STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and review of facility provided documents, it was determined that the facility failed to store and prepare food in a manner which followed kitchen sanitation practices to prevent the potential development of food borne illness. This deficient practice was identified in 2 of 2 kitchens (main kitchen and ethnic specialty kitchen) reviewed, and was evidenced by the following: A.On 4/9/26 at 9:37 AM, during the initial tour of the main kitchen with the Food Service Director (FSD) and the Regional FSD (RFSD), the surveyor observed the following: 1. A stacked refrigerator against the back wall. On the top shelf inside the refrigerator, the surveyor observed a dark cloth bag with a paper attached. The paper had a name and Do not touch 4/10 written on it. The FSD stated the refrigerator was used to store margarine, juice, and other small items for residents that could be grabbed by kitchen staff quickly and easily if needed. The FSD removed the cloth bag from the refrigerator and acknowledged the bag contained a staff member's food which should not have been stored in that refrigerator. 2. The walk-in freezer door did not appear to be completely closed. The FSD stated there was a problem with ice build-up. The RFSD stated he had already put in a work order for the ice build up. Inside the freezer, the following was observed:-Ice build up on the rubber floor mat, the shelves, the refrigeration unit, the freezer ceiling surface, and the food packaging boxes.The FSD removed 2 boxes from the middle shelf, which had been opened prior. The surveyor observed the inner clear plastic bags inside each box were not closed. There was frost and loose ice on the food items in both boxes. The FSD acknowledged there should not be ice build up on the boxes, and the plastic wrapping inside should have been closed. 3. In the walk-in cooler: two cardboard boxes labeled as eggs on the second shelf up from the bottom. The boxes contained several egg cartons of shelled raw eggs. The FSD acknowledged raw shelled eggs should be on the bottom shelf and moved them to the bottom shelf. 4. Dietary Aide (DA) #1 was putting racks of dishes and food service items through the dishwashing machine. The FSD stated the dishwashing machine was a low-temperature machine (used chemical sanitation with chlorine to clean dishes at lower water temperatures than high-temperature dishwashers). He stated he checked the chemical levels every morning and the person who ran the dishwashing machine checked the chemical levels every two to four hours. The RFSD added they (the kitchen staff) checked (the chemicals) before they began washing dishes from each meal. The surveyor observed the RFSD use his foot to tap a white bucket with yellow lid which was on the floor under the dishwashing area table. The RFSD stated to the surveyor the chemical sanitizer bucket for the dishwashing machine was empty. The RFSD then turned to DA #1 and stated everything washed this morning needed to be run through the machine again. The FSD replaced the empty sanitizer bucket. The RFSD stated the machine had to run a few times, then the chemical level had to be checked again, then the dishes had to go through the dishwashing machine again because they weren't sanitized. 5. On the metal shelves against the wall containing pots and pans, identified as the pot drying area. On a middle shelf, the surveyor observed ten (10) deep quarter pans lying on their sides stacked together. The FSD loosened and separated two of the pans near the middle of the stack, which revealed a brown powdery residue along the sides of the pans, The FSD wiped the residue with his finger, acknowledged that the pans were not clean, then (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	removed the two pans to the dishwashing table. The FSD loosened and separated the rest of the pans and moved two additional pans to the dishwashing table. The FSD acknowledged the above concerns at the completion of the initial tour of the main kitchen area. On 4/10/26 at 12:15 PM, the surveyor interviewed the FSD regarding the concerns identified on the initial tour of the main kitchen. The FSD acknowledged there was a large amount of ice build up in the freezer all the time. He acknowledged the potential for contamination with ice penetration into food packaging. The FSD acknowledged the pans on the drying racks had food debris on them and should not have been on the drying racks. On 4/13/26 at 11:24 AM, during a follow up to the main kitchen, the surveyor observed DA #2 standing at a metal table in what she described as the area to get the food ready for the lunch. The surveyor observed DA #2, who was wearing gloves, take a green apple to the handwashing sink. DA #2 turned on the faucet, put the apple under running water, dried it with paper towels, then returned to the table where she wrapped the apple in plastic clear wrap, and set it in a metal pan along with other fruit. On 4/14/26 at 8:56 AM, the surveyor observed the FSD remove a box from the shelf inside of the walk-in freezer. The surveyor observed open clear plastic packaging with several whole fish exposed from head to tail, of a pink/orange color, that the FSD identified as tilapia. The fish were noted to be coated with a white frosty/ice coating and had loose pieces of ice on them. The FSD acknowledged the plastic packaging should have been closed to avoid contamination and removed the box from the freezer. B. On 4/10/26 at 11:09 AM, the surveyor observed the following in the ethnic specialty kitchen area:1.The door to the food preparation room was propped open by a wooden doorstop on the floor. 2.A tower fan was in the room. The fan was running, and the air output was facing into the food preparation area. The surveyor observed the intake vents on the back of the fan were coated with grayish brown debris. At that time, the surveyor observed three staff preparing food at the counter and stove. On 4/14/26 at 8:45 AM, the surveyor returned to the ethnic specialty kitchen area. The surveyor observed DA #3 kneeling on the floor of the food preparation room hitting a bag, which was lying on the floor, with a hammer. DA #3 lifted the bag from the floor and placed it on the counter. The surveyor observed the bag was labeled as 20 pounds of [brand redacted] whole wheat flour. DA #3 reached into the bag and removed what appeared to be large brown irregular shaped pieces of material. DA #3 stated, sugar. DA #3 led the surveyor into the ethnic specialty supply room where she presented a package of brown material to the surveyor. The label indicated the product was solid unrefined sugar. DA #3 repeated hard. On 4/14/26 at 8:50 AM, with the assistance of another surveyor who was able to interview and interpret, the surveyor interviewed DA #3. DA #3 stated the unrefined sugar was used in food preparation. She stated it was difficult to separate into smaller pieces from its original packaging, so it was placed in a large bag and placed on the floor where she hit it with a hammer to break it into smaller pieces for ease of use. DA #3 acknowledged the bag she used was not labeled as sugar. DA #3 stated she needed a large bag, and on that particular day the whole wheat flour bag was empty, so she used it. On 4/14/26 at 2:26 PM, the above concerns were presented by the surveyor during a meeting with the Chief of Clinical Operations (CCO), Regional Administrator (RA), Administrator, and Director of Nursing (DON). The surveyor reviewed the undated facility policy Dietary/Food Handling which reflected the purpose was to provide guidelines for the safe preparation, handling and storage of perishable food and proper environmental cleaning. The general guidelines contained in the policy reflected.all raw fruits must be washed thoroughly. Dishwashing units must be used as per manufacturers directions.Sanitizing may be accomplished in one of the following ways.Contact for at least one (1) minute with a chlorine solution. The surveyor reviewed the undated facility policy Food Storage which reflected that food storage areas shall be maintained in a clean, safe, and sanitary manner. The interpretation and implementation reflected.All foods stored in walk-in refrigerators and freezers will be stored on shelves, racks, dollies, or other surfaces that facilitate thorough cleaning. The surveyor reviewed the undated facility policy Refrigerators and Freezers which reflected the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation. The interpretation and implementation reflected.Refrigerators and freezers will be kept (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, record review and review of pertinent facility provided documents, it was determined that the facility failed to; a.) ensure kitchen staff followed hand hygiene practices to prevent the spread of infection or food borne illness; b.) wear appropriate Personal Protective Equipment (PPE) and use appropriate hand hygiene during tracheostomy care and c.) follow appropriate hand hygiene during meal service to prevent the potential spread of infection. This deficient practice was identified in 2 of 2 kitchens observed for hand hygiene, 1 of 1 resident (#16) reviewed for tracheostomy care, and 1 of 4 dining areas reviewed for infection prevention, and was evidenced by the following: 1. On 4/9/26 at 8:52 AM, during an initial tour of the main kitchen, the surveyor observed [NAME] #1 wipe her bare hands on the sides of her pantlegs then don (put on) gloves and transport a plastic bin of food, which she identified as seasoned raw chicken, to the refrigerator. She returned, removed and disposed of her gloves, and donned new gloves. The surveyor did not observe hand hygiene was performed. On 4/10/26 at 11:09 AM, during an initial tour of the ethnic specialty kitchen, the surveyor observed Dietary Aide (DA) #1 preparing food. DA #1, with bare (ungloved) hands, lifted what appeared to be balls of a dough-like material from a bowl on the counter. She used a rolling pin to flatten and shape the material into circles, and dredged each circle in a bowl that contained a white powdery substance. She then placed each rolled out and dredged circle, one on top of the other, on a plate on the counter. The surveyor observed DA #1 complete this preparation process four (4) times with bare hands. The surveyor was unable to interview DA #2 at that time due to a language barrier. On 4/10/26 at 12:15 PM, the surveyor interviewed the FSD, who stated kitchen staff should wear gloves when handling food, even if the food is wrapped. He stated gloves should be changed after each use. On 4/13/26 at 11:30AM, in the main kitchen, the surveyor observed [NAME] #2 at the hand-washing sink, she used her right hand to expel soap from the dispenser, rubbed her hands together then rubbed her hands up and down her forearms almost to her elbows. The surveyor observed a white soapy film on [NAME] #2's hands and forearms. [NAME] #2 turned on the left and right faucet handles, with her soapy hands and ran her hands and arms up and down under the water then turned off the faucets. [NAME] #2 took paper towels, dried her hands and arms, and threw the paper towels in the trash can. [NAME] #2 took more paper towels from the dispenser, wiped them across her face, used her right hand to wipe the towels across the back of her left hand, then threw the towels in the garbage. [NAME] #2 then donned gloves and went to the cooking area. The surveyor made the FSD aware of the observation. The FSD called the employee out of the kitchen in the presence of the surveyor. The surveyor asked [NAME] #2 to verbalize the proper procedure for hand washing. [NAME] #2 stated, Wash, 20 minutes. The FSD interrupted and stated, 20 seconds. On 4/13/26 at 11:40 AM, [NAME] #2 in the presence of the surveyor and the FSD walked to the hand-washing station. [NAME] #2 turned on the faucet with her left hand while getting soap from the dispenser with her right hand, then put both hands under the running water. She used her right hand to dispense more soap and rubbed her hands together then rubbed her hands up and down her forearms almost to her elbows. The surveyor observed a white soapy residue on her hands and forearms. [NAME] #2 put her forearms and hands under the running water. The time from the second dispensing of the soap onto her hand until rinsing her arms and hands under the water was four (4) seconds. [NAME] #2 took paper towels, turned off the faucets and dried her hands and arms using the same paper towels. The surveyor interviewed the FSD who stated his observation was that [NAME] #2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	performed the hand-washing procedure correctly. On 4/14/26 at 9:30 AM, during a follow up tour in the main kitchen, near the 3-bay sink (three separate sinks designated and labeled for washing, rinsing, and sanitizing food service items that are hand washed), the surveyor observed that all three sinks were filled. The surveyor observed DA #2 walk to the faucet of the 3-bay sink and turn on the faucet. With the water running into the sink identified as rinse water, the surveyor observed DA #2 put his hands under the running water, rub them back and forth, turn off the faucet, shake his hands along his sides, and exit the kitchen. The surveyor made the FSD aware of this observation. On 4/13/26 at 12:08 PM, during an interview with the Infection Preventionist (IP), the IP acknowledged it was her responsibility to complete hand-washing competency tests for all kitchen / dietary staff. The IP stated she did the competency testing yearly and more often if needed. On 4/13/26 at 1:22 PM, the IP provided the surveyor with copies of forms titled Hand Hygiene Competency Checklist. Forms were not provided for [NAME] #1 or DA #1. The surveyor reviewed the undated facility policy Dietary/Food Handling which reflected the purpose was to provide guidelines for the safe preparation, handling and storage of perishable food and proper environmental cleaning. Item 15 reflected food handlers must wash their hands.whenever reentering the kitchen.before handling any food surfaces.after handling soiled equipment or utensils.during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.after engaging in other activities that contaminate the hands. 2.) On 4/13/26 between 11:24 AM and 11:42 AM, the surveyor observed tracheostomy (a surgical procedure that creates a direct opening in the neck into the windpipe [trachea] to facilitate breathing when the airway is blocked, damaged, or requires long-term mechanical ventilation) care performed on Resident #16 by two Registered Nurses (RNs). RN #1 stated they would be the lead and RN #2 would be their assistant to ensure they maintained aseptic (sterile) technique and to help secure the ties. After verifying the resident's identity, consent was obtained and both RNs donned (put on) clean, nonsterile exam gloves to reposition Resident #16 and monitor their oxygen level prior to the procedure; the reading was at 99% (normally 92-100%). RN #1 performed hand hygiene with soap and water, donned new nonsterile exam gloves and cleaned the overbed table to use for supplies. The RN #1 disposed of the gloves and donned another set of nonsterile exam gloves then removed the resident's soiled tracheostomy site gauze then disposed of it and the gloves into the garbage. RN #1 was then observed donning the sterile procedure gloves, no hand hygiene was performed prior to donning the sterile gloves. RN #1 removed the resident's disposable inner cannula (a removable liner that fits inside the main outer tracheostomy tube. It acts as a safety device, allowing for easy cleaning or replacement to prevent mucus blockage without removing the entire tracheostomy tube) using her left hand and disposed of it. RN #1 then cleansed the site as ordered, dried it, and placed a new split gauze at the tracheostomy site. RN #1 was unable to find the new sterile inner cannula with her supplies, and asked RN #2 to get one from the supply cart on the other side of the hallway door. When RN #2 reentered the room, she donned nonsterile exam gloves without performing hand hygiene and opened the inner cannula package for RN #1; RN #1 proceeded to insert the new inner cannula and stated they would also replace the tracheostomy ties (soft foam to hold the device in place around the resident's neck). RN #1 was on the resident's left and RN #2 was on the resident's right side to facilitate a safe tracheostomy tie exchange. At that time RN #1 looked up at RN #2, then down at her scrubs; RN #1 told the surveyor that both RNs were not wearing any PPE (Personal Protective Equipment such as gowns, gloves, and masks) besides gloves, and that they should have worn a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	mask and gown for the procedure as well. RN #1 stated that she always wore appropriate PPE with tracheostomy care and Enhanced Barrier Precaution (EBP - an infection control strategy for nursing homes, requiring gown and glove use during high-contact resident care [e.g., dressing, bathing, transfers] to prevent Multidrug-Resistant Organism transmission) residents and simply forgot due to being nervous. Both RNs then performed hand hygiene with soap and water, donned gowns, masks, and gloves to finish the procedure by changing Resident #16's tracheostomy ties.A review of the admission Record, an admission summary, reflected that Resident #16 had diagnoses which included but were not limited to; acute and chronic respiratory failure (the lungs cannot adequately oxygenate the blood or remove carbon dioxide), tracheostomy status, gastrostomy status (a surgical opening into the stomach for long-term nutrition, medication administration), pressure ulcer of sacral region stage 4 (a severe, full-thickness wound extending to exposed muscle, tendon, or bone, often with slough [dead cells, bacteria], eschar [dead skin], and deep tissue damage), and quadriplegia (the partial or total loss of function in all four limbs and torso).A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 1/30/26, included a Brief Interview for Mental Status (BIMS) score of 0 out of 15, and indicated the resident was rarely understood. A review of the resident's individual comprehensive care plan (ICCP) included a focus area revised on 1/28/26, for Enhanced Barrier Precautions related to an indwelling medical device with a goal of being free from infections. Interventions included, be sure it is noted near the resident that they need EBP, make sure PPE is available and all caregivers know what they should be wearing during care, use gown and gloves during close prolonged contact with the resident. Another focus area, dated 1/26/26, reflected; [Resident #16] has a tracheostomy r/t (related to) to maintain patent airway when obstruction/aspiration (accidental breathing of food, liquid, or saliva) is a risk, with a goal; [Resident #16] will maintain adequate oxygenation. Interventions included, Ensure that trach ties are secured at all times; trach[eostomy] care Q (every) shift and PRN (as needed); and capitalized in the care plan included; Use UNIVERSAL PRECAUTIONS (refers to the practice, in medicine, of avoiding contact with patients' bodily fluids, by means of the wearing of nonporous articles) as appropriate. A focus area, revised on 3/17/26 included that [Resident #16] has an indwelling suprapubic (a thin, flexible tube surgically inserted through the lower abdomen into the bladder to drain urine, used when natural urination is impossible). The goal for the focus was, [Resident #16] will show no s/sx (signs/symptoms) of Urinary infection through the review date of 5/18/26. Interventions for the focus included, monitor