STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315200	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

(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: 1/18/23 Census:158 Sample: 33 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 medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 2 of 33 residents reviewed (Residents #29 and #121). This deficient practice was evidenced by the following: The surveyor reviewed the Admission Record for Resident #29 which reflected that the resident was admitted with diagnoses that included	F 641	F 641 Accuracy of assessments " The MDS for resident #29 was corrected on [redacted] to reflect that resident # 29 does have [redacted]; the MDS for resident # 121 was corrected on [redacted] to reflect that the resident is receiving [redacted] " All residents that wear a wanderguard and who are receiving hospice services	1/20/23

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

Electronically Signed | 02/09/2023

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F 641	Continued From page 1 NJ Exec Order 26.4b1 . The surveyor reviewed the Physician's orders for Resident # 29. There was an order dated NJ Exec Order 26 for: NJ Exec Order 26.4b1 The surveyor reviewed Resident #29's Quarterly MDS, an assessment tool utilized to facilitate the management of care, dated NJ Exec Order 26.4b reflected the section for wandering was coded as NJ Exec Order 26. The section for NJ Exec Order 26.4b1 was coded as NJ indicating that Resident #29 NJ Exec Order 26.4b1 When interviewed on 1/12/23 at 12:38 PM, the MDS Coordinator stated that Resident #29 utilized a wander/elopement alarm. She stated that his/her NJ Exec Order 26.4 MDS was coded incorrectly. She stated that it should have been coded that he/she used a NJ Exec Order 26.4b1 When interviewed on 01/13/23 at 09:37 AM, the Director of Nursing (DON) stated that the MDS should have been coded correctly reflecting that Resident #29 utilizes a NJ Exec Order 26.4b1 The surveyor reviewed the Admission Record of Resident #121 which indicated that the resident was admitted with diagnoses which included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. The surveyor reviewed the Physician's Orders for Resident #121. Resident #121 had an order for NJ Ex.Order 26.4(b)(1) as of NJ Exec Order 26.4b1.	F 641	have the potential to be affected. " The MDS staff was re-educated and in-serviced regarding proper coding of assessments; specific to the requirement of completing a comprehensive care plan " Random audits will be performed by the DON or designee The results of these audits will be reviewed at the monthly QAPI x 3 months; requirement of continued audits will be determined based on findings	

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F 641	Continued From page 2 The surveyor reviewed Resident #121's Quarterly MDS dated [NJ Exec Order 26.4b1]. The section for special treatments, procedures, and programs for hospice was coded as [NJ Exec Order 26.4b1]. When interviewed on 01/11/23 at 10:45 AM, the MDS Coordinator stated that Resident #121 was on [NJ Exec Order 26.4b1] and "I missed it" regarding coding it. When interviewed on 01/11/23 at 12:38 PM, the DON stated that [NJ Exec Order 26.4b1] should have been coded if the resident was [NJ Exec Order 26.4b1]. The DON stated that the MDS should reflect that Resident #121 was [NJ Exec Order 26.4b1] NJAC 8:39-2(e)1	F 641		
F 658 SS=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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standard of practice by: a.) ensuring prescribed medications were unavailable and document communication with the physician, b.) administer [NJ Exec Order] from a [NJ Exec Order 26.4b1] using appropriate [NJ Exec Order 26] per manufacturer instructions, c.) perform proper hand hygiene, and d.) appropriately assess the	F 658	F658 Services Provided Meet Professional Standards " MD informed regarding medication not being administered as per orders to resident # 361, staff hand hygiene competencies were performed " All residents have the potential to be	1/20/23

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F 658	Continued From page 3 NJ Exec Order 26.4b1 [redacted] in accordance with a physician's order, for 2 of 34 residents (Resident #361 and Resident #11) reviewed for professional standards of nursing practice. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The evidence was as follows: On 1/9/23 at 8:35 AM, the surveyor observed Licensed Practical Nurse #1 (LPN #1) during medication administration. While LPN #1 prepared the medication for Resident #361, she	F 658	affected " A) Nurses received education and in-servicing regarding notification of physician when medications are no available B) Nurses received education and in-servicing regarding proper withdraw of insulin from an insulin pen C) All staff received education and in-servicing regarding proper hand hygiene; competency performed D) Nurses received education and in-servicing regarding assessing pain appropriately and medicating as per physicians orders and level of pain reported/assessed " A) Weekly the DON or designee will review MARs for medications not administered and audit if the physician was informed. B) Weekly X4 weeks medication pass will be performed by the DON or designee then monthly C) Random hand hygiene will be performed by the Infection Preventionist or designee D) Weekly X4 weeks the DON or designee will review to MARs for pain medications administered to audit pain intensity matches what pain medication was administered then monthly	

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F 658	Continued From page 4 informed the surveyor that the resident was prescribed NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 both of which, LPN #1 stated, were not available to administer. LPN #1 informed the surveyor that she will notify the physician after completing medication administration to all her residents so that she is only making one call. LPN #1 further informed the surveyor that the NJ Exec Order 26 was ordered on NJ Exec Orde and was not delivered by the pharmacy and she will also call the dispensing pharmacy. LPN #1 stated that she will make note in the resident's electronic medical record (EMR) progress notes of the missed medication and physician notification. On 1/9/23 at 8:50 AM LPN #1 took out a bag from the medication cart containing NJ Exec Order 26.4b1 and an NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 When the surveyor asked LPN #1 if this was the proper way to use this medication, she replied, "I don't have any NJ Exec Order 26 not supposed to do it this way but the resident needs the NJ Exec Order 2" After surveyor inquiry, LPN #1 then identified that the NJ Exec Order 26.4b1 she drew the medication from belonged to a different resident. Identifying the error, LPN #1 discarded the NJ Exec Order 26.4b1 from Resident # 361's NJ Exec Order 2 using the same technique she identified as "not supposed to be done."	F 658	Findings from above will be presented at QAPI x 3 months, then determined based on findings	

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F 658	Continued From page 5	F 658		

On 1/9/23 at 9:18 AM, LPN #1 completed administering medication to Resident #361, and without performing hand hygiene, left the room, gathered the medication cart, and walked down to the next room door. After surveyor inquiry, LPN #1 then used alcohol-based hand rub (ABHR) to perform hand hygiene prior to initiating medication administration to the next resident.

A review of the "Admission Record" face sheet (an admission summary) reflected that Resident #361 had an admit date of NJ Exec Order 26.4b1 with diagnosis which included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

A review of the "Order summary Report" (physician orders) reflected an order for NJ Exec Order 26 one time a day every Monday dated NJ Exec Orde to start NJ Exec Order 2 NJ Exec Order 26.4b1 give one tablet by mouth one time a day dated NJ Exec Order 26.4b, and NJ Exec Order 26.4b1 in the morning for NJ Exec Order 26.4b1

Review of Resident #361's EMR progress notes indicated no communication between the nursing staff and physician or nurse practitioner regarding the missing medications.

On 1/9/23 at 9:42 AM, while the surveyor observed LPN #2 during medication administration, LPN #2 performed hand washing for 13 seconds prior to initiating medication administration to a resident. When the surveyor asked LPN #2 how long hand washing should be, LPN #2 stated 20 seconds.

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F 658	Continued From page 6	F 658		

On 1/9/23 at 10:26 AM, LPN #2 entered Resident #11's room, and informed the resident that she is there to administer their medication. LPN #2 then asked Resident #11 if they had any [NJ Exec O], to which the resident replied, [NJ Exec Order 26] LPN #2 did not properly assess the resident's NJ Exec Order 26.4b1 dispensed NJ Exec Order 26.4b1 and administered it to the resident. At this point the surveyor asked LPN #2 how she would know if the NJ Exec Order 26.4b1 was appropriate for this medication as it is prescribed, and how she would be able to identify its effectiveness, to which LPN #2 did not have a reply.

A review of the "Admission Record" face sheet (an admission summary) reflected that Resident #11 had an admit date of NJ Exec Order 26.4b1 with diagnosis which included NJ Exec Order 26.4b1

A review of the "Order summary Report" reflected an order for Resident #11 for NJ Exec Order 26.4b1 give two tablets by mouth every four hours as needed for NJ Exec Order 26.4b1 .

On 1/9/23 at 1:02 PM, the surveyor interviewed the Director of Nursing (DON) who informed the surveyor that if medications are not available, nurses should notify the physician or nurse practitioner (NP) right away and not wait until finished with medication administration so that it does not interfere with next dose if prescribed or ask the unit manager to assist. The DON also informed the surveyor that the facility has a NP available in the facility during day shifts Monday through Friday.

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F 658	Continued From page 7	F 658		

The DON stated that a medication ordered on [redacted] should have been delivered and the facility usually received "a few pharmacy deliveries a day."
Regarding the use of a separate syringe and needle to administer [redacted] from a [redacted] the DON stated, "nurses are not allowed to access NJ Exec Order 26.4b1 [redacted] further adding this would be "risk of infection control at its finest."
Regarding assessment of [redacted] the DON stated nurses should ask [redacted] before administering, because depending on the [redacted], they could have an order for something else for [redacted]

Review of the facility provided manufacturer's instructions for use of NJ Exec Order 26.4b1 [redacted] "a new needle must be attached before each use. Only use needles that are compatible for use with [redacted]

Review of the facility's undated "Method of Compliance Hand Hygiene" policy included "Employees must perform at least appropriate twenty second hand washing procedures using antimicrobial or non-antimicrobial soap and water ..." "if hands are not visibly soiled, use an alcohol-based rub for the following situations: a. before direct contact with residents, b. before donning gloves, c. before preparing or handling medications."

Review of the facility's undated "Administering Pain Medication" policy included "the purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to

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F 658	Continued From page 8 administering non-narcotic or narcotic analgesics ..." "Steps in the procedure ...3. Obtain subjective information from the resident: a. location. Ask the resident to point to the site(s) of pain ...b. pain intensity. Provide the resident with a 5-point (or 10-point) pain intensity scale and ask the resident to choose the best description of his/her pain experience." NJAC 8:39-11.2(b)	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to a.) clarify and transcribe a Physician's Order (PO) for a [redacted]	F 688	F 688 Increase/Prevent Decrease in ROM/Mobility " Physician order clarified and transcribed accurately for resident # 10	1/20/23

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F 688	Continued From page 9 NJ Exec Order 26.4b1 and b.) follow a physician's order for the application of a NJ Exec Order 26.4b1 and c.) document in the Electronic Medical Administration Record (EMAR) and Treatment Administration Record (TAR) for 1 of 3 residents (Resident #10) reviewed for NJ Exec Order 26.4b1 On 01/03/23 at 1:52 PM, the surveyor observed Resident #10 lying in bed with his/her daughter at the bedside. The daughter stated that she was concerned with the resident's NJ Exec Order 26.4b1 On 01/05/23 at 11:07 AM, the surveyor observed Resident #10 lying in bed with his/her eyes closed and the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 . The resident did not have a NJ Exec Order 26.4b1 On 01/09/23 at 1:00 PM, the surveyor observed the Resident #10 lying in bed with eyes opened and his/her daughter at the bedside. The surveyor observed Resident #10's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . The resident was unable to answer the surveyor's questions. Resident #10's daughter stated that the resident used to have a NJ Exec Order 26.4b1 but has not seen that since before Covid. The daughter further stated that the resident should have something in his/her NJ Exec Order 26.4b1 On 01/11/23 at 10:32 AM and on 01/12/23 at 12:40 PM, the surveyor observed Resident #10 lying in bed with his/her eyes opened and the NJ Exec Order 26.4b1	F 688	" All residents that use splints have the potential to be affected " Nurse and therapy education done regarding entering orders to ensure they are entered accurately " Weekly audits will be performed by the DON or designee X 4 weeks and findings will be presented at QAPI x 3 months, then determined based on findings	

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F 688	Continued From page 10	F 688		

NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1

According to the Admission Record, Resident #10 was admitted to the facility with a diagnosis including but not limited to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

Review of the EMAR reflected a NJ Exec Order 26.4b Physicians' Order that the patient may use a NJ Exec Order 26.4b1

Review of the Annual Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated NJ Exec Order 26.4, reflected that the resident was NJ Exec Order 26.4b1, total staff dependent for activities of daily living as well as having NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

Review of Resident #10's current Care Plan reflected that Resident #10 was at risk for NJ Exec Order 26.4b1 interventions that included NJ Exec Order 26.4b1

Review of Resident #10's Occupational Therapy Evaluation and Treatment Plan, dated NJ Exec Order 26.4b, reflected the reason for the referral was to assess for the NJ Exec Order 26.4b1 The therapist's recommendation was for the resident to use a NJ Exec Order 26.4b1

Review of Resident #10's TAR did not reveal the

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F 688	Continued From page 11	F 688		

Physician's Order for the NJ Exec Order 26.4b1 [redacted]

Review of Resident #10's progress notes did not reveal any documentation that the NJ Exec Order 26.4b1 [redacted] by the resident. The progress notes did not reveal any documentation of the resident's NJ Exec Order 26.4b1 [redacted]

During an interview with the surveyor on 01/11/23 at 10:32 AM, the Certified Nursing Assistant (CNA) stated that the resident needed total care for NJ Exec Order 26.4b1 The CNA further stated that she was unaware of any NJ Exec Order 26.4b1 [redacted]

During an interview with the surveyor on 01/11/23 at 12:20 PM, the Licensed Practical Nurse (LPN) stated that Resident #10 had a NJ Exec Order 26.4 [redacted] and was supposed to have a NJ Exec [redacted] but that the resident didn't like it and would say "No." The LPN further stated that the resident did not have an order for a NJ Exec Order 26.4b1 [redacted]

During a follow up interview with the surveyor on 01/12/23 at 12:47 PM, the LPN stated that if a resident had a NJ Exec Order 26.4b1 then the nurses would document the applicatiom in the TAR. If a resident refused a NJ Exec Order 26.4b1 [redacted] then the CNA would inform the nurse and the nurse would document in the EMAR and notify the doctor. The LPN further stated that an order for a NJ Exec Order 26.4b1 would be transcribed onto the TAR and the nurses would document if the resident tolerated or refused the NJ Exec Order 26.4b1 At

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F 688	Continued From page 12	F 688		

that time, the LPN stated that she did not see a physician's order for a NJ Exec Order 26.4b1 in the TAR.

During an interview with the surveyor on 01/13/22 at 9:35 AM, the Director of Nursing stated that she could not find any documentation that Resident #10's Physician's Order (PO), dated NJ Exec Order 26.4b, was on the TAR or EMAR. The DON further stated that the PO should have been entered into the EMAR correctly so that the order would have been on the TAR. " It was a transcription error on the physician's part." The DON further stated that she could not find any documentation in the EMAR that the NJ Exec Order 26.4b1 was applied as ordered or that the resident had refused the NJ Exec Order 26.4b1

During a follow up interview with the surveyor on 01/13/243 at 11:33 AM, the DON stated that the PO should have been entered into the EMAR correctly and the nurses should have documented in the EMAR if applied or refused.

Review of the Facility's policy "Rehabilitative Nursing Care," undated, revealed that rehabilitative nursing care is performed as per order for those residents who require such service and included but not limited to maintaining good body alignment and proper positioning and others as prescribed by the resident's attending physician.

The facility did not provide a policy on transcribing/documentation of treatment orders or on adaptive/assistive devices.

NJAC 8:39-27.1 (a)

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F 761	Continued From page 13	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) properly store medications, b.) maintain clean and sanitary medication storage areas, and c.) properly label opened multidose medications. This deficient practice was observed in 2 of 2 medication storage rooms and 3 of 3 medication carts and was evidenced by the following:	F 761	F 761 Label/Store Drugs and Biologicals " The medication room door was immediately secured, room cleaned and inspected to ensure that no expired or opened items were in the room, staff education regarding above and food in the medication room refrigerator. Education also performed regarding ensuring that	1/20/23

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F 761	Continued From page 14 On 01/05/23 at 11:05 AM, in the presence of the Unit Manager Registered Nurse (UM/RN), the surveyor observed the two main (2M) medication storage room door unsecured and slightly opened. The UM/RN confirmed that the door to the medication storage room should have been closed and secured. The surveyor and the UM/RN entered the 2M medication storage room and observed the following: Three (3) sterile auto guard intravenous (IV) 24-gauge (24GA) catheters expired on 6/30/2021. One (1) sterile auto guard 22GA catheter expired on 10/31/2020. One (1) sterile auto guard 20GA catheter expired on 06/30/2021. One (1) sterile blood collection set expired on 07/31/2019. Six (6) 5 milliliter (ml) sterile Heparin Lock flush solution (an anticlotting injectable medication) 50USP units/5ml (10usp units/ml) prefilled syringe flushes expired on 12/31/2022. One (1) 5ml sterile Heparin Lock flush solution 50USP units/5ml (10usp units/ml) prefilled syringe flush expired on 11/30/2020. One (1) 12ml sterile Heparin Lock flush solution 50USP units/5ml (10usp units/ml) in 0.9% sodium chloride syringe expired 05/2020. One (1) opened multidose vial of tuberculin purified protein derivative Aplisol 5 TU/0.1ml (5 tuberculin units/0.1 milliliters) (an injectable	F 761	the medication cart is maintained locked when unattended and that medications/pills are not collecting in the bottom of the medication carts " All residents have the potential to be affected " All nurses educated regarding proper medication storage. " Weekly audits will be performed by the DON or designee X 4 weeks and findings will be presented at QAPI x 3 months, then determined based on the findings	

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F 761	Continued From page 15	F 761		

medication used to test for tuberculosis) undated and unlabeled.

The UM/RN at this point informed the surveyor that "any nurse that opens a multidose medication should label and date the medication because each medication has a different expiration time after being opened."

Two (2) sterile IV start kit packages, opened, and stored in a drawer with unopened kits. At that time, the UM/RN stated, "they are not supposed to be kept once opened since they are sterile packages, and once opened they should be thrown out."

One (1) fresh mint fluoride toothpaste opened, used, and stored in the cabinet. To this the UM/RN stated, "it is not supposed to be stored there and possibly a staff member used it and put it back."

On 01/05/23 at 12:28 PM, the surveyor interviewed the Pharmacy Consultant (PC) who stated that multidose medications should be dated and labeled appropriately once opened to comply with expiration times and once opened, the effectiveness of the medication cannot be guaranteed past expiration.

On 01/05/23 at 12:43 PM, in the presence of the Unit Manager Licensed Practical Nurse (UM/LPN), the surveyor observed the three main (3M) medication storage room. The following was observed:

One (1) multidose 10ml vial of insulin lispro (an injectable medication used to treat diabetes) opened and undated.

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F 761	Continued From page 16	F 761		

Two (2) plastic containers containing food in the medication refrigerator stored next to medications and one (1) 5.3-ounce (oz) container of yogurt in the medication refrigerator freezer.

At that time, the UM/LPN informed the surveyor that she kept her lunch in this refrigerator because she did not "trust" keeping her lunch in another refrigerator on the unit. The UM/LPN confirmed that food should not be stored in the medication refrigerator.

On 01/05/23 at 1:00 PM, the PC confirmed to the surveyor that nothing, including food should be stored in the medication refrigerator.

On 01/09/23 at 8:32 AM, while observing medication administration on 2M nursing unit, the surveyor observed Licensed Practical Nurse #1 (LPN #1) enter a resident's room and did not lock the medication cart while it was left unattended in the hallway.

On 01/09/23 at 8:50 AM, during medication administration on nursing unit 2M, in the presence of LPN #1, the surveyor identified that two different unsampled residents' NJ Exec Order 26.3 [redacted] were stored together in one plastic bag labeled for one resident in the medication cart. LPN #1 stated at this time, that the second NJ Exec must have been placed into the wrong bag.

On 01/09/23 at 9:40 AM, while observing medication administration on 3M nursing unit, the surveyor observed LPN #2 enter a resident's room and did not lock the medication cart while it was left unattended in the hallway.

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On 01/09/23 at 1:02 PM, the surveyor interviewed the Director of Nursing (DON) who stated that "medication should be locked behind a locked door in the medication room, and the medication cart should be locked" when unattended by the nurse. The DON also confirmed that only medication and a thermometer to monitor the refrigerator temperature should be stored in medication refrigerators, and food should never be stored in the medication refrigerator. The DON stated that any multidose medication that had been opened should always be properly labeled and dated. Furthermore, the DON stated that medication labeled for one resident should not be kept in a bag labeled for a different resident which could potentially lead to "the wrong medication to be given to the wrong person."

On 01/10/23 at 11:02 AM, in the presence of LPN #3, the surveyor observed nursing unit four main (4M) "A" side medication cart which had a total of 24 loose medication pills of various colors and sizes in the bottom of the drawers. At this time, LPN #3 informed the surveyor that there should not be loose pills in the medication carts.

On 01/10/23 at 11:28 AM, in the presence of LPN #2, the surveyor observed nursing unit 3M "A" side medication cart which had a total of 59 loose medication pills of various colors and sizes in the bottom of the drawers.

On 01/10/23 at 12:07 PM, in the presence of LPN #1, the surveyor observed nursing unit 2C medication cart which had a total of six (6) loose medication pills of various colors and sizes in the bottom of the drawers.

On 01/11/23 at 1:21 PM, in the presence of the

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F 761	Continued From page 18	F 761		

Licensed Nursing Home Administrator (LNHA), the DON informed the surveyor that there should not be loose medication in the medication carts and that the medication carts should be checked by each nurse to make sure it is "not messy."

A review of the facility's undated "Storage of Medications" policy included: "1. drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received ... 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner ... 4 ...shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed ... 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing system. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secure location. Medications must be stored separately from food and must be labeled accordingly. 10. Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys.

A review of the facility's undated "Administering

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F 761	Continued From page 19 Medications" policy included: "7. Check the expiration date on the medication label. When opening a multi-dose container, place the date on the container ... 9. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide ..." N.J.A.C. 8:39-29.4	F 761		
F 812 SS=E	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 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	F 812	F-812 FOOD PROCUREMENT, STORE/PREPARE/SERVE-SANITARY 483.60	1/20/23

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F 812	Continued From page 20 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 01/03/2023 at 9:45 AM, the surveyor toured the kitchen, in the presence of the Food Service Director (FSD) and observed the following: In the dry storage room, there was a red food coloring bottle with the date written on it of October 2020. The FSD discarded the bottle and confirmed that the item should have been thrown away. The surveyor selected random cans from the non-dented shelf and observed 2 dented cans on the non-dented can shelf. The FSD removed the 2 dented cans, placed them on the dented can's shelf and confirmed the cans should not have been there. On the clean dry rack, the surveyor observed a personal disposable cup with a straw sticking out of it. The FSD confirmed the cup should not be placed on the clean dry rack with the clean dishes and immediately discarded it. The surveyor further observed on the clean dry rack, 3 plastic plate covers that had food particles on the plate covers and observed 2 coffee pots, along with a large metal flat pan on the clean dry rack that were visibly dirty. The FSD confirmed that the 3 plastic covers, the 2 coffee pots, and the large flat metal pan were all visibly dirty on the clean dry rack.	F 812	A. CORRECTIVE ACTION: " All residents who eat from the kitchen had the potential to be affected. " The outdated food item was immediately discarded. " The two dented cans were immediately placed on the dented can rack. " The personal disposable cup with straw was discarded. B. HOW WILL THE FACILITY IDENTIFY AND PROTECT RESIDENTS IN A SIMILAR SITUATION? " All kitchen staff was in-serviced on proper labeling and dating. " The Manager or designee will monitor these practices during their daily kitchen round to ensure staff is adhering to these practices. C. SYSTEMATIC CHANGE: " Daily department rounds will be conducted by the FSD or designee to monitor the labeling and dating, dented cans and personal disposable cups along with checking for soiled items on the clean drying racks in the department. " Cooks will check daily at the end of their shift to make sure that all items in the storage room are labeled and dated properly. All items that are found not labeled properly will be corrected and reported to the manager for follow-up and	

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F 812	Continued From page 21 Review of the facility's policy "CCS Dating and Labeling" policy dated 11/05/2022, 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 recived date.....and 5. discard all foods that expire immediately." 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 "General kitchen cleaning" policy undated, revealed the staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. NJAC 8:39- 17.2	F 812	course of action to the rectified situation. " Each week on delivery days the stock person will now check all the cans on the can rack for dents. This person will make sure that there are no dented cans on the and if a dented can is found the will immediately pull it and place the can on the dented can rack. " The daily utility person will check the dry storage rack at the end of their shift to make sure there are no soiled items on the racks. Any items found soiled will be placed in the dishroom area to be cleaned. D. MONITORING OF CORRECTIVE ACTION: " For 30 days, the Food Service Director or designee will monitor these practices during their daily kitchen round to ensure staff is adhering to these practices. " The Food Service Director or designee will report all findings from their daily kitchen rounds and action plan to the Quality Assurance Committee for thre months. " The QAPI committee will determine based on the finding of the FSD if further monitoring is necessary.	

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F 812	Continued From page 22	F 812	COMPLETION DATE: 01-18-2023 and ongoing	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following: On 01/03/2023 at 10:30 AM, the surveyor accompanied by the Food Service Director (FSD) took an exterior tour of the designated facility's garbage area. In the area, was a trash compactor and a dumpster. The surveyor and FSD observed the area around the facility's trash compactor and dumpster were littered with trash, which included plastic wrappers, cardboard boxes, empty containers, paper, and other unidentifiable objects. There were also two cardboard boxes laid across two holes that were filled with water from the rain. On the same date and time, in an interview, the FSD confirmed that the area was dirty and should remain clean at all times and confirmed the	F 814	F-814 DISPOSE OF GARBAGE AND REFUSE PROPERLY 483.60 A. CORRECTIVE ACTION: " All kitchen staff was in-serviced on how they will keep the dumpster area clean. " The area noted around the dumpster and compactor was immediately cleaned. " The Manager or designee will monitor these practices during their daily kitchen round to ensure staff adheres to them. B. HOW WILL THE FACILITY IDENTIFY AND PROTECT RESIDENTS IN A SIMILAR SITUATION? " All residents had the potential to be affected. " The Kitchen will immediately refrain from occurrences associated with this deficient practice and educate the entire dietary staff on keeping a clean environment around the dumpster area.	1/20/23

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F 814	Continued From page 23 cardboard boxes over the holes in the ground that were filled with rainwater. The FSD removed the cardboards and threw them away. The facility's policy revealed "To maintain at all times the dumpster area is clean and organized". 3. If any trash blows out of the trash can or you drop any trash on the ground or around the dumpster, you are responsible to pick it up (tie up the bags first). If you make a mess by the dumpster when throwing out garbage, you must clean it up. NJAC 8:38-19.3(c)	F 814	C. SYSTEMATIC CHANGE: " The FSD or designee will conduct daily department rounds to monitor the area around the compact dumpster and cardboard box container on a daily basis. " Each week on delivery days, the stock person will check to ensure the ground around the compact dumpster is clean. " The daily utility person will check the dumpster area each day at the end of his shift to make sure the area is clean. If the room is not clean, the staff person will clean the area. D. MONITORING OF CORRECTIVE ACTION: " For 30 days, the Food Service Director or designee will monitor these practices during their daily kitchen round to ensure staff is adhering to them. " The Food Service Director or designee will report all findings from their daily kitchen rounds and action plan to the Quality Assurance Committee. " The QAPI committee will determine, based on the reports and findings of the FSD, if further monitoring and reporting will be required. COMPLETION DATE: 01-18-2023 and ongoing	
F 868 SS=D	QAA Committee	F 868		2/15/23

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F 868	Continued From page 24 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

(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 868	Continued From page 25 Based on observation, interview, and record review, it was determined that the facility failed to provide documented evidence on sign-in sheets that the facility's Medical Director had attended the quarterly Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) meetings. This deficient practice was identified for 6 of 8 (QAA/QAPI) monthly meetings and 1 of 3 quarterly meetings reviewed and was evidenced by the following: On 01/20/23 at 10:30 AM, the surveyor reviewed the attendance sign-in sheets for the facility's monthly QAA/QAPI meetings. The surveyor reviewed the sign-in sheets provided by the facility for the months of April, June, July, August, September, October, November, and December of 2022. For the months of June 2022, July 2022, August 2022, September 2022, November 2022, and December 2022 the Medical Director was not signed in on the attendance sheets, indicating he did not attend. On 1/18/23 at 10:30 AM, the surveyor met with the facility Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA said the QAA/QAPI team met monthly and quarterly, and was attended by all department heads, unit managers. When the surveyor asked about the Medical Director the LNHA stated, "the medical director usually does not make the meetings". The LNHA could not speak to the four core individuals required to be in attendance and did not mention the Medical Director needed to attend nor could the LNHA show on the sign in sheets that there was an assigned designee in the Medical Director's absence. The surveyor then asked if the Medical Director	F 868	F 868 QAA Committee " QAA process reviewed and updated, those involved educated " All residents have the potential to be affected " Education performed with those who attend QAA; specifically the DON, Medical Director or designee, Infection Preventionist, LNHA and department heads " Monthly during QAPI meeting attendance records will be provided to the COO and/or CCO for review to ensure compliance, this will be done monthly x 6 months, then determined based on the findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315200	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

