UM/LPN what gets documented for EX Order 26.4B1 after insertion. The UM/LPN told the surveyor, "The actual insertion and the size of the EX Order 26.4B1 will get documented in the computer". The surveyor asked how often EX Order 26.4B1 are changed and the UM/LPN told the surveyor they were changed weekly and documented in the electronic medical record and "there should be a physician order". The surveyor asked if that documentation should be on the Treatment Administration Record and the UM/LPN said "yes". The UM/LPN could not speak to why it was not on the residents TAR. On 2/2/23, the surveyor reviewed the policy titled, "Catheter Care, Urinary", an undated policy. The policy did not contain guidelines for documentation of urinary catheters.	F 690		
F 695 SS=D	NJAC-8:39-33.2 (c) 5 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the	F 695	Resident #19 did not have any adverse	2/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(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 695	Continued From page 13 medical record and other facility documentation, it was determined that the facility failed to obtain a physician order for the use of [redacted] for 1 of 1 residents reviewed for [redacted], (Resident #19). This deficient practice was evidenced by the following: During the initial tour of the facility on [redacted] at 10:40 AM the surveyor observed Resident # 19 in bed receiving [redacted] via [redacted] On 01/24/23 at 11:48 AM and on 01/26/23 10:41 AM the surveyor observed Resident #19 receiving [redacted]. According to the Admission Record, Resident #19 was admitted to the facility with diagnosis of [redacted] The surveyor reviewed the Clinical Physician Orders for Resident #19 and did not observe an order for [redacted] The surveyor reviewed the January 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) and did not observe an order for [redacted] During an interview on 01/26/23 at 11:12 AM, the assigned Licensed Practical Nurse (LPN) stated Resident #19 uses [redacted] continuously. During an interview on 01/27/23 at 9:38 AM, the LPN Nurse Manager (LPN/NM) stated that Resident # 19 uses [redacted] continuously. She furthered that a Physician's Order (PO) is	F 695	effects. Nursing Manager immediately received a physician order and updated residents chart. All residents on oxygen potentially affected. Audit performed for all residents on oxygen to ensure we have a physician order. Education performed with nursing staff to ensure they obtain physician orders. A weekly audit of everyone that is on oxygen to ensure that they have physician orders will be conducted by the DON/Designee. The DON/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly and then report in the QA meeting monthly 2 more months. DON/designee will provide a report of her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 695	Continued From page 14 required for the use of [redacted]. When the Surveyor and LPN/NM reviewed the PO for Resident #19, the LPN/NM replied, "She doesn't have an order." During an interview on 01/30/23 at 11:38 AM the Director of Nursing acknowledged that Resident #19 should have an order for [redacted]. A review of the facility provided [redacted] Administration policy reflects 1. Verify that there is a physician's order for this procedure.	F 695		
F 812 SS=E	N.J.A.C. 8:39-27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		2/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 812	Continued From page 15 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was evidenced by the following: On 01/23/2023 at 9:54 AM, the surveyor toured the kitchen, in the presence of the Director of Dietary (DOD) and observed the following: In the food preparation area, there were 4 cartons of milk and 6 dessert cups that were sitting on the table, unlabeled, and not refrigerated or being kept cold on ice. The DOD stated the items were left over from breakfast and confirmed the milk and dessert cups should have been labeled and refrigerated. In the main area of the kitchen against the wall next to the refrigerator, there were several boxes of ice cream that were unlabeled in the stand alone ice cream freezer cart. The DOD confirmed that the boxes of ice cream should have been labeled. In the dry storage room, the surveyor selected random cans from the non-dented shelf and observed 3 dented cans on the non-dented can	F 812	The 4 cartons of milk and 6 desert cups were labeled immediately, All unlabeled ice-cream was discarded. Dented cans were immediately moved to a dented cans shelf. All items were rewashed and air dried appropriately. Pan which was damaged was discarded immediately. Immediately called down our dishwashing company to service the dish washing machine. All residents who eat from the kitchen have the potential to be affected Dietary director performed in-service/education on labeling properly. Dietary director performed audit on all items that need to be labeled to ensure they are labeled properly. Dietary director performed education on where to store dented cans and performed an audit on all cans to ensure they are not dented. All staff were in-serviced and educated on proper drying techniques and ensuring that no pans be placed on top of each other while wet. Dietary director performed education on damaged pans that they cannot be used and on the shelf with the good pans. Dietary director performed an audit on all current pans being used to ensure they	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 812	Continued From page 16 shelf. The DOD removed the 3 dented cans, placed them on the dented can's shelf and confirmed the cans should not have been there. On the overhead shelf, there was an unlabeled bag of oats and a container of Argo that was open and exposed to the air. In the dry storage room, there was an unlabeled box of large coffee filters that were outside the plastic wrap and exposed to the air. The DOD confirmed there should have been a label on the plastic bag of oats, on the Argos box, and on the box containing the large coffee filters. The DOD also confirmed that the plastic bag of oats, the box of Argos, and the large coffee filters should not have been left open and exposed to the air. On a bottom shelf of the dry pot/pan storage rack, the surveyor observed a wet, watery substance on the base of 2 pans. The surveyor touched the first pan base and it was determined to be wet to the touch. The surveyor then asked the DOD to move the second pan and observed the second pan base to be wet with a watery substance and wet to the touch. The second pan's handle was also melted and burned on top. The DOD observed the same and confirmed that the 2 pans were wet to the touch. The DOD removed the 1 pan to be rewashed and threw the second pan with the burnt handle in the garbage. On 01/30/2023 at 9:40 AM, during the second tour of the kitchen, the surveyor observed the dish machine cycle. The dietary aide (DA) pushed the full rack of food insulated tops through the machine, the surveyor and DOD observed that the final rinse cycle did not reach 180 degrees, even after the second attempt was	F 812	are not damaged. The dishwasher machine was serviced by the dish service company. Dietary director performed a re-education with the staff regarding proper temperatures for washing and rinsing. Staff also re-educated on moving to 3 compartment sink if the temperature is not correct. A weekly audit will be conducted by Dietary Director on all these items. Dietary Director will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks then monthly for 2 more months. Dietary director will provide a report of her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 812	Continued From page 17	F 812		

made. The DA stated "maybe the machine needs time to warm up like when you warm your car up in the morning." The DOD shut the machine down and advised surveyor that the Dish Service company would be called and the facility was equipped with disposables and they also had other dishes that were sanitized at the right temperature that could be used.

Review of the facility's "CCS Dating and Labeling" policy outdated 09/20/2021, revealed "the kitchen will assure food safety by maintaining proper dates and labels for all ready to eat products. 2. all food items will be labeled with a received date upon acceptance of delivery.

Review of the facility's "Dented Can" policy dated 07/06/2022, revealed "kitchen will receive quality acceptable canned goods. Uacceptable, dented canned goods will be reported and returned/discarded in a timely manner. 2. upon discovery, place dented can in the designated "Dented Can" area.

Review of the facility's "Wet Nesting of Kitchen Wares" policy outdated 09/05/2021, revealed the kitchen will wash, rinse, sanitize and air dry (when wet) all pots, pans, cook ware, service wares and small wares following each meal. Items will not be force dried with any type of rags or wipes. 1. After items have been properly cleaned, rinsed and sanitized and items are still wet staff will stack or angle pans in such a way on a designated clean "air drying" rack so they may completely dry prior to usage without any pooling or nesting water visible or to touch.

Review of the facility's Dish Machine Process"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(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 812	Continued From page 18 policy undated, revealed before using dishwashing machine, make sure soap, sanitizer, and drying agent is enough and hooked up properly. Wash is minimum of 150 degrees and rinse is minimum of 180 degrees. NJAC 8:39-17.2	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062020	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 000	Initial Comments The facility was not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
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: Based on interview and review of other facility documents, 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. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 12 of 14 day shifts, and deficient in total direct care staff on one of 14 evening and one of 14 overnight shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	All residents are potentially affected by this practice. Rates increased Sign on with new agencies Offer agency staff bonuses Offer our staff bonuses Job Fair Posting new ads around town and via social media Referral bonuses for our staff Referral bonuses for community Sign on bonus The don to have weekly meetings with staffing coordinator to determine	2/3/23

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

Electronically Signed | 02/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062020	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 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 (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 signed in to work as a CNA and shall perform nurse aide duties: and One (1) 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. As per the "Nurse Staffing Report" completed by the facility for the weeks of 1/8/2023 through 1/14/2023 and 1/15/2023 through 1/21/2023, the staffing-to-resident ratio did not meet the minimum requirements and is documented below: The facility was deficient in staffing for residents on 12 of 14 day, one of 14 evening, and one of 14 overnight shifts as follows: -01/08/23 had 8 CNAs for 105 residents on the day shift, required 13 CNAs. -01/09/23 had 12 CNAs for 105 residents on the day shift, required 13 CNAs. -01/10/23 had 12 CNAs for 105 residents on the	S 560	upcoming schedules to anticipate needs and keep written minutes of the staffing meeting. The DON/designee will report findings regarding the upcoming schedules from the staffing meeting to the administrator weekly. The DON/designee will aggregate findings from these rounds weekly with the administrator and the DON/designee will provide a report of his/her findings to the QA committee for the next 3 months for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062020	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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		

day shift, required 13 CNAs.
-01/13/23 had 12 CNAs for 105 residents on the day shift, required 13 CNAs.
-01/14/23 had 8 CNAs for 105 residents on the day shift, required 13 CNAs.
-01/15/23 had 9 CNAs for 110 residents on the day shift, required 14 CNAs.
-01/16/23 had 11 CNAs for 109 residents on the day shift, required 14 CNAs.
-01/16/23 had 10 total staff for 109 residents on the evening shift, required 11 total staff.
-01/17/23 had 11 CNAs for 109 residents on the day shift, required 14 CNAs.
-01/18/23 had 11 CNAs for 109 residents on the day shift, required 14 CNAs.
-01/18/23 had 7 total staff for 109 residents on the overnight shift, required 8 total staff.
-01/19/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs.
-01/20/23 had 11 CNAs for 107 residents on the day shift, required 13 CNAs.
-01/21/23 had 6 CNAs for 107 residents on the day shift, required 13 CNAs. (17.83 residents per CNA)

On 2/2/23 at 09:55 AM, the surveyor interviewed the facility Staffing Coordinator (SC). The SC told the surveyor she was aware of the required ratios for Certified Nursing Assistants (CNAs). The SC further told the surveyor, " ...sometimes we do [meet staffing requirements], other times we don't, I will get a call out."

Review of the facility's "Staffing Policy Statement," a policy dated December 12, 2022, under the section titled, "Direct Care Staff to Resident Ratio," indicated the facility would have " ...1. one certified nurse aide to every eight residents for the day shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062020	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(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 2. one direct care staff member to every 10 residents for the evening shift ... 3. one direct care staff member to every 14 residents for the night shift ..."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315217 Y1	A. Building B. Wing Y2	3/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0641	Correction	ID Prefix F0658	Correction	ID Prefix F0690	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	02/03/2023	LSC	02/09/2023	LSC	02/09/2023
ID Prefix F0695	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	02/09/2023	LSC	02/09/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
2/2/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062020 Y1	A. Building B. Wing Y2	3/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

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 02/03/2023	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	
2/2/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 1/23/2023 and 1/24/2023 and AristaCare at Norwood Terrace 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. AristaCare at Norwood Terrace is a Three-story, Type I Fire Resistant building that was built in January 1984. The facility is divided into 9 smoke zones.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 1/23/2023 and 1/24/2023, in the presence of the facility Management, it was determined that the facility failed to maintain exit access free from obstructions. This deficient practice was evidenced by the following:	K 211	Maintenance director immediately removed items for exit access path to ensure that it has 44 inch clearance. All residents had the potential to be affected. Director of Maintenance will perform	2/9/23

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

Electronically Signed | 02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 211	Continued From page 1 On 01/23/2023 (day one of survey) during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms and smoke compartments. A review of the facility provided layout identified that there are ten (10) designated exit discharge doors (illuminated exit signs above doors) in the facility. During the building tour in the presence of the DOM, the surveyor observed the following exit access path that did not maintain the required 44 inch clearance. 1) On 1/24/2023 at approximately 10:05 AM, an inspection inside the first floor Class room was performed. The surveyor observed the designated exit discharge path was blocked with a love seat and a rolling cart with a Tele Health computer system set up. The surveyor asked the DOM, should these items be blocking the exit path. The DOM told the surveyor, no. At the same date and time, the surveyor measured and recorded the exit access path had a 30 inch clearance and not the required 44 inches. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 211	weekly audits on all exit access paths and maintain a log of the audits to ensure the discharge path is not blocked. A weekly written audit will be conducted by the maintenance director/designee for all exit access paths and maintain a log of the audits to ensure the discharge path is not blocked. Maintenance director/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. Maintenance director/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222		2/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 222	Continued From page 3 permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 1/23/2023 and 1/24/2023, it was determined that the facility failed to provide 1 of 10 exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 01/23/2023 (day one of survey) during the survey entrance at approximately 9:27 AM a	K 222	Maintenance director immediately disabled the thumb locks on the door. All residents had the potential to be affected. Director of Maintenance will perform weekly audits and maintain a log of the audits to ensure the door lock is disabled is not blocked. Maintenance director/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. Maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 222	Continued From page 4 request was made to the Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms and smoke compartments. A review of the facility provided layout identified that there are ten (10) designated exit discharge doors (illuminated exit signs above doors) in the facility. During the building tour in the presence of the DOM, the surveyor observed the following, 1) On 1/24/2023 at approximately 10:10 AM, the surveyor observed the main entrance set of automatic sliding exit discharge doors (internal set of doors) revealed thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. Thumb turn locks and fastening device on the door could restrict emergency use of the exit. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222	director/designee will provide a report of his/her findings to the QA committee for action as appropriate.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	K 291		3/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 291	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/23/2023 and 1/24/2023, in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above one (1) of one (1) emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 01/23/2023 (day one of survey), during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms and smoke compartments and if the facility had an Emergency Generator. The DOM told the surveyor, "yes, we have a 350 KW diesel generator." On 1/24/2023 (day two of survey), at approximately 10:50 AM, an inspection of the emergency generator transfer switch was performed. The surveyor observed no evidence of a battery back up emergency light in the area for the generator transfer switch. At this time the surveyor asked the DOM, "Do you have a battery back up emergency light for the transfer switch." The DOM told the surveyor, "no we don't." The DOM confirmed the findings at the time of observations.	K 291	Maintenance director immediately called Electric Company to schedule installation of a battery backup emergency light. Installation date given for 3.1.23. All residents had the potential to be affected. Director of maintenance will oversee installation process and ensure the facility is in compliance. Maintenance director/designee will be responsible for monitoring the battery backup emergency lights function. Maintenance director/designee will check the function weekly. Data will be kept weekly for 4 weeks and reported to the administrator and then monthly for two more months by the Maintenance director or designee to the QA committee and the QA team will determine if further action is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 291	Continued From page 6 The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/23/2023 and 01/24/2023, in the presence of facility management, it was determined that the facility failed to provide 1 illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants.	K 293	Maintenance director immediately called Electric Company to schedule installation of a new Exit sign to clearly identify the exit path. Installation date given 3.1.23. All residents had the potential to be affected. Director of maintenance will oversee installation process and ensure the facility is in compliance. Maintenance director/designee will be responsible for monitoring the new exits sign function. Maintenance director/designee will check the function weekly. Data will be kept weekly for 4 weeks and reported to the administrator and then monthly for two	3/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 293	Continued From page 7 NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 01/23/2023, during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms and smoke compartments. A review of the facility provided layout identified	K 293	more months by the Maintenance director or designee to the QA committee and the QA team will determine of further action is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 293	Continued From page 8 that the building is a three story building with Resident sleeping rooms on the 2nd and 3rd floors in the facility. On 1/23/2023 (day one of survey), starting at approximately 10:00 AM, and continued on 1/24/2023 in the presence of the DOM, a tour of the building was conducted. On 1/24/2023 (day two of survey), at approximately 10:22 AM, the surveyor observed of the 1st floor near the elevators that the facility failed to have one illuminated exit sign above the corridor double doors leading to the lobby area. A review of an emergency diagram posted near the elevators identify that was the primary exit access to reach an exit. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings	K 311		2/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 311	Continued From page 9 between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 1/23/2023 and 1/24/2023, in the presence of facility Management it was determined that the facility failed to ensure that 4 of 9 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This was evidenced by the following: On 01/23/2023, during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms and smoke compartments. A review of the facility provided layout identified there are three floors with three (3) exit stairwells. Starting on 01/23/2023, at approximately 10:00 AM and continued on 1/24/2023, a tour of the building with the DOM was performed. During the two day tour, the surveyor performed closure tests of the nine (9) 1-1/2 hour fire rated corridor doors leading into stairwells with the following results: 1. At approximately 10:22 AM, on the 3rd floor	K 311	Maintenance director immediately put latches on all the doors to ensure they are capable of maintaining the 1-1/2 hour fire rated construction. All residents had the potential to be affected. Director of Maintenance will perform weekly audits and maintain a log of audits to ensure that all exit access doors can maintain the appropriate 1-1/2 hour fire rating construction. A weekly written audit will be conducted for exit access door to ensure they maintain the appropriate 1-1/2 hour fire rating construction. Maintenance director/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. Maintenance director/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 311	Continued From page 10 during a closure test of the exit access door leading into the West stairwell, when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. The surveyor observed the door had no means to positively latch the door into its frame. 2. At approximately 11:21 AM, on the 2nd floor during a closure test of the exit access door leading into the East stairwell, when tested and allowed to self-close into its frame, the door did not positively latch into its frame. The surveyor observed the door had no means to positively latch the door into its frame. 3. At approximately 11:34 AM, on the 2nd floor during a closure test of the exit access door leading into the West stairwell, when tested and allowed to self-close into its frame, the door did not positive latch into its frame. The surveyor observed the door had no means to positive latch the door into its frame. 4. At approximately 11:50 AM, on the 2nd floor during a closure test of the exit access door leading into the North stairwell, when tested and allowed to self-close into its frame, the door did not positively latch into its frame. The surveyor observed the door had no means to positive latch the door into its frame. The stairwell doors would need to positively latch into its frame to maintain the fire rated construction to prevent fire, smoke, and poisonous gases to enter the exit stairwell in the event of a fire.	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 311	Continued From page 11 The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM.	K 311		
K 321 SS=E	Fire Safety Hazard. NJAC 8:39- 31.2(e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 321	Continued From page 12 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 1/23/2023 and 1/24/2023, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 01/23/2023, during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms and smoke compartments. A review of the facility provided layout identified that the building is a three story building with Resident sleeping rooms on the 2nd and 3rd floors in the facility. Starting on 01/23/2023, at approximately 10:00 AM and continued on 1/24/2023, a tour of the building with the DOM was performed. Along the two day tour of the facility, the surveyor observed the following hazardous areas that failed to have smoke resisting doors, 1) On 1/23/2023 at approximately 10:06 AM, an inspection of the third floor Medical Records	K 321	Maintenance director immediately fixed the commercial laundry folding door, the maintenance director adjusted the self-closer to ensure it self closes. The medical records door was fixed by adding means to self close. All residents had the potential to be affected. Director of Maintenance will perform weekly audits and maintain a log of audits to ensure that all fire rated doors can self close. Maintenance director/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. Maintenance director/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 321	Continued From page 13 room was performed. During a closure test of the corridor door leading into the Medical Records storage room, the door had an approximately 1/4 inch gap along the top of the door. The surveyor observed the door had no means to self-close and the room was larger than 50 square feet. The surveyor observed in the room multiple combustible medical records in the room. 2) On 1/24/2023 at approximately 10:42 AM, an inspection of the commercial laundry Resident's clothing folding room was performed. During a closure test of the corridor door leading into the Folding room, the door did not self-close. The surveyor observed the door had no means to self-close and the room was larger than 50 square feet. The surveyor observed in the room, several stacks of Residents' clothing hanging on rolling racks, With these corridor doors not self-closing and having gaps, this would allow fire, smoke, and poisonous gases to pass into the exit access corridor, in the event of a fire. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101	K 324		2/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 324	Continued From page 14 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 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation on 1/23/2023 and 1/24/2024, in the presence of facility management, it was determined that the facility failed to inspect the range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. The deficient practice was evidenced by the following:	K 324	Facility already received the semi-annual kitchen suppression inspection one month later than it was due. All residents had the potential to be at risk. Administrator educated Director of maintenance on the importance of adhering to the scheduled inspections.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 324	Continued From page 15 On 01/23/2023, during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide all mandatory inspections from 06/01/21 to 1/23/2023 for review. Review of the facility's range-hood fire suppression system inspections for the previous 19 months identified the system had two (2) semi-annual inspections on the following dates: 1) 12/16/2021 and 8/04/2022 (7 months between semi-annual inspections), no inspections were provided for January, February, March, April, May, June, and July 2022. A request was made to the DOM if the facility could provide any additional kitchen hood semi-annual inspections. The DOM provided an additional inspection dated for 5/28/2021, no additional documents were provided. The facility did not semi-annually inspect the kitchen suppression system for 7 months in 2021 and went 7 months in between inspections in 2022. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM.	K 324	Director of Maintenance will perform bi-annual audits and maintain a log of audits to ensure that all inspections are happening in a timely manner. Director of maintenance will be responsible to report his findings to the administrator. Maintenance director is responsible to report to administrator completion date and compliance of semi-annual inspection for the kitchen suppression for the next two inspections that are due. Maintenance director will report his findings to the QA Committee that meets monthly for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 324	Continued From page 16 NFPA 101, NFPA 96 NJAC 8:39-31.2(e)	K 324		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sidewall spray sprinklers were installed at the bottom of the elevator hoist-way not more than 2 ft (0.61m) above the floor of the pit that contained combustible hydraulic fluids in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) section 8.15.5.1 and 8.15.5.2. Findings include:	K 351	Maintenance director immediately called APS Fire Suppression Company to schedule installation of a new fire sprinkler at the bottom of the hoist-way. APS has provided a date of March 3rd to come out to the facility. All residents had the potential to be affected. Director of maintenance will oversee	3/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 351	Continued From page 17 On 1/24/2023 during a tour of the building at 11:15 AM, the surveyor observed an elevator contracted mechanic had the outer elevator doors in the open position while he was working inside the hoist-way. The surveyor observed that there were not fire sprinklers at the bottom of the hoist-way. At this date and time, the surveyor asked the elevator mechanic, "Are there fire sprinklers at the top or bottom of the elevator hoist-way." The elevator mechanic told the surveyor, "no there is only smoke detection." The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	installation process and ensure the facility is in compliance. Maintenance director/designee will be responsible for monitoring the new fire sprinklers function once installed. Maintenance director/designee will check the function weekly. Data will be kept weekly for 4 weeks and reported to the administrator and then monthly for two more months by the Maintenance director or designee to the QA committee and the QA team will determine of further action is required.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces	K 363		2/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 363	Continued From page 18 that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 1/23/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 34 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following:	K 363	Maintenance director immediately fixed the latch for the door for room #312. All residents had the potential to be affected. Director of Maintenance will perform weekly written audits and maintain a log of audits to ensure that all corridor doors can resist the passage of smoke. Maintenance director/designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 363	Continued From page 19 On 01/23/2023 (day one of survey), during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms, smoke compartments, and how many resident sleeping rooms are in the facility. The DOM told the surveyor, there were 63 resident sleeping rooms in the facility. A review of the facility provided layout identified there were three (3) floors with resident sleeping rooms on the 2nd and 3rd floors in the facility. Starting at approximately 10:00 am on 1/23/2023 and continued on 1/24/2023, in the presence of the facility's DOM, a tour of the building was performed. During the tour the surveyor performed closure tests of the thirty four (34) doors in the corridors with the following results: On 1/23/2023: 1. At approximately 10:23 AM, on the 3rd floor resident room #312, during a closure test of the corridor door, it did not positively latch into its frame and had an opened gap that was approximately 1 inch. The surveyor observed that the corridor door had no means to positively latch the door into its frame. This would allow fire, smoke, and poisonous gases to pass into the exit access corridor in the event of a fire.	K 363	coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. Maintenance director/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 363	Continued From page 20 Review of facility posted emergency evacuation diagram identify that you would need to pass resident room #312 as the primary and/or secondary exit access route to reach an exit. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 1/23/2023 and	K 374	The maintenance director immediately fixed the double smoke doors next to	2/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 374	Continued From page 21 1/24/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 6 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 01/23/2023 (day one of survey), during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms and smoke compartments. A review of the facility provided layout identified that the building is a three story building with six (6) sets of corridor double smoke doors in the facility. Starting on 01/23/2023 at approximately 10:00 AM and continued on 1/24/2023, a tour of the building with the DOM was performed. The surveyor performed closure tests of the six (6) sets of smoke barrier doors in the corridors with the following results; On 1/23/2023 at approximately 11:46 AM, during a closure test of one set of double smoke doors next to resident room #222 on the second floor,	K 374	room #222. The door was adjusted to meet the requirements. All residents had the potential to be affected. Director of Maintenance will perform weekly written audits and maintain a log of audits to ensure that all double smoke doors do not leave an opening gaps from one smoke compartment to the other smoke compartment. A weekly written audit will be conducted by the maintenance director/ designee and maintain a log of audits on all double smoke doors do not leave an opening gaps from one smoke compartment to the other smoke compartment. Maintenance director/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. Maintenance director/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 374	Continued From page 22 when both doors were released from their magnetic hold open devices and allowed to self close into their frame, the surveyor observed one door moved approximately one inch rubbed on the flooring and stopped. This left an approximately 41 inch opening gap from one smoke compartment to the other smoke compartment. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire, and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM.	K 374		
K 911 SS=D	N.B. 8:39-31.1(c), 31.2(e) Electrical Systems - Other 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:	K 911		2/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 911	Continued From page 23 Based on observation on 1/23/2023 and 1/24/2023, in the presence of facility management, it was determined that the facility failed to ensure that 4 of 10 electrical outlets located next to a water source (within 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 01/23/2023, during the survey entrance at approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility's layout which identifies the various rooms and smoke compartments. A review of the facility provided layout identified that the building is a three story building with Resident sleeping rooms on the 2nd and 3rd, floors and offices, kitchen, dining room, Physical Therapy, and salon are on the 1st. floor. Starting on 01/23/2023 at approximately 10:00 AM and continued on 1/24/2023, a tour of the building with the DOM was performed. During the two day tour, the surveyor observed and tested ten (10) electrical outlets (within 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1. At approximately 9:58 AM, the surveyor observed in the first floor Business office one (1) Duplex electrical outlet 22 inches to the left and one (1) Duplex electrical outlet 21 inches to the right of the sink in the room. When the surveyor	K 911	Maintenance director immediately replace the duplex electrical outlets in the Business Office and Beauty Salon with GFCI outlets. All residents had the potential to be affected. Director of Maintenance will perform weekly written audits and maintain a log of audits to ensure that all outlets next to a water source are equipped with Ground-Fault Circuit Interrupter Protection (GFCI). A weekly written audit will be conducted audits and maintain a log of audits to ensure that all outlets next to a water source are equipped with Ground-Fault Circuit Interrupter Protection (GFCI). Maintenance director/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks weekly then monthly for 2 more months. Maintenance director/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 911	Continued From page 24 tested both Duplex electrical outlets with a GFCI tester to de-energize, both Duplex electrical outlets did not de-energize as required by code. 2. At approximately 10:31 AM, the surveyor observed inside the Beauty Salon two hair washing sinks in the room. The surveyor observed next to the right sink one Duplex and one GFCI electrical outlets. When the surveyor tested both Duplex electrical outlet and GFCI electrical outlet with a GFCI tester to de-energize, both Duplex and GFCI electrical outlets did not de-energize as required by code. The DOM confirmed the findings at the time of the observations. The Administrator was informed of the deficiencies at the survey exit on 01/24/2023 at approximately 12:45 PM.	K 911		
K 918 SS=E	NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8 Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		3/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 918	Continued From page 25 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/23/2023 and 1/24/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 01/23/2023, during the survey entrance at	K 918	Maintenance director immediately called RJ Control the company that services our generator to schedule installation of a new remote manual stop station. Installation set for 3.2.23. All residents had the potential to be affected. Director of maintenance will oversee installation process and ensure the facility is in compliance. Maintenance director/designee will be responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING **01** B. WING _____	**02/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE** **PLAINFIELD, NJ 07060**

(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
K 918	Continued From page 26 approximately 9:27 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility's layout which identifies the various rooms and smoke compartments if the facility had an Emergency Generator. The DOM told the surveyor, "yes, we have a 350 KW diesel generator." On 1/24/2023 (day two of survey) at approximately 10:45 AM, an inspection outside of the building where the Emergency Generator was located was performed. The surveyor observed that the emergency shut off was located on the generator's control panel inside the metal housing. At the same date and time, the surveyor requested if the facility had a Remote emergency stop button that was not inside the housing of the generator. The DOM told the surveyor, no. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 01/24/2023 at approximately 12:45 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	monitoring the remote manual stop stations function. Maintenance director/designee will check the function weekly. Data will be kept weekly for 4 weeks and reported to the administrator and then monthly for two more months by the Maintenance director or designee to the QA committee and the QA team will determine of further action is required.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315217 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	02/09/2023	LSC K0222	02/03/2023	LSC K0291	03/02/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	03/02/2023	LSC K0311	02/03/2023	LSC K0321	02/20/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	02/09/2023	LSC K0351	03/07/2023	LSC K0363	02/03/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	02/09/2023	LSC K0911	02/03/2023	LSC K0918	03/09/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/2/2023	☐ YES ☐ NO