output for odor, color, consistency, and amount.Document and report any signs/symptoms of infection.A review of the Order Summary Report included the following physician orders (POs):A PO, dated 2/15/26, for enhanced barrier precaution, every shift for sacral Wound/trach/g-tube.A PO, dated 2/15/26, for Tracheostomy Suction every 2 hours and PRN for excessive secretions, every 2 hours for increased secretions AND as needed.A PO, dated 2/15/26, to Change Disposable Inner Cannula Every Day and PRN, every day shift AND as needed.A PO, dated 2/15/26, for Trach care every shift and PRN.On 4/14/26 at 10:58 AM, the surveyor interviewed the Director of Nursing (DON) regarding the use of PPE during tracheostomy care. She stated that residents with EBP status require gowns, gloves, and ideally a mask for high contact care. When asked if PPE should be worn during direct resident care such as tracheostomy care, the DON stated it was her expectation that a gown, gloves, and mask would be used during tracheostomy care for any resident to prevent contamination. The DON stated that she would expect hand hygiene to be performed between clean gloves, and before donning the sterile gloves.On 4/14/26 at 2:27 PM, in the presence of the survey team and the DON, the surveyor made the Licensed Nursing Home Administrator (LNHA) aware of the concerns regarding Resident #16's tracheostomy care related to infection control practices.A review of the facility's undated Tracheostomy Care policy included.Equipment and Supplies: 1. Gloves (clean and sterile); 2. Mask and eyewear (as indicated) .General Guidelines: 1. Aseptic technique must be used: During tracheostomy tube changes, either reusable or disposable. 2. Gloves must be used on both hands during any or all manipulation of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tracheostomy. Sterile gloves must be used during aseptic procedures.Procedure Guidelines: 3. Wash Hands, 4. Put exam gloves on both hands.8. Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle, 9. Wash hands.Clean the removable Inner Cannula: 1. Open tracheostomy cleaning kit, 2. Set up supplies on sterile field, 3. Maintaining sterile field pour equal parts.8. Put on sterile gloves, 9. Secure the outer neck plate with non-dominate gloved hand, 10. Unlock the inner cannula with gloved dominate hand, 11. Gently remove the inner cannula.14. Remove and discard gloves into appropriate receptacle, 15. Wash hands and put on fresh gloves.A review of the facility's undated Personal Protective Equipment – Using Gowns policy included.Objectives: 1. To prevent the spread of infections, 2. To prevent soiling of clothing with infectious material.When use of a gown is indicated, all personnel must put on the gown before treating or touching the resident.A review of the facility's undated Personal Protective Equipment – Using Face Masks policy included.Objectives: 1. To prevent transmission of infectious agents through the air, 2. To protect the wearer from inhaling droplets (Larger respiratory particles like Flu, RSV, or rhinovirus), 3. To prevent transmission of some infections that are spread by direct contact with mucous membranes.Miscellaneous: Follow established handwashing techniques. 3.On 4/13/26 from 12:50 PM through 12:58 PM, the surveyor observed the Certified Nurse Aide (CNA) delivering the lunch trays to residents in the Cedar Unit dining room. The surveyor observed after the CNA delivered the meal trays to other residents. When he was done passing the trays, he started to feed an Unsampled Resident (UR) #1 and then was observed touching an UR #2 on the shoulder while feeding UR #1. Hand hygiene (HH) or hand washing (HW) was not performed. While feeding UR #1, the CNA left the dining room and returned with a folding chair. The surveyor observed the CNA unfolded the chair and sat behind to the right side of UR #1 and resumed feeding them without performing HH. On 4/13/26 at 1:15 PM, during an interview with the surveyor, the CNA stated we should not touch other residents while feeding them due to contamination and spread of germs. The CNA confirmed that he should have performed HH after completing meal delivery and before he started to feed UR #1. On 4/13/26 at 1:41 PM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated the expectation from the staff was to perform HH during delivering meal trays, before and after the staff feeds the residents. The LPN/UM stated HH was important for infection control. On 4/14/26 at 11:39 AM, the surveyor met with the DON and made her aware of the above-mentioned concerns. The DON stated the CNA should have performed HH prior to start feeding the resident, should not have been touching other residents while feeding UR #1 and HH should have performed before after the CNA returned with a folding chair to resume feeding UR #1. On 4/14/26 at 2:25 PM, the survey team met with the Licensed Nursing Home Administration (LNHA), DON, Regional LNHA and the Chief Clinical of Operations (CCO). The surveyor made the facility administration aware of the above-mentioned concerns from dining observations. A review of the facility's Infection Control Program Overview policy dated 2/25/26 revealed Under Goals.Provide a safe, sanitary, and comfortable environment. Prevent the development and transmission of communicable diseases and infections .Ensure compliance with state and federal regulations relating to infection control. A review of the facility's undated Handwashing/Hand Hygiene policy revealed it is the policy of the facility that handwashing / hand hygiene will be regarded as the single most important means of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	preventing the spread of infections .Appropriate handwashing / hand hygiene must be performed at the follow times .Before and after eating .Before and after all resident care activities. NJAC 8:39-19.4 (a)(m)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and review of facility documents it was determined that the facility failed to maintain the dignity of an unsampled resident who required assistance to eat during lunch. This deficient practice was identified on 1 of 4 units (Cedar Unit) observed during lunch. This deficient practice was evidenced by the following:On 4/13/26 at 12:58 PM, the surveyor observed Certified Nursing Aide (CNA) #1 feeding an unsampled resident while standing up. At 1:01 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) instructed CNA #1 to sit down. CNA #1 left the dining room and returned with a folding chair. CNA #1 sat behind to the right side of the resident and proceeded to feed them. On 4/13/26 at 1:15 PM, the surveyor interviewed CNA #1, who stated staff were supposed to be sitting on the side of the resident or next to the resident when assisting with feeding. CNA #1 further stated you should be facing the resident so you can control and see the resident chewing their food. He further stated, if you are standing while feeding them, you cannot see their face. CNA #1 further stated I made a mistake by sitting in the back. I was standing there first. I shouldn't be standing.On 4/13/26 at 1:41 PM, the surveyor interviewed the LPN/UM about the process for feeding residents. The LPN/UM stated the staff should always be sitting and not standing for resident dignity.On 4/14/26 at 11:39 AM, the surveyor met with the Director of Nursing (DON) and made her aware of the above-mentioned concerns. The DON stated they (staff) should sit while they were feeding the residents and they know they should be sitting. The DON further stated, you cannot feed a resident without having a direct eye contact and making sure the resident was swallowing food before giving them more food. The DON acknowledged that if you are sitting behind the resident, then you would not be able to see the resident.On 4/14/26 at 2:25 PM, the survey team met with the Licensed Nursing Home Administration (LNHA), DON, Regional LNHA and the Chief Clinical of Operations. The surveyor made the facility administration aware of the above-mentioned concerns.A review of the undated facility's Resident Rights policy revealed under section Quality of Life - The facility must care for you in a manner that enhances your quality of life. Under section Accommodation of Needs - You have the right as a resident to receive services with reasonable accommodations to individual needs and preferences.A review of the undated facility's Assisting the Impaired Resident with Meals policy revealed under section Steps in the Procedure: 3. If you are going to be seated during the feeding, position a chair where it will be convenient for you and the resident. NJAC 8:39-4.1(a) 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the resident's call bell (CB; a bell used to summon staff for assistance) was readily accessible and within reach of the resident. The deficient practice was identified for one (1) of one (1) resident, Resident #184, reviewed for accommodation of needs. This deficient practice was evidenced by the following:On 4/9/26 at 11:41 AM, the surveyor observed Resident #184 resting in their bed. The surveyor greeted the resident and the resident sat up to speak with the surveyor. The surveyor observed Resident #184's CB was out of reach on the floor, which was on the left side of the nightstand. The surveyor asked the resident how they would call the staff for help, the resident stated that they would call out (shout out) for help when needed. On 4/10/26 at 12:54 PM, the surveyor observed Resident #184 sitting in their wheelchair. The surveyor observed the CB on the floor, in the same position as it was observed on the previous day. The surveyor asked the resident if they knew where their CB was and the resident stated No. Resident #184 further stated if they needed any help, they would call out for help or come out of their room to ask for help. The surveyor reviewed the electric medical record for Resident #184. A review of the admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; essential (primary) hypertension (high blood pressure that is not due to another medical condition), cerebral infarction (a type of stroke where a blockage in an artery cuts off blood and oxygen to part of the brain, causing brain cells to die), Hemiplegia (a medical condition causing paralysis [unable to move certain parts of your body] or severe weakness on one side of the body, affecting the arm, leg, and face) and Hemiparesis (weakness on one side of the body, affecting the arm, leg, and sometimes the face) following cerebral infarction affecting right dominant (side of the body that is stronger) side.A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 1/16/26, revealed that the resident had a Brief Interview for Mental Status score of 9 out of 15, indicating that the resident had moderately impaired cognition. Further review of the MDS revealed that Resident #184 had impairment on one side in their upper and lower extremities (the outermost parts of the human body, primarily the hands, feet, fingers, and toes) and required maximal assistance with activities of daily living (ADLs). A review of the individual comprehensive care plan (ICCP) had a focus initiated on 11/1/22 that indicated the resident had altered communication due to being usually understood/understands related to (r/t) impaired cognition secondary to diagnosis (dx) of dementia with interventions that included but were not limited to; . Call light in reach. Another focus initiated on 10/18/24 indicated the resident presents need for grab bar while in bed for assistance toward turning, positioning and transferring and assist caregivers with interventions to keep CB within reach. Further review of the ICCP revealed a focus initiated on 8/18/22 that the resident had an ADL self-care performance deficit rt right sided hemiparesis/hemiplegia following cerebral infarction and the interventions included encourage the resident to use CB to call for assistance. On 4/10/26 at 1:14 PM, the surveyor interviewed the Certified Nursing Aide (CNA) assigned to Resident #184's care. The CNA stated that she would make sure the resident's CB was in reach before she would leave resident's room. The CNA further stated it was important to keep the CB within reach for safety even if the residents were able to walk because you never know what could happen. The CNA stated Resident #184 was able to use their CB and had their call bell in reach all the time. The surveyor informed the CNA about the above-mentioned observations, the CNA stated she had not gone to resident's room earlier that day because the resident did not want staff to go in their room early.On 4/10/26 at 1:34 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #184's care. The LPN stated before leaving the resident's room, she would make sure the resident's bed was not too high and the resident had their CB with them if they needed anything and would remind the resident to use CB. The LPN further stated when the CNA's made the resident's bed and/or assisted residents back to their bed, they should place the call bell within the resident's reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/13/26 at 10:41 AM, during an interview with the surveyor, the LPN/Unit Manager (LPN/UM) stated it was important to have the call bell within reach all the time and that was the only way they (the resident) could communicate with us (the staff). The LPN/UM further stated it was important to have the CB in reach because if the resident had an emergency that's how they would call for help. The surveyor made the LPN/UM aware of the above-mentioned concerns. The LPN/UM confirmed the resident should not have to shout for help and the CB should be always within reach. On 4/14/26 at 11:39 AM, during an interview with the surveyor, the Director of Nursing (DON) stated the CB should be in reach at all the time because if a resident needed assistance that was what they would use to call for help. The surveyor made the DON aware of the above-mentioned CB concerns for Resident #184. On 4/14/26 at 2:25 PM, the survey team met with the Licensed Nursing Home Administration (LNHA), DON, Regional LNHA and the Chief Clinical of Operations (CCO). The surveyor made the facility administration aware of the above-mentioned concerns. A review of the facility's undated Call Bells Policy revealed Policy statement: It is the policy of [Name Redacted] that all residents are to have access to call bell. Staff is expected to be as vigilant as possible in keeping the call bell within reach of the resident. Under Guidelines: 2. Be sure the call lights are plugged in and within reach at all times. 5. Ensure all call bells are within the resident's reach before leaving the room. A review of the facility provided, CNA Job Description included but was not limited to; Under section Duties and Responsibilities included Personnel Functions - Perform all assigned tasks in accordance with our established policies and procedures.Section Safety and Sanitation: Keep the nurses' call system within easy reach of the resident. A review of the facility provided, Nurse Job Description included but was not limited to; Under section Duties and Responsibilities included Administration Functions- Ensure that all nursing personnel assigned to you comply with the written policies and procedures.Section Safety and Sanitation- Monitor your assigned personnel to ensure that they are following established safety regulations in the use of equipment and supplies. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to a.) complete timely background checks for 4 out of 155 employees (Employee #1, #4, #12, and #14) and b.) complete timely reference checks for 3 out of 155 employees (Employee #3, #7, and #8). This deficient practice was identified for newly hired, since last survey of 11/21/2024, employee files reviewed.This deficient practice was evidenced by the following:On 4/9/26 at approximately 10:22 AM, during the entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), all newly hired employee files for active and inactive employees from 11/21/24 to the current date.a. A review of the employee personnel files revealed the following:Employee #1, a Speech Therapist with a date of hire (DOH) 7/7/25, the background check was completed 6/5/24. Employee #4, a Registered Nurse (RN) with a DOH 7/18/25, the background check was completed 7/23/25. Employee #12, a RN with a DOH 3/27/26, the background check was completed 4/1/26. Employee #14, an Occupational Therapist with a DOH 6/23/25, the background check was completed 5/10/22. b. A review of the employee personnel files revealed the following:Employee #3, a Certified Nursing Assistant (CNA) with a DOH 8/20/25, there was no evidence of reference checks prior to the start of employment.Employee #7, a RN with a DOH 3/17/25, the reference checks were completed 7/3/24. Employee #8, a Houskeeper with a DOH 3/9/26, the 2 reference check forms were not signed or dated by the facility. On 4/14/26 at 2:25 PM, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were made aware of the above concerns regarding background checks and reference checks for newly hired employees. On 4/15/26 at 10:14 AM, the Director of Human Resources stated background checks were completed immediately upon accepting the position. She further stated that reference checks are completed prior to hiring. She stated they obtained two work references either over the phone or email. She then stated that background checks and reference checks had to be completed prior to hire, especially the background check. On 4/15/26 at 11:42 AM, the survey team met with the LNHA, DON, Assistant Director of Nursing, Chief Clinical of Operations, and the Regional Director. The facility could not provide any additional information for the above concerns.A review of the facility's Employee Health Records policy, revised 5/29/2020 revealed health records will be maintained for current employees.a criminal background check is required prior to hire or as permitted by regulation. Employment is contingent upon acceptable results. Professional references must be obtained and verified.all hiring practices will comply with applicable federal, state, and DOH regulations. A review of the facility's Abuse policy dated April 9, 2024, revealed .Screening Components: it is the policy of this facility to screen employees and volunteers (as applicable per volunteer policy) prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check. Procedure: Employee Screening and Training. Before new employees are permitted to work with residents, references provided by the prospective employee will be verified as well as appropriate board registrations and certifications regarding the prospective employee's background.a criminal background check will be conducted on all prospective employees as provided by the facility's policy on criminal background checks. A significant finding on the background check will result in denied employment consistent with the criminal background check policy in accordance with State and Federal Regulation including Peak law. NJAC 8:39-9.3(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to develop an individual comprehensive care plan (ICCP) to address the needs of a resident with Asthma (a condition that causes your airways to swell, narrow and fill with mucus), and nebulizer treatments (a way to deliver liquid medicine directly into the lungs by turning it into a fine breathable mist). This was identified for 1 of 3 residents (Resident #69) reviewed for Respiratory Care. This deficient practice was evidenced by the following:On 04/09/2026 at 10:21 AM, the surveyor observed Resident #69's nebulizer tubing and mouthpiece (a device used to deliver medication directly into the lungs) on the table in a clear plastic bag, dated 4/8/2026.The surveyor reviewed the electronic medical records for Resident #69 which revealed the following:The admission Record (AR; an admission summary) reflected that the resident was admitted to the facility, with diagnoses that included but were not limited to; Cerebral Infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), Asthma, and Hypertension (high blood pressure).A review of the resident's most comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/20/2026, included a Brief Interview for Mental Status of 13 out of 15, which indicated the resident was cognitively intact.A review of the physician order summary report as of 4/10/2026 revealed a physician's order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML inhalation orally (via nebulizer three times a day for SOB (shortness of breath)/Wheezing (shrill whistle or coarse rattle sound heard when the airway is partially blocked) ., minimum TX (treatment) 15 minutes; and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML 1 via inhalation orally via nebulizer every 6 hours as needed for wheezing.A review of the ICCP revealed a focus of Resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Fatigue initiated on 12/8/2025. Further review of the ICCP did not reveal a Focus for Asthma or nebulizer treatment.On 04/10/2026 at 12:18 PM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) stated the purpose of the CP was to know what to do for the resident which included the resident's care, ADLs, feeding, code status, medical condition, skin condition, and smoking. The surveyor asked the LPN if she would expect to see a CP for a resident with diagnoses of Asthma and nebulizer treatment, she stated, yes, it should be included in the CP. The LPN confirmed that there was no record of the resident's Asthma diagnosis or nebulizer treatment in the CP. The LPN further stated it was important for the Asthma diagnosis and the nebulizer treatment to be on the CP because it was a breathing concern.On 04/10/2026 at 12:35 PM, during a meeting with the surveyor, the Unit Manager (UM) stated the CP was the story of the resident and tells how to cater to all the resident's needs based on diagnosis, mobility, transfers, and hygiene. It involves the ADLS of the resident. The surveyor asked the UM if she would expect to see a CP for a resident with diagnoses of Asthma and she stated, Definitely, a resident with asthma should be included on the care plan to continue to monitor. The UM confirmed that there was no respiratory care including Asthma diagnosis on this resident's CP, and that there should have been one because it was one of the resident's diagnoses.On 04/14/2026 at 1:32 PM, during an interview with the surveyor, the Director of Nursing (DON) stated, the care plan depicts the care and services that the resident receives. We put pretty much every thing that pertains to the resident care and services. The DON confirmed that the diagnosis and treatment should be on the resident's care plan to show the care and treatment the resident was receiving.On 4/14/26 at 2:41 PM, the survey team met with the Licensed Nursing Home Administration (LNHA), DON, Regional LNHA and the Chief Clinical of Operations (CCO). The surveyor made the facility administration aware of the above-mentioned CP concern for Resident #69.A review of the undated Floor Nurse Job Description, revealed:Care Plan and Assessment Functions:Review resident care plans for appropriate resident goals, problems approaches, and revisions . A review of the Unit Manager undated Job Description, revealed:Care Plan and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment Functions:Participate in the development of a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/needs of the resident, indicates the care plan to be given, goals to be accomplished, which professional service Is responsible for each element of care. A review of the facility's policy Care Plans with a date of 2/25/26, revealed:Policy Statement:An individualized care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs is developed for each resident. Policy Interpretation and Implementation:2. Each resident's comprehensive care plan has been designed to:a. Incorporate identified problem areas.b. Incorporate risk factors associated with identified problems .4. Care plans are revised as changes in the resident's condition may dictate. Care plans are reviewed at least quarterly. A review of the facility's Administering Medications through a Small Volume (Handheld) Nebulizer with a date of 2/25/26, revealed:Purpose:The purpose of this procedure is to safely administer aerosolized particles of medication into the resident's airway.Preparation:2. Review the resident's care plan . N.J.A.C 8:39-11.2 (d) (e) (1) (2) (3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a low air loss (pressure reducing) mattress was functioning properly and accurately setup according to resident weight for a resident who was previously identified to have had an alteration in skin integrity.This deficient practice was identified for 1 of 4 residents (Resident #16) reviewed for pressure ulcers and was evidenced by the following:On 4/10/26 at 10:06 AM, the surveyor observed Resident #16 lying in bed, awake, on an air mattress. The air mattress pump was observed to be set to a weight of 380 pounds. Resident #16 was wearing a hospital gown and noted to have a tracheostomy site (a surgical hole in the neck to assist breathing). The resident was able to communicate with the surveyor using short one- or two-word answers. Resident Representative #1 was at the bedside and able to provide resident history and information to the surveyor with the resident's consent and input. Resident Representative #1 stated that they came to the facility every day to spend time with and advocate for Resident #16.On 4/10/26 at 11:50 AM, the surveyor reviewed Resident #16's electronic medical record (EMR) which reflected a resident weight of 149 pounds on 4/7/26.On 4/13/26 at 9:57 AM, the surveyor observed Resident #16 in bed, the air mattress pump set to a weight of 380 pounds. The resident was in bed wearing a hospital gown with positioning wedges on their right side to offload their sacrum (the bone located at the top, back part of the pelvis, linking the spine to the pelvis, which includes the tail bone). A review of the admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to; acute and chronic respiratory failure (the lungs cannot adequately oxygenate the blood or remove carbon dioxide), tracheostomy status, gastrostomy status (a surgical opening into the stomach for long-term nutrition, medication administration), pressure ulcer of sacral region stage 4 (a severe, full-thickness wound extending to exposed muscle, tendon, or bone, often with slough [dead cells, bacteria], eschar [dead skin], and deep tissue damage), and quadriplegia (the partial or total loss of function in all four limbs and torso).A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 1/30/26, included a Brief Interview for Mental Status score of 0 out of 15, and indicated the resident was rarely understood. Further review of the MDS reflected that the resident was admitted to the facility with an unhealed stage 4 pressure ulcer. Additional review of the MDS, in the section Skin and Ulcer/Injury Treatments included an intervention for a pressure reducing device for the bed and for pressure ulcer/injury care.A review of the resident's individual comprehensive care plan (ICCP) included a focus area revised 3/24/26, the resident had a wound to their sacrum. Interventions included: adding the resident to wound consults and follow orders accordingly and medicating the resident prior to wound care. Another focus area dated 1/23/26, reflected that the resident had an ADL self-care performance deficit related to limited mobility. Interventions included: having 2 staff members provide care and for safe repositioning as necessary, and to provide skin care to keep clean and prevent skin breakdown. A review of the Order Summary Report included the following physician orders (PO):A PO, dated 3/30/26, for repositioning every hour and as needed. A PO, dated 4/9/26, to use 2 wedges to offload the sacrum every 2 hours, including night shift, every day for stage IV sacrum ulcer.A PO, dated 3/10/26, for wound evaluation and treat with [Company] Wound Care.A review of the Wound Care Progress Notes (WCPN) revealed that the resident was assessed weekly by a wound care specialist. A review of a WCPN, dated 4/6/26, for a follow-up evaluation reflected that the wound remained stable/unchanged from the previous evaluation.On 4/14/26 at 10:58 AM, the surveyor interviewed the Director of Nursing (DON) regarding the use of support surfaces. The DON stated that the machines at the end of some of the beds were air pumps used with specialized mattresses designed to offload pressure. The DON stated that they were used mostly for residents with wounds, but also for residents at high risk for skin breakdown related to malnutrition or other factors that might cause it. She told the surveyor that Maintenance set the bed up and nursing staff would ensure it was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	providing adequate relief during rounds and while providing care. When asked what the numbers on the dial indicated on the air pump, the DON responded that it was different for different companies; some had weights on the dial to be set to a specific resident weight, while others were numbered (example 1-6 given), and that each number correlated to a weight range. She stated that if an air mattress pump had weight settings on the dial, that the mattress should be set to the resident's weight to ensure proper pressure distribution. On 4/14/26 at 11:35 AM, the surveyor observed Resident #16 in bed wearing a hospital gown with Resident Representative #1 at bedside. The surveyor noted the pump on the resident's air mattress was set to 380 pounds, the resident was sleeping at that time. On 4/14/26 at 12:31 PM, the surveyor asked the Licensed Practical Nurse (LPN) caring for Resident #16 about the pump located at the foot of the resident's bed. The LPN walked the surveyor into Resident #16's room, Resident Representative #1 was at the bedside. The LPN pointed to the pump and stated that the pump was used for the resident's air mattress; that the Wound Care team would usually order them for residents with wounds or at high risk of developing them. She told the surveyor that Maintenance set them up and took care of them if they malfunctioned. When asked who checked to make sure that the mattress was functioning properly and how often; the LPN responded that the mattresses were seen every shift by nursing staff and that she would observe to see if the resident looked okay in bed and use nursing judgement if something looked wrong. The surveyor asked the LPN what the different numbers on the dial meant. The LPN stated that the numbers mean hard or soft and stated that the middle number (280) was medium. When asked to read the text under the dial, the LPN responded, it says pounds. The surveyor then asked the LPN if the number on the dial should correlate to the resident's weight; the LPN responded I'm not really sure, I wasn't trained on it. It should probably be set to the resident's weight, but it's set to 400 pounds, the dial was between 360 pounds and 400 pounds (380 pounds). The LPN stated that she would check with her supervisors and that the resident was due for a weekly weight check to record an accurate number in the EMR.On 4/14/26 at 2:27 PM, in the presence of the survey team, the surveyor made the Licensed Nursing Home Administrator (LNHA) aware of the concerns regarding Resident #16's air mattress. On 4/15/26 at 12:14 PM, the LNHA and DON acknowledged that an air mattress should be set according to a resident's weight to prevent skin breakdown and promote healing.A review of the facility's undated Support Surface Guidelines, included.any individual at risk for developing pressure ulcers should be placed on a pressure reducing device, such as foam, static air, alternating air, gel, or water mattresses when lying in bed.for residents that recline and depend on staff for repositioning, change positions at least q (every) 2 hours. If a resident has a Stage 1 or above pressure ulcer, q 2 hour turning is inadequate.monitor for other pressure ulcer risk factors and provide interventions as indicated.the following information may be recorded in the resident's EHR (electronic health record): 1. The specialty bed settings are appropriate and correspond with physician's orders, 2. The date and time when the specialty bed settings were checked.NJAC 8:39-27.1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to follow a physician's order for oxygen therapy. This deficient practice was identified for 1 of 3 residents (Resident #101) reviewed for respiratory care.This deficient practice was evidenced by the following: On 4/9/26 at 11:25 AM, during the initial tour of the facility, the surveyor observed Resident #101 lying in their bed watching television. The surveyor observed an oxygen concentrator (device that delivers oxygen) with a nasal cannula tubing (NC - device that delivers additional oxygen through the nose) administering oxygen at 3 liters per minute (lpm). The resident stated that they always wear the nasal cannula and receive oxygen continuously. On 4/10/26 at 9:49 AM, the surveyor observed the resident in their room lying in bed awake watching television. The surveyor observed the resident receiving oxygen via nasal cannula at 3 lpm. On 4/10/26 at 12:25 PM, the surveyor observed the resident in the dining room area in their wheelchair eating lunch. The surveyor observed the resident receiving oxygen via nasal cannula from the portable oxygen tank (small and quiet devices that allow you to receive supplemental oxygen). The oxygen concentrator was set at 3 lpm at this time. On 4/13/26 at 9:35 AM, the surveyor observed Resident #101 in their bed, seated upright, eating breakfast. The resident was receiving oxygen via nasal cannula at 3 lpm. The resident stated they were doing well, and breakfast was good. The surveyor reviewed the electronic medical record (EMR) for Resident #101. A review of the admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; encephalopathy (syndrome of general brain dysfunction), other nontraumatic subarachnoid hemorrhage (bleeding events in the brain's subarachnoid space), and heart failure (chronic condition where the heart cannot pump enough blood to meet the body's needs). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 2/27/26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating moderately impaired cognition. A further review of section O special treatments, procedures and programs revealed that Resident #101 received oxygen therapy while a resident. A review of the individualized comprehensive care plan (ICCP) included a focus area with a revision date of 9/16/25, the resident has altered respiratory status/difficulty breathing related to hypoxic hypercapnic respiratory failure (oxygen failure, categorized by a low level of oxygen in the blood) and OSA (Obstructive Sleep Apnea - serious sleep disorder where breathing repeatedly stops and starts). The ICCP interventions included; monitor for signs and symptoms of respiratory distress and report to the MD PRN (as needed).Oxygen settings at 4 L (liters) via N/C (nasal cannula) continuous. A review of the Order Summary Report included the following physician orders (PO). A PO, dated 6/6/24, O2 (oxygen) continuous at 4L (liters) via NC every shift for O2. On 4/13/26 at 1:25 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated she tried to go around hourly to check the resident's oxygen settings to ensure it was on the correct lpm. She further stated that Resident #101 received oxygen at 3 lpm continuously. The surveyor and LPN confirmed that the oxygen concentrator in the resident's room was set for 3 lpm. The LPN in the presence of the surveyor reviewed the physician's orders in the EMR and she confirmed that the resident's orders were for oxygen at 4 lpm continuously. On 4/13/26 at 2:03 PM, the surveyor interviewed the Unit Manager, who acknowledged that the nurse should be checking the resident's oxygen concentrator settings each shift. She further verified that Resident #101's oxygen order was for 4 lpm. She then stated that we will change his oxygen settings from 3 lpm to 4 lpm and contact the physician for clarification. On 4/14/26 at 11:06 AM, the surveyor interviewed the Director of Nursing (DON), who stated the nurse should set the oxygen concentrator at the correct lpm according to the physician's order. She then stated that each nurse assigned to the resident was supposed to make sure the oxygen concentrator setting was correct each shift. The DON in the presence of the surveyor confirmed that Resident #101 had a physician order for 4 lpm. She then stated that the importance of following the physician orders (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the oxygen concentrator settings was because it was a respiratory concern for the resident. On 4/15/26 at 11:44 AM, the DON, in the presence of the Licensed Nursing Home Administrator, Assistant Director of Nursing, Regional Director, and the Chief Clinical of Operations, and the survey team, acknowledged that the resident's physician order should have been followed as ordered. A review of the facility's Oxygen Administration: policy, undated, included the purpose of this procedure is to provide guidelines for oxygen administration. Preparation: Verify that there is a provider order for this procedure. Review the physician's orders or facility protocol for oxygen administration.Review the resident's care plan to assess for any special needs of the resident. NJAC 8:39-27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure professional standards of nursing practice were followed by performing accurate verification of a resident's name on the label of a medication (Eliquis) (a medication used to thin the blood) prior to administration. The deficient practice was identified for one (1) of three (3) nurses administering medications to one (1) of five (5) residents, (Resident #3) observed during the medication administration observation. 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 case finding, 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 case finding; 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 deficient practice was evidenced as follows: On 4/13/26 at 9:00 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) administer nine (9) medications which included one (1) tablet of Eliquis 5 milligrams (MG) to Resident #3 in their room. Upon returning to the medication cart, LPN #1 reviewed with the surveyor the prescription label on the package she removed the Eliquis from for administration to Resident #3. The surveyor with the LPN #1 observed the label for the Eliquis 5 MG tablets had the name of an unsampled resident. LPN #1 stated I did not realize the resident's name was wrong. LPN #1 added that according to the electronic medication administration record (EMAR), Eliquis 5 MG was the correct medication for Resident #3. The surveyor with LPN #1 reviewed the EMAR which revealed for an administration time of 8 AM there was a physician's order (PO) with a start date of 4/3/26 for Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for A-fib. LPN #1 confirmed she had removed the Eliquis 5 MG tablet for Resident #3 from another resident's labelled medication. LPN #1 then showed the surveyor Resident #3 had their own labeled Eliquis 5 MG packaged by the provider with their name on the label. LPN #1 added she should not have removed the Eliquis 5 MG tablet from another resident's supply and should have read the name on the label. LPN #1 stated that she thought the unsampled resident was discharged and that was why the medication was in the cart. The surveyor reviewed the electronic medical record for Resident #3. A review of the admission Record revealed Resident #3 was admitted with diagnoses which included but not limited to; atrial fibrillation (A-fib) (an irregular heart rhythm). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/25/26 reflected that the resident had a Brief Interview of Mental Status (BIMS) score of 14 out of 15 which indicated the resident had intact cognition. Further review of the MDS revealed the resident spoke another language and required an interpreter. A review of the Order Summary Report (OSR) for active orders dated 4/14/26 indicated a PO with a start date of 4/3/26 for Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for A-fib. A review of the unsampled resident's medications on the OSR for active orders dated 4/14/26 indicated a PO with a start date of 4/11/26 for Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet via G-tube (a medical device inserted into the stomach) two times a day for Prevent blood clot Monitor for bleeding. On 4/13/26 at 1:10 PM, the surveyor interviewed the Unit Clerk (UC #1) who stated the unsampled resident was discharged to the hospital last week and had returned and was currently residing on the unit. UC #1 added if there (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was a question regarding the unsampled resident then the nurse on the low side medication cart would be able to answer it. UC #1 explained there were three (3) medication carts and one (1) nurse assigned to each cart based on the resident room numbers. UC #1 added the unsampled resident had remained in the same room. On 4/13/26 at 1:42 PM, the surveyor interviewed LPN #1who stated she was assigned to the ?high side' medication cart and had been off for three (3) days and was unsure why the unsampled resident's Eliquis was in her medication cart because the unsampled resident was in a room assigned to the low side. LPN #1 added there was a previous time the unsampled resident was assigned to the high side medication cart even thought they were in a room that would have been in the low side cart, and their medications were stored in the high side cart. LPN #1 confirmed the unsampled resident was not assigned to her and the medications should not have been in her cart. LPN #1 also stated when she was assigned to the unsampled resident, their medications were removed from the low side cart and put into her high side cart. LPN #1 added moving the medications could have led to the confusion. On 4/14/2026 at 9:32 AM, the surveyor interviewed the Director of Nursing (DON) who stated there was a unit that had three (3) medication carts referred to as low, middle, and high. The DON added depending on the census of the unit the assignment of residents was divided among the three (3) nurses and consideration given to the level of care each resident needed to try to accommodate a fair division. The DON explained the nurses would switch residents or take residents from another nurses' assignment to accommodate. The DON further explained the nurses would also remove resident's medications and put them in the medication cart of the nurse who was then assigned to them as a convenience, so the nurse did not have to go between different medication carts. On 4/15/26 at 11:42 AM, the survey team met with the facility administrative team. The DON stated LPN #1 was inserviced on following the five (5) rights during a medication pass which included ensuring the medication was labelled for the right resident. The DON further stated the nurses were not to be switching medications for the residents between carts. The Licensed Nursing Home Administrator (LNHA) verified the facility policy for Administering Medications provided to the surveyor was the current policy. The surveyor reviewed the facility undated policy for Administering Medications provided by the Regional Director of Clinical Operations revealed Medications shall be administered in a safe and timely manner, and as prescribed. In addition, the policy revealed The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method of administration before giving the medication. NJAC 8:39-11.2(b), 29.2(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the medical record, and review of other facility documentation, it was determined that the facility failed to respond timely to the monthly Consultant Pharmacist (CP) recommendations. This deficient practice was identified for 2 of 5 residents reviewed for unnecessary medications (Resident #46 and #194). The deficient practice was evidenced by the following:1.On 4/9/2026 at 11:45 AM, during initial tour, the surveyor observed Resident #194 sitting in a wheelchair, in their room. The surveyor reviewed the electronic medical record (EMR) for Resident #194 A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions and could cause excessive worry), end stage renal disease (kidneys no longer function well enough to meet a body's needs) and dependence on renal dialysis (a life-sustaining treatment for kidney failure that filters waste, salt, and excess water from the blood, acting as an artificial kidney). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 3/24/26, revealed the resident had a Brief Interview for Mental Status (BIMS) of 11 out of 15, indicating the resident was moderately cognitively impaired. Further review of the MDS revealed the resident was receiving dialysis. A review of the individual comprehensive care plan (ICCP) revealed a focus of potential for complications due to hemodialysis, revision date of 10/6/2025. A review of the pharmacy consultant recommendations (PCR) for 2/6/26 revealed the following: -Please clarify the order for bisacodyl. The order says to administer if MOM (Milk of Magnesia) is ineffective however, there is no order for MOM noted on the MAR (Medication Administration Record). Signed as completed on 4/12/26; initialed by Licensed Practical Nurse/Unit manager (LPN/UM) #1. -Please clarify lisinopril MWF (Monday, Wednesday, Friday) order. The supplementary documentation needs to be updated so that the blood pressure can be documented with each dose. Signed as completed on 4/12/26; initialed by LPN/UM #1. A review of the PCR for 3/5/26 revealed the following: -Please clarify the order for bisacodyl. The order says to administer if MOM is ineffective however, there is no order for MOM noted on the MAR. Milk of Magnesia should be avoided in residents on dialysis. Contact the physician to discontinue MOM and obtain orders for alternate therapy. Signed as completed on 4/12/26; initialed by LPN/UM #1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Please clarify lisinopril MWF order. The supplementary documentation needs to be updated so that the blood pressure can be documented with each dose. Signed as completed on 4/12/26; initialed by LPN/UM #. A review of the February and March 2026 MARS revealed the following: -An active physician order for Lisinopril Oral tablet 20 MG (milligram) Give 1 tabled by mouth one time a day every Mon, Wed, Fri for HTN (hypertension) was signed as administered from 2/6/2026 every M, W, F at 11 am until 3/27/2026 without the supplementary documentation of the blood pressure being added to the MAR. -An active order Dulcolax Suppository 10 MG (Bisacodyl) insert 1 suppository rectally every 24 hours as needed for constipation/MOM ineffective, PRN (as needed). Further review did not reveal an order for MOM. On 4/14/2026 at 9:52 AM, the surveyor interviewed LPN/UM #1, who stated the PCR were printed by the Director of Nursing (DON) and then given to the unit managers. He said the PCRs were usually addressed within 3 to 7 days. LPN/UM #1 reviewed the PCR for Resident #194 for February and March 2026 in the presence of the surveyor. He acknowledged his signature on both forms dated 4/12/2026. He also acknowledged the same recommendations were made for both months. LPN/UM #1 reviewed the EMR, in the presence of the surveyor. He reviewed the progress notes and acknowledged the PCR were not addressed. He stated, I should have put a note in to clarify it was done. LPN/UM #1 stated the PCR were important because it is for the safety of the patients. On 4/14/2026 at 10:37 AM, the surveyor interviewed the Director of Nursing (DON) who stated the PCR reports were printed and then given to the unit managers to follow up on the recommendations. She stated every recommendation should be addressed and documentation should be done even if the physician refused or did not want to follow the PCR. The surveyor showed the DON the PCR reports for February and March for Resident # 194, she acknowledged it was late and stated that the PCR should be addressed within a week. 04/14/2026 2:25 PM, in the presence of the survey team, the surveyor made the Licensed Nursing Home Administrator, the DON, the Assistant DON, the Chief Clinical of Operations and the Regional Administrator aware of the above concerns. 2.On 4/10/2026 at 10:17 AM, Resident #46 was observed sitting in wheelchair in prayer in the Day Room. The resident was quiet, calm, and not interactive. On 4/13/2026 at 10:40 AM, the resident was observed in the Day Room during activities, the resident was sitting in wheelchair, not engaging in activities and was non-interviewable. The surveyor reviewed the EMR for Resident #46. A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; acute on Chronic diastolic (Congestive) Heart Failure, Type 2 Diabetes, other specified mental disorders due to known physiological condition, and other specified depressive episodes (mood disorders characterized by significant depressive symptoms that do not fulfill the complete diagnostic criteria for any specific depressive disorder), and Hypertension (high blood pressure). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission Minimum Data Set, dated [DATE], revealed the resident had a Brief Interview for Mental Status of 13 out of 15, indicating the resident was cognitively intact. Further review revealed the resident was receiving antidepressant, anticoagulant, antibiotic, hypoglycemic, antiplatelet, and antipsychotic medications. A review of the individual comprehensive care plan revealed the focus of client was a new admission and adjusting to current placement, date initiated 3/18/2026. On 4/14/2026 at 9:00 AM, the surveyor reviewed the IMRR (Interim Medication Review) Nursing Report, an observation made by the consulting pharmacist on 3/18/2026 as high priority, revealed: Please clarify the order for diltiazem. The supplementary documentation needs to be updated so that the hold parameters (Blood Pressure) can be documented with each dose. A review of the March 2026 Medication Administration Record (MAR) revealed the following: -An active physician order for Diltiazem HCl Oral Tablet 90 MG, give 1 tablet by mouth three times a day for HTN, hold for SBP (Systolic Blood Pressure) less than 110 was signed as administered from 3/18/2026 to 3/29/26 every shift at 9:00 AM, 1:00 PM, and 5:00 PM without the supplementary documentation of the blood pressure being added to the MAR. A review of the March 2026 Medication Administration Record (MAR) revealed the above-mentioned PO had been documented as completed as of 3/18/2026 without the parameter as requested by the pharmacy consultant. On 4/15/2026 at 11:15 AM, during an interview with the surveyor, the Unit Manager (UM) stated the purpose of the pharmacy consultant was to review the purpose of the medications with regards to timing, food administration, drug interaction, if the medications are spaced out well enough, timing wise, and if they are contraindicated with other medications, and also poly pharmacy. The UM confirmed there was no supplemental documentation of the resident's BP on the MAR from 3/18/26 through 3/29/26 as the pharmacist had recommended. The UM stated there should have been a supplemental documentation with the order as soon as it was recommended, the Doctor/Nurse Practitioner should have been made aware that the medication was administered without the parameter as recommended by the pharmacist on 3/18/26. On 04/14/2026 at 12:47 PM, the surveyor interviewed the Director of Nursing (DON), who stated the pharmacy consultant recommendations were received electronically via email, then printed and given to the managers, and they have 7 days to complete the recommendations. The DON stated the managers would speak to the Medical Doctor (MD) or Nurse Practitioner (NP) for clarification and the order would be created. The DON confirmed that the recommendation was given on 3/18/26 and it was for the resident's BP medication diltiazem, needed supplementary documentation to be done for each time it was given. The DON confirmed that on 3/18/26, the BP was not reflected on the MAR until 3/30/26 and the supplementary documentation was not added until 3/30/26, 12 days after pharmacy consultant recommendation. The DON further confirmed that the pharmacy consultant recommendation was not addressed within the required timeframe. The DON stated that the manager should have spoken to the MD/NP regarding the pharmacy consultant recommendation to ensure the recommended guidelines were followed. On 4/14/26 at 2:41 PM, the survey team met with the Licensed Nursing Home Administrator, DON, Regional LNHA and the Chief Clinical of Operations. The surveyor made the facility administration (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware of the above-mentioned concerns regarding the pharmacy consultant recommendations for Resident #46. A review of the facility's policy Pharmacy Consultant Policy and Procedure dated 2/25/2026, revealed Purpose: The purpose of this policy is to delineate the responsibilities and relationships of the consultant Pharmacist to the residents and facility staff. Policy.6. The Nurse Managers are responsible to implement the therapeutic interventions indicated in the Consultant Pharmacist report and submit the completed report to the DON within seven days of receiving them. NJAC 8:39-29.3 (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observations, interviews, record review, and review of pertinent documentation, it was determined that the facility failed to obtain consent to ensure that the residents did not receive an unnecessary medication for 1 of 5 residents reviewed for unnecessary medications, (Resident #46). This deficient practice was evidenced by the following:On 04/10/2026 at 10:17 AM, Resident # 46 was observed sitting in a wheelchair in the activities, in the Day Room. The resident was quiet, calm, and not interactive.On 04/13/2026 10:40 AM, the resident was observed in the Day Room during religious activities, the resident was sitting in a wheelchair, not engaging in activities.The surveyor reviewed the electronic medical record (EMR) for Resident #46:A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; other specified mental disorders due to known physiological condition, and other specified depressive episodes (mood disorders characterized by significant depressive symptoms that do not fulfill the complete diagnostic criteria for any specific depressive disorder). A review of the admission Minimum Data Set, an assessment tool dated 3/20/26, revealed the resident had a Brief Interview for Mental Status of 13 out of 15, indicating the resident was cognitively intact. Further review revealed the resident was receiving antidepressant, anticoagulant, antibiotic, hypoglycemic, antiplatelet, and antipsychotic medications.A review of the individual comprehensive care plan revealed the focus of client was a new admission and adjusting to current placement, date initiated 3/18/2026. A review of the Order Summary Report revealed the following POs:- Aripiprazole Oral Tablet 5 MG (Abilify) Give 1 tablet by mouth in the morning for Major Depressive disorder, one time a day for depression, start 3/17/2026.-Escitalopram Oxalate Oral Tablet 10 MG (Lexapro), Give 1 tablet by mouth in the morning for Depression, start 3/17/26.A review of the March 2026 Medication Administration Record (MAR) revealed the above-mentioned POs had been documented as completed as ordered from the date of orders. A review of the progress notes for March 2026 showed no documentation that the resident or RR consented to the administration of the Psychotropic medications.On 04/13/2026 at 10:59 AM, during an interview with the surveyor, the Unit Manager (UM) stated the standard practice was when a resident came to the facility on psychiatric medications, the psychiatric Nurse Practitioner followed the resident, but before any changes were made, the Nurse Practitioner (NP) would talk to the family to get the history (Hx) as to why the resident was on the medication, and what behaviors were exhibited. On 04/14/2026 at 12:10 PM, during interview with the surveyor, the Psychiatric Advance Nurse Practitioner (APN) stated the process was when a resident was admitted she reviewed the chart and hospital records. The APN stated she saw Resident #46 once but was unable to reach the resident's representative to discuss the risk versus benefits of the medications, and the common and adverse side effects of the medications. The APN stated her colleague followed up with the resident while she was on vacation, however, she later reviewed the colleague's note and saw that the resident's representative (RR) was present during the follow up review, but there was no documentation on any additional information regarding risk versus benefits and the common and adverse side effects regarding the Lexapro 10 mg and the Abilify 5 mg. The APN stated that the colleague should have called the family or discussed with the family who was present during the visit to get the indication for the medications. The APN further stated there should have been the justification and diagnosis, and target symptoms for the medications.On 04/14/2026 at 1:49 PM, during an interview with the surveyor, the Director of Nursing (DON) stated, we do not use signed consent. The Assistant Director of Nursing who was also present, stated the process was to speak to the resident or responsible party and then document that they obtained consent and that the psych provider gets the consent. The DON stated, if it was not documented, it was not done. The DON was unable to provide a consent from the admission on the administration of Psychotropic medication.On 4/14/26 at 2:41 PM, the survey team met with the Licensed Nursing Home Administration (LNHA), DON, Regional LNHA and the Chief Clinical of Operations (CCO). The surveyor made the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cedar Oaks	1311 Durham Avenue South Plainfield, NJ 07080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	administration aware of the above-mentioned concerns for Resident #46.No additional information was provided.The surveyor reviewed the facility policy dated 2/25/26 for Psychotropic Medications provided by the Licensed Nursing Home Administrator (LNHA) revealed:PolicyTo ensure proper use, and monitoring of psychotropic medication. Procedure:3. Residents have the right to be informed of and participate in their treatment.a. Prior to initiating or increasing a psychotropic medication, the resident/RP may be informed of the benefits, risks, and alternatives for the medication.b. The resident/RP has the right to accept or decline the initiation or increase of a psychotropic medication. N.J.A.C. 8:39-27.1(a)