(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 868	Continued From page 26 would call in for the meetings and the DON confirmed that if he did, it would have been indicated on the sign in sheet as a phone call. The DON then confirmed the Medical Director's sign in line on the attendance sheets and there was no signatures next to his name. The LNHA and DON both confirmed that the Medical Director was at the April and October meeting. On 1/20/23 at 1:00 PM, the surveyor reviewed the facility's policy "Quality Assurance Performance Improvement Plan," undated. The policy did not include who should be in attendance at the quarterly meetings. Under the section titled, "Authority", number two indicated that the Administrator (LNHA) was responsible for assuring that the facility's QAA/QAPI Program complies with federal, state, and local regulatory agency requirements. NJAC 8:39 33.1(b)	F 868		

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	062017	A. BUILDING: _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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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 11 of 14 day 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) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	S560 Regulatory staffing was reviewed and education provided to the staffing coordinator. Our measures to avoid this issue is to continue to hire staff and utilization of agency. Offering bonuses to those who assist with staffing coverage. Our system to keep on top of missing staff is by discussing every morning at morning report daily staffing levels per unit. Amongst the staffing coordinator, administration, HR.	2/9/23

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

Electronically Signed | 02/09/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062017	A. BUILDING: _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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S 560	Continued From page 1 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 12/18/2022 through 12/24/2022 and 12/25/2022 through 12/31/2022, the staffing-to-resident ratio did not meet the minimum requirements and is documented below: The facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -12/18/22 had 14 CNAs for 154 residents on the day shift, required 19 CNAs. -12/19/22 had 18 CNAs for 153 residents on the day shift, required 19 CNAs. -12/20/22 had 18 CNAs for 153 residents on the day shift, required 19 CNAs. -12/21/22 had 18 CNAs for 153 residents on the day shift, required 19 CNAs. -12/22/22 had 18 CNAs for 153 residents on the day shift, required 19 CNAs.	S 560	The staffing coordinator will bring information forward following the QAPI process monthly x 3 months and will re-evaluate thereafter.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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S 560	Continued From page 2 -12/24/22 had 17 CNAs for 155 residents on the day shift, required 19 CNAs. -12/25/22 had 18 CNAs for 155 residents on the day shift, required 19 CNAs. -12/27/22 had 19 CNAs for 157 residents on the day shift, required 20 CNAs. -12/29/22 had 18 CNAs for 157 residents on the day shift, required 20 CNAs. -12/30/22 had 15 CNAs for 157 residents on the day shift, required 20 CNAs. -12/31/22 had 15 CNAs for 157 residents on the day shift, required 20 CNAs. On 01/17/23 at 09:44 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 told the surveyor she felt "adequately staffed, but we do have call outs and people on vacations". On 01/20/23 at 09:00 AM, the surveyor reviewed the policy titled "Staffing Policy Statement", a policy dated December 12, 2022. Under the section titled, "Direct Care Staff to Resident Ratio", number one indicated the facility would have one certified nurse aide to every eight residents for the day shift.	S 560		
S2110	8:39-31.1(a) Mandatory Physical Environment (a) No construction, renovation or addition shall be undertaken without first obtaining approval from the Department, Long-Term Care Licensing and Certification Program and/or the Department of Community Affairs, Health Care Plan Review Unit	S2110		3/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S2110	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to: a.) disclose the extent of construction work to the New Jersey Department of Health (NJDOH), b.) ensure DCA plans were approved by the NJDOH prior to initiating construction in accordance with state requirements, and c.) ensure that newly constructed areas were inspected by the NJDOH prior to re-occupying the space with residents. This deficient practice was identified to affect 4 of 4 floors of the building (Ground, 1st, 2nd, and 3rd Floors). The evidence was as follows: The surveyor reviewed the NJDOH letter dated 10/04/21 which reflected that the NJDOH had reviewed the facility's functional review submission dated 09/07/21 of construction/renovation work to be done at the facility. The letter indicated that interior renovations and alterations were going to be done on the ground, second, and third floors. The scope of work was listed as interior finish renovations such as painting and flooring as well as some lighting alterations. The alterations will	S2110	S2110 All residents have the potential to be affected due to the construction. The Administrator will report all future construction projects to the QAPI committee to determine if it fits within the boundaries of the deficient practice and are required to be reported. The current on-going construction work was re-reported to the DOH due to inability to confirm origional notification to the DOH on 2/27/23. Residents weren□t affected by construction project upon completion as new unit is now designated sub-acute for new admissions. The LNHA will make sure to ensure that newly constructed areas will be inspected by the NJDOH prior to re-occupying the space with residents. This will remain open until CO from City of Linden is acquired, after CO from City of	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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S2110	Continued From page 4 reconfigure the existing Rehabilitation area, the existing Lobby area, the second-floor Central Bathing area, and third-floor Central Bathing/Dining area. Additionally, a new vestibule will be added at the front entrance. The construction will be in limited areas at a time and anticipated to be completed in 12 months; it is not anticipated to have to relocate any residents in completing this project. The NJDOH letter dated 10/04/21 further instructed the facility that, "Authorization from the department is required in order to use or occupy any space in a facility that requires a license from the department." Further the letter indicated, "In accordance with NJAC 8:39-2.4, the facility shall contact the Certificate of Need and Healthcare Licensure Program for inspection and/or licensure upon completion of the project/project phase and prior to occupying the space at issue." On 1/06/23 at 8:32 AM, the surveyor arrived to the facility and observed that exterior construction work was underway at the facility. Approximately half of the facility's building exterior was covered in a clear plastic tarp and the Stucco had been removed, exposing yellow insulation. There were construction workers operating a large boom machine removing Dryvit/Stucco from the exterior of the building from the fourth floor of the building. The main exit was closed and the fire lane was subsequently blocked. The surveyor interviewed the Licensed Nursing Home Administrator (LNHA) at 9:10 AM, who acknowledged that exterior construction work was underway. The LNHA explained that there was a crack in the Dryvit/Stucco and when the crack was being repaired, the contractor indicated the Dryvit/Stucco was separating from the building	S2110	Linden is obtained we will notify the DOH to receive permanent CO as 2nd floor is opened with temporary CO at this time. The QAPI committee will monitor the construction project and will make sure that all necessary steps are taken before opening up the construction area. They will make sure that DOH/DCA complete their approval process before occupying the space. They will then notify relevant parties of the findings.	

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S2110	Continued From page 5 and it needed to be removed. At that time, the LNHA provided the surveyor a document from their engineer dated September 22, 2022. The document was titled, "Structural Assessment" job #3072.4 The document specified: "Based on the conditions observed at the time of the site visit, the building main structure is considered not to be directly affected by the partial facade exposure, and safe to be occupied as per all applicable NJ [New Jersey] code requirements." It further indicated that "The evaluation is relevant to the specific areas visited and issues observed at the time of the visit. It should be noted that these assessments and evaluations are based on visual observations from readily accessible spaces during our cite visit. No mechanical testing, structural calculations, or openings in the walls/floors were used as part of this evaluation." The LNHA was unable to provide documented evidence that they submitted a functional review submission on or around 09/22/22 for the exterior construction work, and there was no evidence provided that the final plans were approved or approved for occupancy by the NJDOH. On 1/6/23 at 10:30 AM, the Regional Plant Operations Director (RPOD) and the LNHA informed the surveyor that currently the facility had no Maintenance Director. The RPOD and LNHA acknowledged that the second floor was occupied by residents as the renovation project on that floor only involved wallpaper and paint application. On 1/6/23 at 11:10 AM, the surveyor toured the units and observed that there was construction that exceeded the NJDOH approvals located on	S2110		

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S2110	Continued From page 6	S2110		

the second floor. The surveyor observed the following: A and B-wing were newly renovated with mechanical, electrical, and plumbing including resident rooms 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225,226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, dining room, Indian dining room, and TV room. There was no evidence in the NJDOH letter dated 10/04/21 that these spaces were submitted to the NJDOH as areas to be renovated or that they were approved to be renovated.

Further, the surveyor observed that the completed renovations on the 2nd floor A and B wings were occupied by residents and staff. A new nurse station was observed along with new flooring, lighting, new drop ceiling tiles, and wall coverings including new handrails. Resident rooms were provided with new sinks, toilets, wall covering, new wall switches, new drop ceiling tiles, added light fixtures, and doors were provided with a new plastic finish using Accuban.

On 1/6/23 at 12:36 PM, the surveyor interviewed the LNHA regarding the renovations to the 2nd floor and notification to the NJDOH. The LNHA acknowledged that the renovations were completed and the area was occupied. The LNHA confirmed that the locals were notified but stated "this is my first renovation done and I was not aware that DOH needed to be notified as well". The LNHA was referred to the NJDOH letter dated 10/4/21, which stated the facility shall contact the Certificate of Need and Healthcare Licensure Program for inspection and/or licensure upon completion of the project/project phase and prior to occupying the space at issue.

The LNHA provided a "Temporary Certificate of

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S2110	Continued From page 7 Occupancy/ Compliance Certificate date issued: 11/03/22 permit# 20220330 this certificate indicates "only for 2nd floor !!!!!" The description of work/use: Renovations with Electric, Fire, and Plumbing Permits and 1-Alarm Device. However, the LNHA was unable to provide documented evidence that the NJDOH had approved the initial plans or the revised plans from the Department of Community Affairs or that NJDOH approved the second floor for occupancy of residents and staff.	S2110		

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
315200 Y1	A. Building B. Wing Y2	3/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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 F0688	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	01/20/2023	LSC	01/20/2023	LSC	01/20/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	01/20/2023	LSC	01/20/2023	LSC	01/20/2023
ID Prefix F0868	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/15/2023	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/18/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
062017		3/21/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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 02/09/2023	ID Prefix S2110 Reg. # 8:39-31.1(a) LSC	Correction Completed 03/15/2023	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
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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	
1/18/2023	☐ 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
	315200	A. BUILDING **01** B. WING _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	**400 W STIMPSON AVE** **LINDEN, NJ 07036**

(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 The nursing home building construction was stated to be 1980s. It is a four story building with a partial basement Type II (222) protected construction and is fully sprinklered. The building has 16 smoke zones. The 275 KW generator does approximately 50% of the building. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door holds open devices, exterior door releases, emergency facility lighting, and life safety components utilized for preservation of life. The facility has 240 certified beds. At the time of the survey, the census was 158. Currently floor 3C is closed for renovation. Currently the exterior stucco is being removed and replaced Floor 2 was renovated except for resident rooms 243 to 257. There is no generator anunciator panel as the generator is 35 years old and does not have an annunciator option. This document was provided by the facility vendor dated: 10/22/2018. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 111 SS=F	Building Rehabilitation CFR(s): NFPA 101 Building Rehabilitation Repair, Renovation, Modification, or Reconstruction	K 111		2/9/23

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

Electronically Signed | 02/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315200	A. BUILDING **01** B. WING _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	**400 W STIMPSON AVE** **LINDEN, NJ 07036**

(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 111	Continued From page 1 Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/6/23, 1/9/23, and 1/10/23, in the presence of the Administrator (A) and Maintenance Staff Member (MSM), the facility failed to conduct daily inspection of construction repair, alterations or additions, and means of egress are in place and continuously maintained in accordance with the	K 111	K111 All means of egress are clear and maintained. Currently construction is complete as we wait DCA/DOH approval. Daily logs will be implemented in all future	

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K 111	Continued From page 2 requirements of NFPA 101, 2012 Edition, Section 19.1.1.4.4, 4.6.10, 4.6.10.1. The deficient practice was evidenced for 1 of 1 renovation projects observed by the following: On 1/6/23 at approximately 09:30 AM, the surveyor reviewed construction documentation provided by the Administrator. The floor 1 front lobby area was being completely renovated including the main exit/egress area. The required daily inspection of the means of egress and construction areas for the new updated main entrance (currently in progress) were not recorded. On 1/6/23 at 10:30 AM, the surveyor observed that the updated main entrance exit/egress path was clear and maintained. The findings were verified by the Administrator and Maintenance Staff Member at the time of the observations, where they indicated no daily logs were completed for the current facility renovation projects. The Administrator was notified of the findings at the Life Safety Code exit conference on 1/10/23.	K 111	construction areas to adhere to the regulations listed in K111 tag. The maintenance team were educated on the regulation of the daily logs and will submit the daily logs to the QAPI committee to monitor compliance. The maintenance department will report findings to the QAPI committee monthly x3, and the QAPI committee will decide based on the findings and reports if reporting is necessary.	
K 293 SS=E	NJAC 8:39-31.2(e) 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	K 293		2/9/23

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K 293	Continued From page 3 (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 interview conducted on 1/9/23, in the presence of the Regional Plant Operations Director (RPOD) and Administrator (ADM), it was determined that the facility failed to provide exit signs that included a continuous illumination indicator showing the direction of travel, in every location, where the direction of travel to reach the nearest exit was not apparent, in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 6 of 28 exit signs observed and was evidenced by the following: At 10:00 AM, the surveyor, RPOD and ADM observed that the set of smoke doors on each floor 4, 3, and 2 on the nurse station-side, when the smoke doors were closed, there was no illuminated exit sign visible to indicate that through the smoke doors there was an exit at the end of the A and B wings. The findings were verified by the RPOD and ADM at the time of the observations. The ADM was informed of the findings at the Life Safety Code exit conference on 1/10/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1.	K 293	K293 Illuminated exit signs will be installed by nursing stations on floors 4,3,2 on the nursing station side with completion date of February 9, 2023. The administrator will in-service maintenance team on illumination sign inspection. The Director of Maintenance or designee will audit exit signage monthly to ensure proper function and compliance. The maintenance department will report findings to the QAPI committee monthly x3, and the QAPI committee will decide based on the findings and reports if reporting is necessary.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101	K 324		2/2/23

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K 324	Continued From page 4 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 record review and interview on 1/9/23, in the presence of the Regional Plant Operations Director (RPOD) and Administrator (ADM), it was determined that the facility failed to ensure that their kitchen's cooking equipment met the requirements of NFPA 96. This deficient practice was evidenced for 1 of 2 systems by the following:	K 324	K324 All residents in the facility have the potential to be affected. Hood suppression system was non-compliant. System was replaced with compliant hardware on 2/2/23. Suppression system is now in compliance	

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K 324	Continued From page 5 At 9:45 AM, the surveyor reviewed the facility's semi-annual fire suppression system reports dated: 09/29/22. The report indicates the system is non-compliant and indicated that the hood was replaced on the 6-gallon suppression system for the main cooking area. "The protection over the coverage area is now wrong. Pyro Chem nozzle protection being used with a Badger suppression system and they are (Not Compatible)" and non-compliant with UL-300 requirements. At 1:15 P.M., an interview was conducted with the ADM and he stated and agreed that the facility kitchen fire suppression document dated 9/29/22, indicated the system is non-compliant with the above deficiencies and he was unaware why the deficiencies were not corrected. The ADM was informed of the deficiencies at the life safety code exit conference on 1/10/23. NJAC 8:39-31.2(e) NFPA 96	K 324	with hood. Director of Maintenance of designee will perform monthly checks to ensure proper function. Findings will be shared with the QAPI committee monthly x 3 months and then re-evaluated.	
K 345 SS=F	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 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 documentation review and interviews	K 345	K345	3/15/23

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K 345	Continued From page 6 conducted on 01/09/23, in the presence of the Regional Plant Operations Director (RPOD) and Administrator (ADM), it was determined that the facility failed to A). conduct Semi-annual fire alarm inspection on the fire alarm system in accordance with NFPA 72, B). ensure the fire alarm system was in optimal condition, C). ensure the smoke alarm sensitivity inspection report was documented in accordance with NFPA 72. This deficient practice was evidenced for 1 of 1 fire alarm systems by the following: A). At 10:25 AM, review of the facility's fire alarm system inspection reports for the previous 12 months revealed that the licensed vendor identified the fire alarm system with (sealed lead acid) batteries. The inspections were marked: Semi Annual and the reports were dated: 04/07/22 (annual) and 06/28/21 currently not on a semi annual basis. The system used sealed lead acid batteries which required Semi-annual inspections in accordance with NFPA 72. An interview was conducted with the ADM during document review and he stated he was new and was not sure why the fire alarm inspection reports were not conducted. B)-1. At 12:18 PM, the surveyor observed on floor #2 by the nurse station that the remote fire alarm annunciator panel indicated common trouble. B)-2. At 01:09 PM, the surveyor observed the floor #1 fire alarm annunciator that indicated "trouble mode" with an yellow indicator light. The annunciator panel window was dated: Dec 9, 2022 at 3:57 PM 1st floor horn circuit from booster, TRB 005 of 005.	K 345	The facility is working with vendor to correct K345 on inspecting the alarm system and performing the sensitivity test. The semi-annual inspection was missed and is now being rescheduled. The Panel box is scheduled to be repaired/replaced to clear error codes and trouble mode from annunciator. The sensitivity inspection is being scheduled as well. The work is scheduled to be completed by 3/15/23. The Director of Maintenance or designee will audit logs monthly to ensure that inspections are completed timely and alarm system is functioning properly. All panels will be audited daily by maintenance aide to ensure that they are not in trouble mode. The Director of Maintenance will share findings with the QAPI team monthly x 3 months then re-evaluate.	

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K 345	Continued From page 7 During the observation and in an interview with the ADM, he stated this may be due to the lobby construction currently in progress and could produce no other documentation indicating so. C). At 10:15 AM, the surveyor asked the ADM for the smoke detector sensitivity test as required by NFPA 72 section 7-3.2.1. The ADM could not locate the test and communciated with the fire alarm vendor. The vendor could not produce any further documentation. The ADM was informed of the findings at the Life Safety Code exit conference on 01/10/23. NJAC 8:39-31.2(e) NFPA 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		1/24/23

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K 353	Continued From page 8 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 01/06/23, in the presence of the Regional Plant Operations Director (RPOD) and Administrator (ADM), it was determined that the facility failed to inspect the automatic fire sprinkler system quarterly for 3 of 4 inspections in accordance with NFPA 25. This deficient practice was evidenced for 2 of 2 (Wet Systems)by the following: A review of the facility's fire sprinkler system inspections for the previous 12 months revealed that the system was inspected by a licensed vendor for 1 of 4 quarters only. The RPOR and A provided all the fire sprinkler vendor inspection reports for 2022 and 2023. The only inspection report observed was dated 1/20/22. In an interview at 12:30 PM, the facility's (new) ADM stated he was not sure why the vendor did not inspect the fire sprinkler system quarterly. He reached out to the vendor and could not provide any further information at the Life Safety exit on 01/10/23. He stated that the previous Maintenance Director did not follow-up and understand inspection requirements. The ADM was informed of the findings at the Life Safety Code exit conference on 01/10/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353	K353 When informed that Sprinkler system was last inspected 1/10/22 but was due quarterly as opposed to annually, vendor was reached out to. Vendor came on 1/12/23 to perform inspection and put facility down on a quarterly inspection schedule. The incoming Director of Maintenance on 2/7/23 will be directed to keep clear logs to make sure that inspections aren□t missed. Director of Maintenance or designee will monitor logs monthly to ensure inspections are scheduled and completed as required. The Director of Maintenance will share findings with the QAPI team monthly x 3 months and then re-evaluate continued reporting.	
K 355 SS=E	Portable Fire Extinguishers	K 355		2/9/23

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K 355	Continued From page 9 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 interview on 1/9/23 in the presence of the Maintenance Staff Member (MSM) and Administrator (ADM), it was determined that the facility failed to perform and document on the tag attached to the fire extinguisher, a monthly visual examination for 3 of 19 fire extinguishers. This deficient practice was evidenced by the following: 1). At 12:33 PM, the surveyor observed in the main kitchen that the red ProTex II wall mounted ansul extinguishing system was provided with a monthly inspection tag dated March 2022. The tag did not have any monthly inspections logged. 2). At 12:45 PM, the surveyor observed in the main kitchen that the wall mounted ansul activation assembly was provided with an inspection tag. The monthly inspection tag was blank. 3). At 12:55 PM, the surveyor observed in the indian kitchen that the wall mounted ansul activation assembly was filled in only 1-month. The MSM and ADM confirmed the findings during the observations.	K 355	K355 The 3 extinguishers were examined and the documentation completed on the tag. The monthly visual inspection of fire extinguisher and wall mount ansul will follow an updated list of fire extinguisher and ansul locations. New fire extinguisher list added missing locations for monthly rounds that is done by the maintenance department. The Director of Maintenance or designee will conduct monthly audit to ensure compliance. The maintenance department will report findings to the QAPI committee monthly x3, and the QAPI committee will decide based on the findings and reports if reporting is necessary.	

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K 355	Continued From page 10 The ADM was informed of the findings at the Life Safety Code exit conference on 1/10/23. NJAC 8:39-31.2(e) NFPA 10, Standard for Portable Fire Extinguishers.19.3.5.12, NFPA 10	K 355		
K 363 SS=E	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 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	K 363		2/24/23

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K 363	Continued From page 11 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 and interview on 1/10/23, in the presence of the Maintenance Staff Member (MSM) and Administrator (ADM), it was determined that the facility failed to ensure that corridor doors 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. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was further identified in 6 of 50 resident room doors observed and was evidenced by the following: During the building tour from 9:15 AM to 2 PM, the surveyor in the presence of the MSM and ADM toured the facility and observed the following: Resident Room doors: # 434 hardware issue # 329 door rubs on frame # 314 loose hardware	K 363	K363 Rooms 434, 329, 314, 244, 246 and 250 had their door not closing properly. Maintenance team will start doing monthly rounds to inspect doors to see if they close properly. All doors that will not close properly will be repaired. Expected completion date is 2/24/23. The Director of Maintenance of designee will conduct monthly audits to ensure proper function of the doors closing. The maintenance department will report findings to the QAPI committee monthly x3, and the QAPI committee will decide based on the findings and reports if reporting is necessary.	

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K 363	Continued From page 12 # 244 door will not latch # 246 door rubs on frame # 250 top of door when closed 1/2" opening At the time of observations, the surveyor interviewed the MSM and ADM, both confirmed the above findings. The ADM was informed of the findings at the Life Safety Code exit conference on 1/10/23. 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 771 SS=F	Engineer Smoke Control Systems CFR(s): NFPA 101 Engineer Smoke Control Systems 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 01/09/23, in the presence of the Regional Plant Operations Director (RPOD) and Administrator (ADM), it was determined that the facility failed to ensure that smoke control systems (smoke dampers) were maintained in a safe operating condition. This deficient practice was evidenced for 4 of 4 floors of the building by the following: At 10:00 AM, during a review of the facility's inspection and testing reports for their internal fire/smoke extinguishing and detection	K 771	The facility is working with a vendor on maintaining and inspecting the smoke damper system. Completion date is 3/15/23. The incoming Director of Maintenance on 2/7/23 will be directed to keep clear logs to make sure that inspections aren□t missed. Director of Maintenance or designee will audit logs monthly to ensure proper	3/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315200	A. BUILDING **01** B. WING _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	**400 W STIMPSON AVE** **LINDEN, NJ 07036**

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K 771	Continued From page 13 equipment, it was revealed that the building's smoke dampers were not currently being tested. Observations of the upper wall vents from floors 4 through floor 1 approximately 6"x24" and 18"x18" vent grill sizes, revealed that it was undetermined if fire dampers were in place and operating. The RPOD and ADM both confirmed the observations and revealed currently no documentation on when the last inspection of smoke dampers could be provided. It was undetermined if all smoke dampers were properly tested and maintained and were found to function as required. The ADM was informed of the findings at the Life Safety Code exit conference on 01/10/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 8.4.6.2, 19.7.7 NFPA 90A (99) Sec. 3-4.7	K 771	function of the smoke dampers and follow QAPI guidance. The Director of Maintenance will share findings with the QAPI team monthly x 3 months and then re-evaluate for continued need.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914		3/21/23

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	315200	A. BUILDING **01** B. WING _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	**400 W STIMPSON AVE** **LINDEN, NJ 07036**

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K 914	Continued From page 14 manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 1/9/23, in the presence of the facility's Regional Plant Operations Director (RPOD) and Administrator (ADM), it was determined that the facility failed to A). functionally test electrical receptacles in resident rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. Maintenance and testing 6.3.3.2 Receptacle Testing in Patient Care Rooms, B). ensure an annual electrical inspection was performed as per NFPA 99, and C). ensure electrical outlets were maintained in optimal condition. This deficient practice was evidenced by documentation review and interview with the ADM, for all resident rooms by the following: A). Record Review of the facility's annual electric inspection report from the facility vendor dated : 02/25/20 indicated a visual electrical survey only. The ADM indicated resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The last annual electrical inspection by the facility vendor dated 02/25/22, indicated that there was no documentation for the annual inspection and itemized list of receptacle testing in patient care	K 914	K914 Room 421 - The PTAC outlet box is now attached to the wall securely Room 313 - windowsill wall outlet was replaced and functioning properly Room 425 - the side wall outlet cover is now in place Medical records office - the coffee pot is now plugged directly into the wall outlet. The electrical company was contacted to come and inspect the facility for the yearly inspection. The maintenance team was in-serviced that when they make repairs in the room, they should look around and see if anything else is needs to be fixed. Staff as well know that they can put in a work order for maintenance if the see outlet covers, etc. that need repair. The Director of Maintenance or designee will conduct weekly checks to ensure no repairs are necessary and monitor when inspections are due and completed.	

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	315200	A. BUILDING **01** B. WING _____	**01/18/2023**

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ARISTACARE AT PARKSIDE	**400 W STIMPSON AVE** **LINDEN, NJ 07036**

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K 914	Continued From page 15 rooms. An interview was conducted with the ADM during document review and the ADM stated that he was unsure if the facility electrical vendor was doing this inspection and currently could not provide any documentation that this inspection was being performed. B). Document review indicated that the annual electrical inspection was last done on 02/25/20. An interview was conducted with the ADM during document review, where the ADM stated he did not know why the electrical inspection was not completed annually and could not produce any further documents. C)- 1. At 11:19 AM, the surveyor observed in resident room 421 that the PTAC (packaged terminal air conditioner) unit was plugged into a wall mounted electrical outlet box. The outlet box was observed to not be attached to the wall and leaning forward unsecured. C)- 2. At 11:24 AM, the surveyor observed in resident room 313 that the windowside wall outlet was broken and could not be used. C)- 3. At 11:39 AM, the surveyor observed in resident room 425 that the side wall outlet was missing the outlet cover plate. C)- 4. At 12:17 PM, the surveyor observed in the Medical Records office that a coffee maker was plugged into a multi- outlet power strip. The power strip was then plugged into an extension cord then plugged into the duplex wall outlet.	K 914	The maintenance department will report findings to the QAPI committee monthly x3, and the QAPI committee will decide based on the findings and reports if reporting is necessary.	

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	315200	A. BUILDING **01** B. WING _____	**01/18/2023**

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K 914	Continued From page 16 The RPOD and ADM confirmed the finding's during the observations. The ADM was informed of the finding's at the Life Safety Code exit conference on 01/09/23, No further information was provided. NJAC 8:39-31.2(e) 6.3.4 (NFPA 99)	K 914		
K 918 SS=F	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. 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	K 918		2/9/23

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K 918	Continued From page 17 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 observations, interview, and review of facility documents on 01/09/23, in the presence of the Regional Plant Operations Director (RPOD) and Administrator (ADM), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was evidenced for 1 of 1 generator logs provided by the ADM for the following: At 10:25 AM, a review of the generator records for the previous eleven months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the Maintenance Staff Mamber was performing a monthly load test, but he was not recording the required transfer times on the testing log for 11 of 11 documented times. The current monthly dates observed on the provided log: Dates: Transfer times: 12 not tested 0	K 918	K918 Generator logs will be updated to make sure it includes the transfer times on monthly testing. Maintenance team will be in-serviced on how to check for transfer times. The incoming Director of Maintenance will be directed to keep clear logs to make sure that inspections aren□t missed. The Mainenance Director of designee will audit logs monthly to ensure completion. The maintenance department will report findings to the QAPI committee monthly x3, and the QAPI committee will decide based on the findings and reports if reporting is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 18 11/22 0 10/11 0 8/30 0 8/17 0 7/26 0 6/21 0 5/31 0 4/26 0 3/31 0 1/18 0 An interview was conducted with the ADM during document review and he stated that currently the transfer time was not provided on the current document. The ADM was informed of the finding's at the LSC exit conference on 1/10/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal	K 920		3/7/23

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K 920	Continued From page 19 electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/09/23, in the presence of the Maintenance Staff Member (MSM) and Administrator (ADM), the facility failed to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was idenitified in 3 of 3 extension cords observed and was evidenced by the following: At 11:40 AM, the Surveyor, MSM, and ADM observed in the main kitchen that three (3) black extension cords were supplying power to 3-kitchen appliances. The black extension cords	K 920	K920 The wiring in the kitchen will be rewired to conform with the NFPA code. Expected completion date is 3/7/23. The Director of Maintenance will conduct weekly checks to ensure the wiring conforms with NFPA code. The maintenance department will report findings to the QAPI committee monthly x3, and the QAPI committee will decide based on the findings and reports if reporting is necessary.	

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K 920	Continued From page 20 were then installed into the drop ceiling tiles and plugged into an unknown power source in the ceiling. The finding was verified by the MSM and ADM at the time of the observations, where they stated and confirmed that extensions cords were not a substitute for fixed wiring. The ADM was notified of the findings at the Life Safety Code exit conference on 01/10/23. NJAC 8:39-31.2(e)	K 920		

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
315200 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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 K0111	02/09/2023	LSC K0293	02/09/2023	LSC K0324	02/02/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	03/15/2023	LSC K0353	01/24/2023	LSC K0355	02/09/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	02/24/2023	LSC K0771	03/15/2023	LSC K0914	03/21/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	02/09/2023	LSC K0920	03/07/2023	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	
1/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO