STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING **01** B. WING ___	**08/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 08/02/2023 and 08/03/2023 and Aristcare at Cedar Oaks was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Aristacare at Cedar Oaks is a 3-story building that was built in the January 1984. It is composed of Type II Protected construction. The facility is divided into 15 smoke zones.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as	K 324		9/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/30/2023

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

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K 324	Continued From page 1 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 observations on 08/03/2023, in the presence of facility management it was determined that the facility failed to ensure that cooking equipment was protected in accordance with NFPA (National Fire Protection Association) 96. This deficient practice was evidenced for 1 of 2 six (6) burner natural gas stoves and was evidenced by the following, On 08/03/2023 at approximately 12:20, in the presence of the facility Maintenance Director (MD) the surveyor observed in the main kitchen, two six (6) burner gas stoves. The right side 6 burner stove had the wet chemical's suppression systems two nozzles pointing away off to the right side of the stove and not aiming towards the 6 burner stove. The MD confirmed the finding at the time of observation. On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NFPA 96. NJAC 8:39-31.2 (e).	K 324	F324- Cooking Facilities Immediate Action The right side 6 burner stove had the wet chemical's suppression systems two nozzles pointing away off to the right side of the stove were re-aligned by the Maintenance Director on 8/3 to aim towards the 6 burner stove. The FSD/designee and Maintenance Director were verbally re-in-serviced on proper direction of kitchen suppression system nozzles. The FSD/designee added to their monthly audit sheet proper direction of kitchen suppression system nozzles to ensure compliance. Identification of Others All residents have the potential to be affected by the deficient practice. The Maintenance Director/designee audited all other possible locations on 8/3 that have wet chemical's suppression systems with no other issues found.	

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K 324	Continued From page 2 NFPA 101- 2012: -19.3.2.5	K 324	Systemic Changes The Maintenance Director/designee will do a visual audit of the kitchen chemical's suppression systems nozzles daily for 1 week, then weekly x 1 month for 3 months to ensure the right side burner wet chemical's suppression systems nozzle are aiming towards the 6 burner stove using an audit tool. The audit tool will be reviewed with Administrator for 1 week, then weekly x 1 month for 3 months. Quality Monitoring The Maintenance Director/designee will immedaetly inform the Amdinistrator of any negative findings specific to improper direction of burner stove nozzles. The Maintenance Director/designee will bring results of the audits to Quality Assurance Performance Improvement Committee monthly x3 months. Quality Assurance Performance Improvement Committee, based on results of these audits, a decision will be made regarding the need for continued submission and reporting to the committee.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		9/10/23

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K 345	Continued From page 3 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility provided documentation on 08/02/2023 and 08/03/2023, it was determined that the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficiency was evidenced by the following: During the the survey entrance on 08/02/2023 at approximately 9:17 AM, a request was made to the facility's Maintenance Director (MD) to provide all mandatory inspections from January 1, 2022 through August 1, 2023 and provide a copy of the last Smoke Detector Sensitivity testing. Later that day at approximately 12:09 PM, a review of the facility provided mandatory inspections was performed. The surveyor reviewed the following Fire Alarm and Detection system inspections, - 06/16/2023 Semi-annual inspection. - 12/08/2022 Annual inspection. - 06/21/2022 Semi-annual inspection. - 02/08/2022 Annual inspection. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. At approximately 1:50 PM a request was made to the MD to place a call to the facility fire alarm and	K 345	K345 - Fire Alarm System Immediate Action The Maintenance Director/designee immediately communicated with the facilities alarm vendor and added to mandatory inspections preformed by alarm vendor - that smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2). The smoke detector sensitivity testing was completed on August 17th by alarm vendor. Identification of Others All residents have the potential to be affected. Systemic Changes The Maintenance Director/designee will ensure the fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available for inspection. To ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA	

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K 345	Continued From page 4 detection inspection vendor and request a copy of the last Sensitivity Testing of the smoke detectors. On 08/03/2023 at 9:22 AM, the MD stated that the vendor had not performed a sensitivity test of the smoke detectors. A review of an e-mail from the alarm vendor provided by the MD indicated, "We have you scheduled to do the smoke detector sensitivity test Thursday August 17th... We will be in touch the day before to confirm." The MD confirmed the smoke detector sensitivity testing had not been performed. On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.1 (c), -31.2 (e) NFPA 70, 72.	K 345	72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2., the Maintenance Director/designee will include documentation in the facilities inspection log book to ensure records of system acceptance, maintenance and testing are readily available. The facilites inspection log book will be reviewed with Administrator after current inspection has been preformed, then every other year to ensue compliance. Quality Monitoring The Maintenance Director/designee will immediately inform the Administrator of any negative findings specific to smoke detection sensitivity testing. The Maintenance Director/designee will bring results of the smoke detection sensitivity testing to the Quality Assurance Performance Improvement Committee the month after testing was preformed every other year. Quality Assurance Performance Improvement Committee, based on results, a decision will be made regarding the need for continued submission and reporting to the committee.	
K 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	K 351		9/25/23

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K 351	Continued From page 5 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/02/2023 and 08/03/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice was evidenced by the following, On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.	K 351	K351 - Sprinkler System Immediate Action Maintenance Director/designee immediately communicated with Sprinkler contractor requesting estimate to ensure, adjust sprinkler coverage, and/or install new fire sprinkler inside the basement level West stairwell landing area to cover the 21 feet by 7 feet 9 inch lower landing area, the Willow wing shower room inside a 3 feet by 3 feet shower stall, and 1 Oak wing shower room inside the 6 feet deep by 3 feet wide shower stall to comply with CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition.	

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K 351	Continued From page 6 A review of the facility provided lay-out identified the facility was a three story building with one hundred and fifty one (151) Resident sleeping rooms and common areas. Starting at approximately 9:50 AM on 08/02/2023 and continued on 08/03/2023 in the presence of the facility's MD a tour of the facility was conducted. During the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 08/02/2023: 1.) At approximately 9:56 AM, inside the basement level West Stairwell landing area, the surveyor observed no evidence of a fire sprinkler system to cover the 21 feet by 7 feet 9 inch lower landing area. At that time the surveyor asked the MD, "Do you see and fire sprinklers here." The MD looked up and around and said, "No." On 08/03/2023: 2.) At approximately 9:52 AM, inside the 2nd. floor Willow Wing shower room, the surveyor observed no evidence of fire sprinkler coverage inside a 3 feet by 3 feet shower stall. The locations of the fire sprinklers inside the shower room would not reach into the 3 feet by 3 feet stall. 3.) At approximately 11:40 AM, inside the 1st floor Oak Wing shower room, the surveyor observed no evidence of fire sprinkler coverage inside the 6 feet deep by 3 feet wide shower stall. The locations of the fire sprinklers inside the shower room would not reach into the 6 feet by 3 feet shower stall.	K 351	The Maintenance Director/designee audited/checked all other areas of the facility for proper sprinkler coverage on 8/4 determining that all other areas provided proper fire sprinkler coverage according to CMS regulation 483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. Identification of Others All residents and staff have the potential to be affected. Systemic Changes The Maintenance Director/designee will add automatic fire sprinkler protection to their Preventative Maintenance Monthly Round Log to ensure compliance. The Sprinkler contractor installed new /adjusted exsiting sprinkler heads to provided proper fire sprinkler coverage in areas noted. Quality Monitoring The Maintenance Director/designee will inform the Administrator immediately of any negative findings immediately regarding sprinkler protection to ensure identification/corrections are made timely. The Maintenance Director/designee will bring results of the Preventative Maintenance Monthly Round Log and the Sprinkler contractor completion proof to	

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K 351	Continued From page 7 The MD confirmed the findings at the time of observations. On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee, based on results, a decision will be made regarding the need for continued submission and reporting to the committee.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 08/02/2023 and 08/03/2023 in the presence of facility management, it was determined that the facility failed to: 1.) Perform a monthly examination for 3 of 32 portable fire extinguishers, 2.) Replace 1 of 32 portable fire extinguishers when discharged, 2.) Install portable fire extinguishers with-in the required height for 1 of 32 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70.	K 355	K355 -Portable Fire Extinguishers Immediate Action Maintenance Director/designee immediately completed on 8/3 the monthly visual examinations on 1 "ABC-Type" fire extinguisher inside the 2nd floor day room , 1 Willow unit pantry on the 1st floor, 1 "Class K" wet chemical fire extinguisher inside the main kitchen, and replaced inside the first floor stairwell next to the recreation office- 1 "ABC-Type" fire extinguisher to comply with NFPA 10 Edition 2010 Standard. 8/3 the installation height of same "Class	9/10/23

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K 355	Continued From page 8 Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. This deficient practice was evidenced by the following: On 08/02/2023 (day one of survey) during the	K 355	K" wet chemical fire extinguisher inside the main kitchen was adjusted by the Maintenace Diectort/designee to be not more than 5 feet above the floor and clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. 8/3 the Maintenance Director/designee examined all other areas of the facility that portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. No other issues found. 8/17 Maintenance Director/designee re-educated staff on standard for portable fire extinguishers. 8/17 Mainteance Director was re-educated by Administrator on NFPA 10 Edition 2010 Standard for portable fire extinguishers. Identification of Others All residents and staff have the potential to be affected. Systemic Changes Maintenance Director/designee revised/will use portable fire extinguisher locations map during monthly inspections intervals and as needed, to ensure accuracy of inspection with NFPA 10 Edition 2010 Standard for portable fire extinguishers. A copy of the portable fire extinguisher locations map will be retained monthly for referance and validation in	

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K 355	Continued From page 9 survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. Starting at approximately 9:50 AM on 08/02/2023 and continued on 08/03/2023 in the presence of the facility's MD a tour of the facility was conducted. During the two day building tour the surveyor observed and inspected thirty two (32) portable fire extinguishers in various locations. These 32 portable fire extinguishers were last annually inspected in September and November 2022 with the surveyor observing the following issues that were identified: On 08/02/2023: 1.) At approximately 11:10 AM, One "ABC-Type" fire extinguisher inside the 2nd. floor Day room was last annually inspected September 2022. There was no evidence of monthly visual examinations performed and documented for February, March, April, May, June and July 2023. On 08/03/2023: 2.) At approximately 11:30 AM, One "ABC-Type" fire extinguisher, inside the Willow Unit Pantry on the 1st. floor was last annually inspected November 2022. There was no evidence of monthly visual examination performed and documented for July 2023. 3.) At approximately 12:05 PM, inside the first floor stairwell next to the recreation office, the surveyor observed One "ABC-Type" fire	K 355	maintenace log book. Quality Monitoring The Maintenace Director/designee will inform the Administrator immediately of any negative findings regarding compliance with portable fire exstigishers to ensure corrections are made timely. The Maintenance Director/designee will bring results/copy of portable fire extinguisher locations map to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee, based on results, a decision will be made regarding the need for continued submission and reporting to the committee.	

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K 355	Continued From page 10 extinguisher with the pressure indicating needle in the RED discharge zone of the pressure indicating gauge. At that time, a request was made to the MD to replace the fire extinguisher. The MD complied with the request. 4.) At approximately 12:25 PM, One "Class K" Wet Chemical fire extinguisher inside the main Kitchen was last annually inspected September 2022 with no evidence of of a monthly examination being performed and documented on the tag for November 2022. The surveyor observed that the extinguisher was mounted at a higher elevation on the wall. At that time, the surveyor measured and recorded the fire extinguisher and identified that it was mounted 5'- 8" to the center of the pressure indicating needle. The MD confirmed the finding at the time of observations. On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		9/10/23

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 11	K 521		

This REQUIREMENT is not met as evidenced by:
Based on observations on 08/02/2023 and 08/03/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 8 of 13 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A.

This deficient practice was evidenced by the following:

On 08/02/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility was a three story building with 151 Resident sleeping rooms and various common areas in the facility..

Starting at approximately 9:50 AM on 08/02/2023 and continued on 08/03/2023 in the presence of the facility's MD a tour of the facility was conducted.

During the two day tour the surveyor inspected and tested thirteen (13) Resident sleeping rooms and unisex bathrooms exhaust systems.

K521 - HVAC

Immediate Action
Maintenance Director immediately communicated with HVAC contractor on 8/3 who identified Resident rooms #247, #249, #255, 2nd floor unisex bathroom, #257, #264, #107, and #172 when tested the exhaust system did not function properly. Contractor identified and fixed the issue on 8/10. 8 of 13 identified facility area exhaust systems were fixed and verified working in accordance with the manufacturer's specifications as per the National Fire Protection Association (NFPA) 90A, 18.5.2.1, 19.5.2.1, 9.2.

The Maintenance Director/designee on 8/3 audited, using the single ply tissue paper method, all other Resident sleeping rooms, bathrooms, and various common areas in the facility to ensure that the facility's ventilation system was being properly maintained. No other issues were found.

The Maintenance Director/designee re-tested on 8/10, using the single ply tissue paper method, and verified that the exhaust systems were functioned properly for identified Resident rooms #247, #249, #255, 2nd floor unisex bathroom, #257, #264, #107, and #172.

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	315214	A. BUILDING 01 B. WING	08/11/2023

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K 521	Continued From page 12 This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation was present), the exhaust did not function properly in 8 of 13 resident bathrooms in the following locations: On 08/03/2023: 1.) At approximately 9:32 AM, inside Resident room #247 bathroom, when tested the exhaust system did not function properly. At the time of the inspection, the surveyor informed the MD that the exhaust system did not function properly. The bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2.) At approximately 9:37 AM, inside Resident room #249 bathroom, when tested the exhaust system did not function properly. The bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3.) At approximately 9:50 AM, inside Resident room #255 bathroom, when tested the exhaust system did not function properly. The bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4.) At approximately 9:54 AM, inside a 2nd. floor Resident Unisex bathroom, when tested the exhaust system did not function properly. The bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5.) At approximately 10:10 AM, inside Resident	K 521	Identification of Others Residents in rooms #247, #249, #255, 2nd floor unisex bathroom, #257, #264, #107, and #172 have the potential to be affected. Systemic Changes The Maintenance Director/designee will highlight facility's ventilation systems on their Preventative Maintenance Monthly Round Log to ensure compliance with Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A, 18.5.2.1, 19.5.2.1, 9.2. Resident sleeping room exhaust systems, bathroom exhaust systems and various common areas with facility exhaust systems will be randomly tested monthly by the Maintenance Director/designee, by placing a piece of single ply tissue paper across the grills to confirm facility's ventilation systems were being properly maintained. The Preventative Maintenance Monthly Round Log will be reviewed with Administrator monthly for 3 months. Quality Monitoring The Maintenance Director/designee will inform the Administrator immediately of any negative findings on the Preventative Maintenance Monthly Round Log to identify/ensure corrections are made timely.	

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	315214	A. BUILDING **01** B. WING ______	**08/11/2023**

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K 521	Continued From page 13 room #257 bathroom, when tested the exhaust system did not function properly. The bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 6.) At approximately 10:19 AM, inside Resident room #264 bathroom, when tested the exhaust system did not function properly. The bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 7.) At approximately 11:22 AM, inside Resident room #107 bathroom, when tested the exhaust system did not function properly. The bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 8.) At approximately 11:39 AM, inside Resident room #172 bathroom, when tested the exhaust system did not function properly. The bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The MD confirmed the findings at the time. On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	The Maintenance Director/designee will bring results of the Preventative Maintenance Monthly Round Log and contractor completion dates to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee, based on results, a decision will be made regarding the need for continued submission and reporting to the committee.	
K 531 SS=E	Elevators CFR(s): NFPA 101	K 531		9/10/23

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K 531	Continued From page 14 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/02/2023 and 08/03/2023, in the presence of facility management it was determined that the facility failed to maintain elevator emergency communications for 2 of 4 elevators tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: On 08/02/2023 during the survey entrance at 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) asking how many elevators were in the building? The MD told the surveyor that there were four elevators. On 08/02/2023 during a tour of the building in the	K 531	Immediate Action - NFPA 101 Elevators Maintenance Director immediately communicated with Elevator Contractor and Phone Contractor on 8/2 to fix elevator #1 and #2 emergency communication phones in accordance with ASME/ANSI A17.3. Elevator phones were fixed on 8/4. On 8/2 staff were educated and increased hallway supervision was initiated on both elevators #1 and #2 to ensure increased staff awareness and that emergency communication was present. On 8/4 safety team held an ad-hoc	

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	315214	A. BUILDING **01** B. WING ___	**08/11/2023**

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K 531	Continued From page 15 presence of the facility MD at approximately 10:14 AM, a test of elevator #1 emergency telephone was performed. When the surveyor tested the emergency communication phone, it did not function properly. The emergency communication phone rang and no one answered. This test was repeated a two additional times with the same result. At approximately 10:18 AM, a test of elevator # 2 emergency telephone was performed. When the surveyor tested the emergency communication phone, it did not function properly. The emergency communication phone rang and no one answered. This test was repeated an additional two times with the same result. The MD confirmed the findings at the times of observations. On 08/03/2023 at approximately 1:05 PM, an interview with an elevator mechanic (who was called in by the facility) was conducted. The Elevator mechanic told the MD and surveyor that elevator #1 had no emergency communication phone line. On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	meeting and reviewed elevator contractors inspection and test monthly log to ensure compliance and safety. Elevator contratacted management/designee inserviced elevator contracted technician on preventitive mainteance procedure, emergency communication phones function, and notification to facility of any negative findings monthly. The Maintenance Director/designee on 8/3 audited elevator #3 and #4 emergency communication phones. No other issues were found. Identification of Others All residents have the potential to be affected. Systemic Changes The Maintenance Director/designee will verify elevator #1 and #2 emergency communication phones are in good working order, monthly with the elevator contractor present. Quality Monitoring The Maintenance Director/designee will inform the Administrator immediately of any negative findings of the elevator emergency communication phones to ensure identification and corrections are made timely. The Maintenance Director/designee will bring results of verifing elevator #1 and #2 emergency communication phones are in	

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K 531	Continued From page 16	K 531	good working order, monthly with the elevator contractor present to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee, based on results, a decision will be made regarding the need for continued submission and reporting to the committee.	
K 911 SS=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: Based on observations on 08/02/2023 and 08/03/2023, in the presence of facility management, it was determined that the facility failed to ensure that 4 of 13 electrical outlets located next to a water source (with-in 6 feet) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 08/02/2023 during the survey entrance at 9:17 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.	K 911	K911 -Electrical Systems Other Immediate Action The Maintenance Director/designee immediately contacted the Electrical contractor on 8/2 to ensure that 4 of 13 electrical outlets located next to a water source (with-in 6 feet) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. Electrical contractor replaced duplex outlets with Ground-Fault Circuit Interrupter (GFCI) protected outlets on 8/4 inside the 3rd floor Soiled Linen Room, inside the 2nd floor Soiled Utility Room, inside the 2nd floor Willow Unit Unisex Bathroom, and inside the 1st floor Oak	9/10/23

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K 911	Continued From page 17 A review of the facility provided lay-out identified there were three floors in the facility. Starting at 9:50 AM on 08/02/2023 and continued on 08/03/2023, in the presence of the facility's MD a tour of the building was performed. During the two (2) day tour of the facility, the surveyor observed and tested thirteen (13) electrical outlets in wet (with-in 6 feet of a sink) locations that failed to de-nergize when tested in the following locations, On 08/02/2023: 1.) At approximately 10:44 AM, inside the 3rd floor Soiled Linen Room, one Duplex electrical outlet located two (2) feet to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 2.) At approximately 11:24 AM, inside the 2nd floor Soiled Utility Room one Duplex electrical outlet located twenty (20) inches to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. On 08/03/2023: 3.) At approximately 9:54 AM, inside the 2nd floor Willow Unit Unisex Bathroom one Duplex electrical outlet located twenty two (22) inches to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 4.) At approximately 11:29 AM, inside the 1st floor Oak Wing Unisex Bathroom next to the Pantry, one Red Duplex electrical outlet located twenty	K 911	Wing Unisex Bathroom next to the Pantry. The Maintenance Director/designee audited all other possible locations on 8/4 electrical outlets located next to a water source (with-in 6 feet) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. No other issues found. Identification of Others All electrical outlets located next to a water source (with-in 6 feet) have the potential to be affected. Systemic Changes The Maintenance Director/designee will do a visual audit monthly for 3 months to ensure all electrical outlets located next to a water source (with-in 6 feet) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. The audit tool will be reviewed with Administrator for monthly for 3 months. Quality Monitoring The Maintenance Director/designee will bring results of the audits to Quality Assurance Performance Improvement Committee monthly x3 months. Quality Assurance Performance Improvement Committee, based on results of these audits, a decision will be made regarding the need for continued submission and reporting to the committee.	

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K 911	Continued From page 18 seven (27) inches to the right of the sink when tested with a GFCI tester to de-energize, the Red Duplex electrical outlet did not de-energize as required by code. The MD confirmed the findings at the time of observations. On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 916 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/02/2023 and 08/03/2023 in the presence of facility management, it was determined that the facility failed to provide a working remote annunciator panel for 1 of 1 emergency generator's electrical system to alert staff of the system's condition in accordance with National Fire Protection Association (NFPA) 99.	K 916	K916 - Electrical Systems -Essential Immediate Action The Maintenance Director/designee immediately communicated with the facilities Generator vendor to connect a working remote annunciator panel for 1 of 1 emergency generator's electrical system	9/25/23

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K 916	Continued From page 19	K 916		

This deficient practice was evidenced by the following:

On 08/02/2023 during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Maintenance Director (MD), "Does the facility have an emergency generator and where is the location of the remote annunciator panel for the generator?" The MD told the surveyor, yes the facility had one (1) emergency generator and that the generator annunciator panel was located on the 1st floor Oak Wing Nursing station.

On day 08/03/2023 (day two of survey) during a tour of the building with the facility MD at approximately 11:11 AM, an inspection at the 1st. floor Oak Wing Nursing station was performed. The surveyor observed one Emergency Generator annunciator panel. When the surveyor pressed the test button to activate all of the indicator lights, no lights illuminated. The surveyor asked the MD, "Does this annunciator panel work?" The MD told the surveyor that the facility had a temporary emergency generator connected and the facility was waiting for the new generator to be connected. The annunciator panel was not connected yet.

The MD confirmed the findings at the times of observations.

On 08/03/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency.

Reference:
NFPA 99 - 6.4.1.1.17 Alarm Annunciator. A

to alert staff of the system's condition in accordance with National Fire Protection Association (NFPA) 99.

Identification of Others
All residents have the potential to be affected.

Systemic Changes
Generator vendor connected the existing remote annunciator panel located on the 1st floor Oak wing nursing station to the facility emergency generator's electrical system. The system is hard-wired to indicate alarm conditions of the emergency power source. When pressed the annunciator panel test button will activate all of the indicator lights.

Maintenance Director/designee will check annunciator panel weekly by pressing the annunciator panel test button, to activate all of the indicator lights. Documentation will be kept in the facilities maintenace inspection log book for review.

Maintenance Director/designee created weekly generator annunciator panel test form.

Quality Monitoring
The Maintenance Director/designee will review with the Administrator weekly for 3 months, the generator annunciator panel test log form to ensure compliance.

The Maintenance Director/designee will bring results of the weekly generator annunciator panel test form to the Quality

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K 916	Continued From page 20 remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load. (b) When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall include the following: (a) Low lubricating oil pressure (b) Low water temperature (below that requirement in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less that a 4-hour operating supply (e) Over crank (failed to start) (f) Over speed NJAC 8:39-31.2(e) NFPA 99, 110	K 916	Assurance Performance Improvement Committee monthly for 3 months. Quality Assurance Performance Improvement Committee, based on results, a decision will be made regarding the need for continued submission and reporting to the committee.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315214 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	9/28/2023 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 09/10/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 09/10/2023	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 09/25/2023
ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 09/10/2023	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 09/10/2023	ID Prefix Reg. # NFPA 101 LSC K0531	Correction Completed 09/10/2023
ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 09/10/2023	ID Prefix Reg. # NFPA 101 LSC K0916	Correction Completed 09/25/2023	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

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	
8/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO