STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ170669, NJ172400 Survey Date: 12/13/24 to 12/20/24 Census: 86 Sample: 18 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to document the [NJ Ex Order 26.4(b)(1)] ([NJ Ex Order 26.4(b)(1)] [redacted]) for 2 of 4 residents reviewed (Resident #31 and # 49) for [NJ Ex Order 26.4(b)(1)]. This deficient practice was evidenced by the following: 1. On 12/13/24 at 11:40 AM, during the initial tour, the surveyor observed Resident #31 in bed. The resident was observed with [NJ Ex Order 26.4(b)(1)] and	F 678	1. Resident #31 and Resident #49 had their [NJ Ex Order 26.4(b)(1)] clarified with the resident/resident representative and physician by the Director of Nursing . A physician order was obtained and documented in the electronic medical record and a hard copy placed in the appropriate area of the paper chart on 12/18/24. An in-service education was conducted on 12/19/24 by the Director of Nursing for all nursing staff and interdisciplinary team members regarding obtaining a	1/24/25

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

Electronically Signed | 01/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 1	F 678		

was NJ Ex Order 26.4(b)(1). The resident was NJ Ex Order 26.4b1 .

The surveyor reviewed Resident #31's electronic medical record (EMR).

A review of the resident's Face Sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1))

A review of the resident's EMR and hard paper chart, revealed there was no physician's order (PO) for the resident's NJ Ex Order 26.4(b)(1) .

On 12/17/24 at 12:26 PM, the surveyor interviewed Registered Nurse (RN) #1, who stated Resident #31 was NJ Ex Order 26.4(b)(1) . RN#1 reviewed the EMR in the presence of the surveyor and was unable to locate a NJ Ex Order 26.4(b)(1) PO. She then reviewed the hard paper chart in the presence of the surveyor. She reviewed the NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1) and verified that it was blank. She continued to look through the chart and stated that I know the resident is NJ Ex Order 26.4(b)(1) . After further review of the paper chart, she was able to show the surveyor the "admission sheet" that listed the resident as a NJ Ex Order 26.4b . She confirmed that was not a PO.

2. On 12/13/24 at 11:22 AM and on 12/16/24 at 10:13 AM, the surveyor observed Resident #49 in

physician's order and the importance of accurate and readily accessible code status documentation, including the facility's process on obtaining, documenting, and verifying code status. Attendance was documented.

It was determined by Root Cause Analysis that the deficient practice occurred as a result of not having a formalized process supported by policy regarding the documentation of code status.

2. All residents have the potential to be affected by the same deficient practice. A chart audit was conducted by the Director of Nursing and Unit Managers with the use of an audit tool on 12/19/24 for 100% of current residents to ensure physician's order and code status documentation was present, accurate, and readily accessible. Any issues identified were immediately corrected.

3. A policy and procedure on code status documentation will be developed by 1/15/2025 by the interdisciplinary team and the administrator to include:
-Specific location within the medical record for code status documentation (e.g., first page of physician orders, designated tab).
-Requirement for code status to be reviewed and updated upon admission, change in condition, and at least annually.
-Process for verifying code status during emergencies.
-Designated staff responsible for ensuring code status documentation is complete.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 2 bed with his/her eyes closed and did not respond to surveyor. A review of the resident's Face Sheet revealed the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). A review of the resident's EMR and hard paper chart, revealed there was no PO for the resident's NJ Ex Order 26.4(b)(1). On 12/17/24 at 11:45 AM, the surveyor interviewed the U.S. FOIA (b) (6). She stated that she had access to the hospital EMR's and before a resident was admitted she would check for NJ Ex Order 26.4(b)(1). If she was able to obtain a resident's NJ Ex Order 26.4(b)(1), she would include that information on the "Hartwyck at Oak Tree Wing Note" under "NJ Ex Order 26.4(b)(1)." In addition, she stated that this informative sheet was provided to department heads prior to the resident's admission. On 12/17/24 at 11:55 AM, the surveyor interviewed RN #1 and Licensed Practical Nurse (LPN) #1. Both stated that Resident #49 was NJ however they were unable to provide documented evidence of a PO. RN #1 reviewed the resident's hard paper chart in the presence of the surveyor and LPN #1 and was able to provide a "Wing Note" which indicated the resident was NJ Ex Order 26.4(b)(1). Both nurses acknowledged that this was not equivalent to a	F 678	-Process for obtaining physician order for resident code status -The nurse admitting the patient will confirm the code status and will get an order from the physician. -The Code status will then be entered into the EMR. A hard copy of the code status will be filed in the designated section of the medical records and scanned into the EMR -The Code status order will be a part of the admission orders . -During the admission review meeting, the unit manager will ensure that the accurate code status order is obtained from the physician and entered in the EMR and the hard copy of the Advance Directive and/or POLST are filed in the resident's medical record designated code status section and scanned into the EMR. -An alert Icon for the code status will be entered into the EMR as a visual cue. -During the admission, quarterly and significant change care planning meeting, the IDC team will confirm the Code status of the resident and ensure it is documented in the EMR and hard copy is scanned and properly filed into the medical record. -The Social Worker will confirm the code status of the resident when they complete their social assessment and ensure a copy of the code status is properly filed in the code status section of the resident's record. All nursing staff will be re-educated on the revised policy and procedure on Code status order and documentation by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 3 signed PO. On 12/17/24 at 11:10 AM, the surveyor interviewed the U.S. FOIA (b) (6) in presence of the survey team. She stated that she was unaware that Resident #49 did not have a PO for NJ Ex Order 26.4(b)(1). She further stated that as far as she knew, the nurses were aware of the NJ Ex Order 26.4(b)(1) On 12/17/24 at 1:15 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the residents NJ Ex Order 26.4(b)(1) should have been in the EMR and there needed to be a PO. The U.S. FOIA further stated that a NJ Ex Order 26.4(b)(1) order should be obtained at the time of admission, when the nurse calls the doctor for admission orders. She reviewed the EMR in the presence of the surveyor and acknowledged there was no PO for NJ Ex Order 26.4(b)(1) for Resident #31 or Resident #49. At that time, the U.S. FOIA was able to show the surveyor Resident #31's completed NJ Ex Order 26.4 that was in the facility's previous EMR chart. The U.S. FOIA stated the purpose of the NJ Ex Order 26.4(b)(1) was to know the wishes of the resident and the goals of care. The facility was unable to provide a policy related to code status.	F 678	Clinical educator or designee by 1/24/25. Education on new Policy and Procedure on Code status documentation will be integrated into the new nurse orientation program and annual education program by the Clinical Educator. 4. The Social Worker will perform a weekly audit using an audit tool of 10% of resident charts to verify code status order(s) and documentation compliance for 3 months, then monthly for 3 months. Results of the audit will be tracked and reported to the administrator, and will be presented to the Quality Assessment and Assurance Committee quarterly and to the QAPI committee monthly.	
F 698 SS=D	NJAC 8:39-4.1(a)2 Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		1/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 4 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication times of administration to accommodate for [redacted] (NJ Ex Order 26.4(b)(1) [redacted]) scheduled times. This deficient practice was identified for 1 of 1 residents (Resident #56)reviewed for [redacted]. 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	F 698	1. The medication administration records (MARs) for resident #56 were immediately reviewed by the Director of Nursing with the Administrator to ensure the medication administration times were adjusted appropriately to accommodate the [redacted] schedule. The attending physician of resident #56 was notified on 12/18/24 of the medication timing issues on [redacted], [redacted] & [redacted] and the missed doses of medications: On [redacted] and [redacted] the doses for NJ Ex Order 26.4(b)(1) at 2:30pm was not administered On [redacted], and [redacted] the doses for NJ Ex Order 26.4(b)(1) at 2pm were not administered On [redacted] and [redacted] the dose for NJ Ex Order 26.4(b)(1) [redacted] was not administered at 12 noon. An in-service education was conducted by the Director of Nursing for all nursing staff involved in medication administration for Resident # 56 on 12/19/24. The training emphasized the importance of coordinating medication times with dialysis schedules, identifying medications affected by dialysis, and reviewing physician orders, for specific instructions. Attendance was documented. A root cause analysis was conducted to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 5 authorized physician or dentist." The deficient practice was evidenced by the following: On 12/13/24 at 10:51 AM, the surveyor observed Resident #56 in bed with eyes open but was [redacted] The surveyor interviewed the resident representative (RR) that had walked into the room to visit Resident #56. The RR stated that the resident had [redacted] and had been [redacted] prior to coming to the facility and had remained [redacted] while in the facility. The surveyor reviewed the medical record for Resident #56. A review of the resident's Face Sheet revealed diagnoses which included but not limited to; [redacted]. A review of a significant change Minimum Data Set, an assessment tool used to facilitate the management of care dated [redacted] reflected the resident had a brief interview for mental status score of [redacted] out of 15, indicating that the resident had a [redacted]. A review of the resident's Care Plan Activity Report, (an interdisciplinary care plan) revealed an active focus area, with an effective date of [redacted] and review date of [redacted], that the resident was currently [redacted] related to [redacted]. An intervention/task included	F 698	identify the underlying causes of the deficient practice. It was determined from RCA that the underlying cause was lack of education / training of agency nurses on adjusting the timing of medication for individuals on dialysis to accommodate dialysis schedules. It was also identified that adjustment of timing of medication was not included in the dialysis policy. 2. All dialysis patients have the potential to be affected by the same deficient practice. No other dialysis residents were identified in the facility. 3. The facility's Dialysis Policy and Procedure was revised on 1/7/24 to include : Adjustment of medication administration times per doctor□s order to accommodate dialysis schedule. A process for clear communication between the dialysis unit and the facility nursing staff regarding medication administration. All nursing staff will be re-educated on the revised policy and procedure by 1/15/24 . The facility orientation process of agency nurses will be revised to add the updated Dialysis policy to general orientation of agency nurses upon hire and annually. The updated Dialysis Policy will be included in the general orientation and annual education for all clinical team members. The unit manager will check the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 6 but was not limited to, "Ensure medications administration times are adjusted to the [redacted] schedule." The goal reflected "The risk for [redacted] complications will be minimized." A review of the resident's electronic physician's order (PO) reflected a PO for '[redacted] on Tuesday-Thursday-Saturday @ (at) 9:45 AM Pick up time 9AM at{name of [redacted] facility, and phone number and transportation phone number redacted]" with a start date of [redacted]. Further review of the PO reflected the following: -a PO dated [redacted] for 'NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted] [redacted] oral [redacted], give 1 NJ Ex Order 26.4(b)(1) [redacted] 3 times per day for [redacted] -a PO dated [redacted] for [redacted] . give 1 tablet by [redacted] 3 times per day with food Dx: [redacted] -a PO dated [redacted] for 'NJ Ex Order 26.4(b)(1) [redacted], instill 1 [redacted] every 6 hours for [redacted]." A review of the resident's [redacted] book, that was kept on the unit, reflected that [redacted] was scheduled for a 9 AM PM pick up time and a chair time of 9:45 AM. In addition, the [redacted] book contained a '[redacted] & Facility Communication Sheet" for the dates of [redacted], [redacted] and [redacted] that were completed indicating that the resident had received [redacted] on those days.	F 698	medication administration record of patients on dialysis to ensure the medication administration time is adjusted to accommodate the dialysis schedule. Pharmacy consultant to review the dialysis medication administration record to ensure proper medication times and any identified concerns with medication adjustment will be immediately communicated verbally to the administrator or Director of Nursing. During the daily clinical meeting, the medication administration record of each dialysis resident will be reviewed by the clinical team for appropriate adjustment of medications. 4. The Director of Nursing, or designee, will audit 2 agency nurse's education files monthly for one year to ensure that education on the dialysis policy was provided. The Director of Nursing, or designee, will audit the medication administration record of all dialysis patients weekly and ongoing for one year for proper medication administration time adjustment to accommodate dialysis schedule. The Director of Nursing will report the audit results to the QAA Committee quarterly and to the QAPI team monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 7	F 698		

A review of the [NJ Ex Order 26.4(b)(1)] electronic medication administration record (EMAR) indicated medication administration times that occurred during the time that the resident was out of the facility at [NJ Ex Order 26.4(] The EMAR revealed the following:

-on [NJ Ex Order 26.4(b] [NJ Ex Order 2] and [NJ Ex Order] the doses for NJ Ex Order 26.4(b)(1) at 2:30 PM indicated that the medication was not administered. There was a corresponding reason for [NJ Ex Order 26.4(b] that indicated "out [NJ Ex Order 26.4(b)(1] " and on [NJ Ex Order 26.4(b] the reason indicated "LOA" (leave of absence). There was no documented reason for [NJ Ex Order 26.4(b].

-on [NJ Ex Order 26.4(b] [NJ Ex Order 2] and [NJ Ex Order] the doses for NJ Ex Order 26.4(b)(1) at 2 PM indicated that the medication was not administered. There was a corresponding reason for [NJ Ex Order 26.4(b] that indicated "out [NJ Ex Order 26.4(b)(1] " and on [NJ Ex Order 26.4(b] the reason indicated "LOA" (leave of absence). There was no documented reason for [NJ Ex Order 26.4(b)(].

-on [NJ Ex Order 26.4(b] and [NJ Ex Order] the doses for [NJ Ex Order 26.4(b] at 12 noon indicated that the medication was not administered. There was a corresponding reason for [NJ Ex Order 26.4(b)(] that indicated "out [NJ Ex Order 26.4(b)(1] ." There was no reason documented for [NJ Ex Order 26.4(b].

A review of the resident's corresponding electronic progress notes (EPN) revealed that there was no documentation of the reason for the above medications to not be administered.

On 12/17/24 at 9:44 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1) who verified that Resident #56 went out to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 8	F 698		

NJ Ex Order 26.4 on Tuesday, Thursday and Saturday. The surveyor with LPN#1 reviewed the EMAR for Resident #56. LPN#1 explained that the EMAR indicated a marking for the dates of NJ Ex Order NJ Ex Order 2 and NJ Ex Order that indicated medications were not administered. LPN#1 then verified that on NJ Ex Order 26.4(b) she had not administered the resident's NJ Ex Order 26.4(b)(1) because the resident was out NJ Ex Order 26.4(b)(1). LPN#1 then stated that the resident had been returning by 2 PM and that the medications were able to be administered but that lately the resident was returning later from NJ Ex Order 26.4(LPN#1 also stated that on NJ Ex Order 26.4(b) the NJ Ex Order 26.4(b)(1) dose had an administration time changed to 3 PM. The LPN#1 could not speak to why the administration time for the NJ Ex Order 26.4(b)(1) was not changed prior to NJ Ex Order and that the NJ Ex Order 26.4(b)(1) e administration time remained at 2 PM. LPN#1 added that the procedure was that if a medication was not able to be administered when the resident was out to NJ Ex Order 26.4 then the administration time should be changed.

On 12/18/24 at 10:27 AM, the surveyor interviewed the U.S. FOIA (b) (6)) via telephone who stated that during her review she would make the recommendation that medication times need to be adjusted to accommodate NJ Ex Order 26.4 times. The U.S. FO added that she was unsure if the nurses were required to obtain a PO for a time change but that a U.S. FO was required if the physician wanted specific medications held on NJ Ex Order 26.4 days and only administered on non-NJ Ex Order 26.4 days.

On 12/18/24 at 12:26 PM, the survey team met with the facility administrative team. The U.S. FOIA (b) (6)) and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 9	F 698		

U.S. FOIA (b) (6)) acknowledged that Resident #56's medications should be adjusted to accommodate when the resident was out to NJ Ex Order 26.4(b)

On 12/18/24 at 1:00 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that for NJ Ex Order 26.4 residents adjusting the administration time of medications was important in order for the resident to be able to receive their medications. The U.S. FOIA (b) (6) stated that the procedure was for the medication nurse to adjust medication times to allow for the resident being out of the facility. The U.S. FOIA (b) (6) also stated that if the resident was not receiving their medications or there was a delay in receiving their medications because they were out to NJ Ex Order 26.4 then the physician should be notified, and the physician may make a change in the PO. The U.S. FOIA (b) (6) added that if the EMAR reflected medications were not administered because the resident was out to NJ Ex Order 26.4 then he should have been notified. The U.S. FOIA (b) (6) stated that he thought Resident #56 returned to the facility in time to receive 2 PM medications.

On 12/19/24 at 9:24 AM, the survey team met with the administrative team. The U.S. FOIA (b) stated that he thought in NJ Ex Order 26.4(b)(1) the medications were recognized as needing to be adjusted but was not aware that in NJ Ex Order 26.4(b)(1) the medications continued to indicate out to NJ Ex Order 26.4(The U.S. FOIA (b) also stated that there was no mention of medication timing regarding NJ Ex Order 26.4 in either of the facility policies for "Medication Administration" and/or "Dialysis Services" that had been provided to the surveyor.

A review of the facility policy dated as last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 10 approved 4/2024 for "Medication Administration" provided by the U.S. FOIA (b reflected that "Medications must be administered in accordance with written orders of the attending physician." In addition, "The nurse administering the medication must record the administering, refusal, or holding of medication on the resident's MAR." A review of the facility policy dated as last approved 8/2024 for "Dialysis Services" provided by the U.S. FOIA (b reflected that "The facility will ensure that residents/patients who require hemodialysis services receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's/patient's goals and preferences." NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)	F 698		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/19/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that the volume on the resident call bell system at the nurse's station on floor 3 was set to a level to be heard. This	F 919	1. The call bell volume at the 3rd floor nurses station was immediately restored to an audible level. Rooms 315 and 316 were tested and confirmed operational with both visual and auditory alerts.	1/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 11 deficient practice had the potential to affect all residents and was evidenced by the following: An observation on at 11:50 AM revealed when the call bell was tested from resident room 315, there was no audible notification of the call bell activation. An observation at 11:55 AM revealed when the call bell was tested from resident room 316, there was no audible notification of the call bell activation. In an interview at 12:05 PM, nursing staff informed the surveyor that they discovered that the volume on the call bell system had been turned all the way down and it had been corrected. An observation at 12:07 PM revealed when the call bell was tested from room 317, there was now audible notification of the call bell activation as the facility turned on the volume to the system. In interviews at the time, the U.S. FOIA (confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on at 12:30 PM. NJAC 8:39-31.2(e). 31.8(c)9	F 919	All nursing staff were notified of the deficiency and instructed on the importance of maintaining appropriate call bell volume levels. A reminder was issued emphasizing that adjusting the call bell volume downwards is unacceptable on 12/20/24. 2. All residents have the potential to be affected by this practice. All 3 call bell systems throughout the facility were checked to ensure appropriate volume levels and functionality. 3. A facility policy and procedure on call bell system management will be created by 1/15/25 to include: -Specific instructions regarding appropriate call bell volume levels. -A prohibition against turning down or muting call bell volumes. -A defined requirement for regular checks of call bell system functionality, including volume levels -A process for documenting call bell system checks. -Clear instructions on how to troubleshoot call bell system issues. All nursing and maintenance staff will be re-educated on the new policy and procedure by 1/24/25 by the clinical nurse educator. 4. Daily audits of call bell system functionality and volume levels in all resident rooms and common areas will be completed by the maintenance department for 4 weeks and then monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 12	F 919	ongoing. Results will be tracked and reported to the Quality Assurance Committee quarterly and to the QAPI Committee monthly.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315251	A. Building B. Wing	2/12/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0678 Reg. # 483.24(a)(3) LSC	Correction Completed 01/24/2025	ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 01/15/2025	ID Prefix F0919 Reg. # 483.90(g)(1)(2) LSC	Correction Completed 01/24/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Hartwyck at Oak Tree is in non-compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) facilities	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2),	E 041		2/11/25

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

Electronically Signed | 01/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 2 (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview 12/19/2024 and 12/20/2024, it was determined that the facility failed to ensure that emergency generators were maintained in accordance with NFPA 99:2012 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Documentation review on 12/19/2024 revealed, the generator was not tested at least once every 36 months, under load for a minimum of four continuous hours. Additionally, a report from	E 041	1. All residents have the potential to be affected by this deficient Life Safety Code. A qualified contractor, NJ Ex Order 26.4(b)(1), was contacted and came to assess the generator on 1/6/25 and will complete the following : -The Maintenance Director contacted NJ Ex Order 26.4(b)(1) and executed a new MOU for a portable rental generator on 1/6/25. Rental generator was installed and operational to begin generator repairs on 1/6/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 3 routine maintenance conducted on 2024-08-06 stated: "The fuel system may need to be rebuilt on this unit including injection pump and injectors, please provide second opinion: 2024-08-07: "The Cummins/ genset has over 1000 hours and a long history of failures. From not being able to carry load or erratic engine speed. With an extended history of water in the fuel system issues were inevitable". "Due to the current condition and symptoms presented, assuring dependability of the site generator would not be advisable". "Recommend that unit either be repaired or replaced". In an interview at the time, the U.S. FOIA (confirmed the review and stated that repairs have not been made yet. The U.S. FOIA (confirmed that they did not have a current Memorandum Of Understanding (MOU) for a portable rental generator but they were in the process of looking for a portable rental generator so that repairs could be made to the onsite generator. Additionally, an observation at 12:00 PM on 12/20/2024 revealed the emergency generator's remote annunciator panel did not appear to be functioning at the nurse's station on floor 2. The panel did not have a means to show that it was receiving power and was not provided with a lamp test switch(es) to test the operation of all alarm lamps. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on at 12:30 PM. NJAC 8:39-31.2(e), 31.2(g)	E 041	-NJ Ex Order 26.4(b)(1) began work to rebuild the generator fuel pump on 1/6/2025. Work was completed on 2/10/2025. -Upon completion of the fuel pump rebuild NJ Ex Order 26.4(b)(1) will perform a four-hour generator load test. Load test was completed on 2/11/2025. -Upon completion of the fuel pump rebuild NJ Ex Order 26.4(b)(1) will repair/replace the remote annunciator panel to include a means to show that it is receiving power and a lamp test switch(es) to test the operation of all alarm lamps. This work was completed by NJ Ex Order 26.4(b)(1) on 2/11/2025 2. NJ Ex Order 26.4(b)(1) has been contracted by the facility to provide the required 4 hour load test of the generator every 36 months. The Maintenance Director added the required 4 hour load test to the generator maintenance schedule and will ensure completion every 36 months. The Maintenance Director will be the designated individual responsible for ensuring a current MOU is in place for a rental generator and will provide evidence of this to the administrator annually. The Maintenance Director added a monthly annunciator panel test to the generator maintenance schedule and ensure completion monthly. 3. The Maintenance Director will review the generator maintenance and inspection reports monthly ongoing to ensure that the required testing was completed timely. The results of this will be submitted to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 4 NFPA 99, 110	E 041	administrator and to the QAPI committee monthly and to the QA committee quarterly ongoing.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 12/18/2024 to 12/20/2024 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Hartwyck at Oak Tree is a three story building that was built in 1980's. It is composed of Type II construction. The facility is divided into 6- smoke zones. The generator powers approximately 35% of the building.	K 000		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by	K 131		1/9/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 131	Continued From page 5 an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/19/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that sections of health care facilities classified as other occupancies were separated from areas of healthcare occupancies by construction having two hour fire resistance rating in accordance with NFPA 101:2012 Edition, Section 19.1.3.3, 42 CFR 482.41, and 42 CFR 485.623. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 2:00 PM revealed the 2-hour separation between the Healthcare occupancy and the Residential occupancy contained a 1.5 -inch and 2.5 -inch unprotected penetration for the pass through of wires. Additionally, a 2-inch-high by 48-inch-wide section of brick was missing above the fire rated door assembly between the two occupancies. In an interview at the time, the U.S. FOIA (confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 12/20/2024 at 12:30 PM.	K 131	1. All residents have the potential to be affected by this deficient Life Safety Code. The maintenance department repaired the 2 unprotected penetrations for the pass-through of wires on 1/8/25 using UL listed NJ Ex Order 26.4(b)([redacted] LC 150 fire-stop sealant. The maintenance department repaired the 2 inch by 48 inch wide section of brick missing above the fire rated door assembly between the two occupancies on 1/8/25 using NJ Ex O [redacted] intumescent fire-stop pillows and UL listed NJ Ex Order 26.4(b)([redacted] LC 150 fire-stop sealant. 2. The facility's maintenance schedule will be revised by the Director of Maintenance to include a monthly inspection of fire-rated assemblies between the healthcare occupancy and the residential occupancy to confirm that the two hour fire resistance rating is intact with no penetrations using an audit tool. 3. The Director of Maintenance will review the fire rated assembly inspection reports monthly ongoing and report the results to the administrator and to the QAPI committee monthly for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 131	Continued From page 6 N.J.A.C 8:39-31.2(e)	K 131		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING	K 222		1/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 7 ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/19/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that doors provide with delayed egress locking arrangements were installed in accordance with NFPA 101:2012 Edition, Sections 7.2.1.6.1 and 19.2.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:10 PM revealed the 15-second delayed egress locking arrangement on the stairway enclosure near room 312 on floor	K 222	1. All residents have the potential to be affected by this deficient Life Safety Code. NJ Ex Order 26.4(b)(1) repaired the delayed egress locks in the following locations on 1/6/25: floor 3 near room 312, floor 2 near room 212, and the stairway enclosure on the mauve wing. The Maintenance Department conducted an audit of all facility delayed egress locks to confirm function on 1/6/25. 2. The Maintenance Director will modify the scheduled maintenance calendar to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 8 3 did not function when tested by the U.S. FOIA (b An observation at 12:34 PM revealed the 15-second delayed egress locking arrangement on the stairway enclosure near room 212 on floor 2 did not function when tested by the U.S. FOIA (b An observation at 12:47 PM revealed the 15-second delayed egress locking arrangement on the stairway enclosure on the mauve wing did not function when tested by the U.S. FOIA (b In interviews at the time, the U.S. FOIA (confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 12/20/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 222	include monthly delayed egress checks to confirm function. 3. The Maintenance Director will review the monthly delayed egress lock testing documentation to ensure compliance. The details of this testing will be submitted to the administrator and to the QAPI committee monthly for 6 months.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/20/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that a sign with directional	K 293	1. All residents have the potential to be affected by this deficient Life Safety Code. A directional exit sign was installed near the kitchen on 12/31/24 by NJ Ex Order 2 The	12/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 9 indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit is not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:00 AM revealed that when exiting the smoke barrier doors near the kitchen, there was no directional exit sign indicating the direction of travel to the nearest exit. In an interview at the time, the U.S. FOIA (b) (6) confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 293	sign is wall mounted, is internally illuminated and clearly indicates the direction of travel to the nearest exit. A complete facility-wide inspection of all exit signs was conducted on 12/31/24 to ensure no other areas are lacking proper signage. 2. The Maintenance Director will modify the scheduled maintenance calendar to include a quarterly Exit Sign inspection to be conducted to ensure all facility exit signs are in the proper location and functioning. 3. The maintenance director will review the quarterly exit sign inspection reports with the administrator quarterly and submit to the QAA committee quarterly for 1 year.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321		12/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 10 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interviews on 12/20/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7, 8.4 and NFPA 13. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:20 AM revealed the laundry room door did not positive latch when tested by U.S. FOIA (b) [redacted] In an interview at the time, the U.S. FOIA [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 12/20/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 321	1. All residents have the potential to be affected by this deficient Life Safety Code. The laundry room door and latching mechanism were repaired by the facility maintenance department on 12/20/24. The door was then tested and confirmed to latch positively. 2. All hazardous areas were audited to confirm door and latching mechanisms were functioning properly by the maintenance department on 12/20/24. 3. The Director of Maintenance will update the maintenance schedule to include a monthly inspection of Hazardous Areas to ensure that doors are functioning properly. 4. The Safety Committee will audit all hazardous area doors for proper function and submit the results to the administrator and to the QAPI committee monthly for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 11	K 321	months.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/20/2024 in the presence of the [U.S. FOIA (b) (6)] [redacted], it was determined that the facility failed to ensure that cooking equipment was maintained in accordance with NFPA 101:2012 Edition, Sections 9.2.3, NFPA 17:2009	K 324	1. All residents have the potential to be affected by this deficient Life Safety Code. -Nozzle Caps/Covers: Missing caps/covers were installed on all four affected discharge nozzles on 1/7/25 by [NJ Ex Order 26.4(b)] [redacted]	1/8/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 12 Edition, Section 4.3.1.5, 7.2.2 and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:55 AM revealed the kitchen range-hood fire suppression system contained 8 discharge spray nozzles. Four of the 8 discharge nozzles observed were not provided with a cap or cover device to protect against grease vapors or moisture. Additionally, the system's monthly inspection tag on the Class-K fire extinguisher was not signed for monthly inspections. In an interview at the time, the U.S. FOIA (confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 12/20/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 17, 96	K 324	-Class K Extinguisher Inspection: The Class K fire extinguisher was inspected on 1/7/25 by NJ Ex Order 26.4(b) The inspection tag was signed and dated to document the inspection. -System Inspection: The entire kitchen fire suppression system was inspected by NJ Ex Order 26.4(on 1/7/25 to ensure proper operation and compliance with NFPA 101. 2. The maintenance director modified the facility maintenance schedule to include a requirement for quarterly inspections of the entire kitchen fire suppression system, including checking for missing nozzle caps/covers and inspecting the associated Class K fire extinguisher. 3. The maintenance director, or designee will audit the kitchen fire suppression system quarterly to check for missing nozzle caps/covers and to confirm inspection of the Class K fire extinguisher. The results of the quarterly audit of the kitchen fire suppression system will be submitted to the administrator and to the QA committee quarterly for one year.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K 761		1/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 13 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 12/20/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives, Section 5.2.4.2. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed annual fire door assembly inspections were not conducted. The monthly fire door inspections provided did not include all fire doors and assemblies and did not cover the minimum requirements. In an interview at the time, the U.S. FOIA (confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 12/20/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 761	1. All residents have the potential to be affected by this deficient Life Safety Code. Facility maintenance department completed an annual fire door assembly inspection on 1/10/25. 2. The Maintenance Director modified the facility maintenance schedule to include a fire door assembly inspection and testing to be completed annually. 3. The Maintenance Director will audit the fire door assembly inspection and testing to confirm completion and submit the report to the administrator and to the QAA committee annually.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 916		2/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 916	Continued From page 14 Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/20/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that the emergency generator was provided with a remote annunciator that was in accordance with NFPA 99 Sections 6.4.2.2.6, 6.4.1.1.17 - 6.4.1.1.17.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:00 PM revealed the emergency generator's remote annunciator panel did not appear to be functioning at the nurse's station on floor 2. The panel did not have a means to show that it was receiving power and was not provided with a lamp test switch(es) to test the operation of all alarm lamps. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 12/20/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 916	1. All residents have the potential to be affected by this deficient Life Safety Code. A qualified contractor, NJ Ex Order 26.4(b)(1) [redacted], was contacted and came to assess the generator on 1/6/25 and will repair/replace the remote annunciator panel to include a means to show that it is receiving power and a lamp test switch(es) to test the operation of all alarm lamps. This work was completed by NJ Ex Order 26.4(b)(1) [redacted] on 2/11/2025 2. The maintenance Director added a monthly annunciator panel test to the generator maintenance schedule. 3. The Maintenance Director will review the generator maintenance and inspection reports monthly to ensure that the required testing was completed timely. The results of this review will be submitted to the administrator and to the QAPI committee monthly and to the QA committee quarterly ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 15	K 918		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		2/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 16 Based on documentation review and interview 12/19/2024 and 12/20/2024, it was determined that the facility failed to ensure that emergency generators were maintained in accordance with NFPA 99:2012 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review on 12/19/2024 revealed the generator was not tested at least once every 36 months, under load for a minimum of four continuous hours. Additionally, a report from routine maintenance conducted on 2024-08-06 stated: "The fuel system may need to be rebuilt on this unit including injection pump and injectors, please provide second opinion: 2024-08-07: "The Cummins/ genset has over 1000 hours and a long history of failures. From not being able to carry load or erratic engine speed. With an extended history of water in the fuel system issues were inevitable". "Due to the current condition and symptoms presented, assuring dependability of the site generator would not be advisable". "Recommend that unit either be repaired or replaced". In an interview at the time, the [redacted] confirmed the review and stated that repairs have not been made yet. The [redacted] confirmed that they did not have a current Memorandum Of Understanding (MOU) for a portable rental generator but they were in the process of looking for a portable rental generator so that repairs could be made to the onsite generator. The facility's [redacted] was informed of the deficient practices at the Life Safety Code exit	K 918	1. All residents have the potential to be affected by this deficient Life Safety Code. A qualified contractor, [redacted], was contacted and came to assess the generator on 1/6/2025 and performed a four-hour generator load test on 2/11/2025. 2. The Maintenance Director added the required 4-hour load test every 36 months to the facility maintenance schedule. 3. The Maintenance Director will review the generator maintenance and inspection reports monthly to ensure that the required testing and maintenance was completed timely. The results of this review will be submitted to the administrator and to the QAPI committee monthly and to the QA committee quarterly ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING **01** B. WING _____	**12/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	**2048 OAK TREE ROAD** **EDISON, NJ 08820**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 17 conference on at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 99, 110	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315251	A. Building B. Wing	2/12/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0041 Reg. # 483.73(e) LSC	Correction Completed 02/11/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315251 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0131	01/09/2025	LSC K0222	01/07/2025	LSC K0293	12/31/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	12/21/2024	LSC K0324	01/08/2025	LSC K0761	01/11/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0916	02/11/2025	LSC K0918	02/11/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO