CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			TE SURVEY MPLETED
		315472	B. WING _		0	8/04/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	E AT EAST BRUNSWICK			599 CRANBURY ROAD		
				EAST BRUNSWICK, NJ 08816		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
E 000	Initial Comments		EC	00		
K 000	Appendix Z-Emergen Provider and Supplie	quirements for Long Term	KC	00		
	New Jersey Departm Survey and Field Ope found to be in noncor requirements for part Medicare/Medicaid at Safety from Fire, and National Fire Protecti	icipation in 42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING				
K 291 SS=D	building that was built Type V protected. Th	inswick is a one-story t in 2001, It is composed of e facility is divided into 4- enerator does 100% of the	K 2	91		8/5/21
	is provided automatic 18.2.9.1, 19.2.9.1 This REQUIREMENT by: Based on observatio	f at least 1-1/2-hour duration ally in accordance with 7.9. is not met as evidenced n and interview on 08/03/21,		1. The equipment for lighti		
	battery backup emergency generator	's transfer switch, uilding's electrical system		the same day and installed 2. Other areas for lighting v There is only one generato other resident areas identif could be affected by this du	vere inspected. r room, no ied. The facility	

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

08/22/2021

PRINTED: 04/12/2022

FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-0
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED		
		315472	B. WING		08/04/2021
NAME OF PROVIDER OR SUPPLIER			•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
CARE ON	E AT EAST BRUNSWICK			599 CRANBURY ROAD EAST BRUNSWICK, NJ 08816	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
K 291	Continued From page	e 1	K 29	11	
	This deficient practice was evidenced by the following: During a tour of the building, in the presence of the Maintenance Director at approximately 11:58 AM, the surveyor observed in the Electrical room, where the emergency generator transfer switch is located, was not equipped with a backup battery emergency light. This finding was confirmed by the Maintenance Director, Housekeeping Director and Regional Plant Operations Director in an interview during the observation. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 08/03/21.			emergency and there would be no lig near the emergency generator's tran switch. 3. Director of Maintenance and/or his	sfer
				 designee will conduct weekly inspect of the areas in the facility that require emergency lighting. 4. Findings of these audits will be presented to the Administrator and presented at the Quality Assurance Committee meeting for a period of the months. 	3
K 521 SS=D	NJAC 8:39-31.2(e) NFPA 101:2012 - 19.3 HVAC CFR(s): NFPA 101	2.9.1, 7.9	K 52	1	8/5/21
	HVAC Heating, ventilation, a comply with 9.2 and s accordance with the r specifications. 18.5.2.1, 19.5.2.1, 9.2	manufacturer's			
	by:	is not met as evidenced n and interview on 08/03/21,		1. The vendor was contacted the sa	ame

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Event ID: U6PQ21

Facility ID: NJNDFH9U

completed

day and the equipment was ordered, the repairs were scheduled and have been

2. Rounds were completed and no other

in the presence of the facility Maintenance

Director, Housekeeping Director and Regional Plant Operations Director, it was determined that

the facility failed to ensure resident bathroom

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUI		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
		315472	B. WING _				08/04/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CARE ON	IE AT EAST BRUNSWICH	K			9 CRANBURY ROAD AST BRUNSWICK, NJ 08816		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 521	ventilation system's f adequately maintaine National Fire Protect B. This deficient practice following: Starting from 11:00 A surveyor observed th following resident roo function: The surveyor reques Director, Housekeep Plant Operations Dire were functioning by p toilet tissue paper ac confirm ventilation. W not hold in place. The not provided with a w on mechanical ventils At that time, the surv Maintenance Directo and Regional Plant O confirmed that the ap vents in the above re not functioning when The Regional Plant O Maintenance Directo Breaker for the first w	ted that the Maintenance ing Director and Regional ector, confirm if the units olacing a piece of single-ply ross the ceiling grills to Vhen tested, the tissue did e resident bathrooms were vindow and required reliance ation.	K	521	resident rooms were identified. All residents may be affected by bathro ventilation systems not being adequ maintained. 3. The Director of Maintenance will continue to monitor exhaust fans an report variances from the inspection a corrective action if needed. 4. Director of Maintenance and/or his designee will report the outcome of inspections at the Quality Assurance Committee for a period of three mor	ately d with these	

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Event ID: U6PQ21

Facility ID: NJNDFH9U

If continuation sheet Page 3 of 4

	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE NO. 0938-039	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARE ONE AT EAST BRUNSWICK STREET ADDRESS, CITY, STATE, ZIP CODE (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) (X3) COMPLET DATE K 521 Continued From page 3 The Administrator was informed of this deficiency at the Life safety code exit conference on 08/03/21. K 521 K 521 NFPA 90A NFPA 101-2012 - 19.5.2.1 section 9.2.2 NFPA 101-2012 - 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NFPA 90.1 Utilities NFPA 90.1 Utilities								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARE ONE AT EAST BRUNSWICK STREET ADDRESS, CITY, STATE, ZIP CODE (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) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x6) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x7) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x8) (COMPLET TAG K 521 Continued From page 3 The Administrator was informed of this deficiency at the Life safety code exit conference on 08/03/21. K 521 NFPA 90A NFPA 101-2012 - 19.5.2.1 section 9.2.2 NFPA 101-2012 - 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NTIME ADDRESS			315472	B. WING		_	08/04/2021	
EAST BRUNSWICK, NJ 08816 (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 ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE K 521 Continued From page 3 The Administrator was informed of this deficiency at the Life safety code exit conference on 08/03/21. K 521 K 521 NFPA 90A NFPA 101-2012 - 19.5.2.1 section 9.2.2 NFPA 101-2012 - 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NTHE Addition of the section 9.2.2 NFPA 101-2012 - 19.5.2.1 Chapter 9.1 Utilities Image: Colspan="2">Image: Colspan="2">Continued From page 3 The Administrator was informed of the deficiency at the Life safety code exit conference on 08/03/21.	NAME OF PROVIDER OR SUPPLIER						-	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE K 521 Continued From page 3 The Administrator was informed of this deficiency at the Life safety code exit conference on 08/03/21. K 521 K 521 NFPA 90A NFPA 101-2012 - 19.5.2.1 section 9.2.2 NFPA 101-2012 - 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NTIME ADMINISTRATION OF A DEFICIENCY Image: Completence on Co	CARE ON	E AT EAST BRUNSWICK	k		EAST BRUNSWICK, N	J 08816		
The Administrator was informed of this deficiency at the Life safety code exit conference on 08/03/21. NFPA 90A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRI	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	(X5) COMPLETION DATE	
		Continued From page The Administrator wa at the Life safety code 08/03/21. NFPA 90A NFPA 101-2012 -19.5 NFPA 101-2012- 19.5 9.2.1	e 3 s informed of this deficiency e exit conference on 5.2.1 section 9.2.2					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: U6PQ21

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