

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25316	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER PEACEFUL PINES RESIDENCE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1288 RT 34 ABERDEEN, NJ 07747		
(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) COMPLETE DATE
R 000	Initial Comments Type of survey: Standard Census: 14 Sample: 5 THE FACILITY IS NOT IN COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE N.J.A.C. 8:37 STANDARDS FOR LICENSURE OF DEMENTIA CARE HOMES.	R 000		
R 016	8:37-1.1(b) Purpose and Scope This chapter is promulgated for the purpose of establishing interim licensing standards for dementia care homes in the State of New Jersey to ensure that they are maintained and operated in such a manner that will protect the health, safety and welfare of its residents and at the same time preserve and promote a home-like atmosphere appropriate to such facilities. This STANDARD is not met as evidenced by: Based on interview and review of records, it was determined that the facility failed to protect the health, safety and welfare of the facility residents by failing to ensure that employees were screened for NJ Ex Order 26.4(b)(1) and deemed safe to work with the residents; additionally failed to ensure staff that were certified in Cardiopulmonary Resuscitation (CPR) and Autonomic External Defibrillator (AED), were scheduled at all times for 5 of 7 Employees reviewed, Employee #'s 1, 2, 5, 6, and 7. This deficient practice was evidenced by the following:	R 016		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/23/25

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R 016	Continued From page 1 1. On 3/20/25 at 11:00 a.m., the surveyor reviewed five employee files which revealed no documented evidence that the employees received a NJ Ex Order 26.4(b)(1) upon hire. Employee #1, a Certified Home Health Aide (CHHA), who was hired on NJ Ex Order 26.4(b) Employee #2, a Certified Medication Aide (CMA) who was hired on NJ Ex Order 26.4(b)(1) Employee #5 a Licensed Practical Nurse (LPN), who was hired on NJ Ex Order 26.4(b) Employee #6 an Activity Assistant who was hired NJ Ex Order 26.4(b) and Employee #7 a LPN who was hired on NJ Ex Order 26.4(b) There was no documented evidence that the employees received their NJ Ex Order 26.4(b)(1) upon hire. At 11:30 a.m., the surveyor interviewed a Certified Medication Aide (CMA), who was in charge, and inquired about the above employees' NJ Ex Order 26 and she stated that she would check with the Administrator. At 11:55 a.m., the CMA provided the surveyor with a binder and stated that the employees NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) histories were in the binder. Surveyor review of the binder revealed no further documented evidence that Employee #1, Employee #2, Employee #5, Employee #6 and Employee #7 received a NJ Ex Order 26.4(b)(1) upon hire. The surveyor reviewed an undated facility policy titled, "PPD Test Policy", which revealed the following: "Due to state regulations, all of our employees will need to receive a PPD test....This is a 2 part test.... This should be completed	R 016		

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R 016	Continued From page 2 during your first week of employment...." 2. At 12:15 p.m., the surveyor reviewed the employee files and observed that there was no documentation of CPR certification located in the employee files. The surveyor interviewed the CMA and the Executive Director regarding the CPR certifications. They both stated that there were employees who were currently CPR certified, and that they would provide the surveyor with the list of CPR certifications. At 1:00 p.m., the CMA provided documentation of current staff that were CPR/AED certified, Employee #1, and Employee #4, an Activity Assistant, and an un-sampled employee. The surveyor reviewed the following staffing schedule, provided by the facility, and observed that there was no documented evidence to indicate that the staff members scheduled to work were CPR certified on the following dates and times: On 3/11, 3/12, 3/16 and 3/19/25, during the hours of 7:00 p.m.-7:00 a.m., and on 3/9, 3/11, 3/13, 3/14, 3/15, 3/17, 3/18, 3/20/25, during the hours of 3:00 p.m. - 7:00 a.m.	R 016		
R 365	8:37-3.1(a)(12) Resident Rights Every resident of a dementia care home shall have the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident.	R 365		

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R 365	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide a safe living environment for the residents, by failing to ensure that the Laundry room, Electrical Closet, and Activity Cabinet were locked; and, by failing to prevent the potential for residents to access the Kitchenette, for 14 of 14 residents that resided at the facility. This deficient practice was evidenced by the following: 1. On 3/19/2025 at 9:39 a.m., during the tour of the facility, the surveyor observed that the Laundry Room door, which was equipped with a keypad door handle, was unlocked and slightly open. Upon entering the Laundry room, the surveyor observed two washers and dryers, and one dryer was in use. The surveyor also observed, a mop, a mop bucket, a large bucket of laundry cleaners, multiple boxes of disposable razors, containers of shaving cream, multiple bottles of body cream, multiple bottles of conditioner, multiple bottles of liquid deodorant and NJ EX Order 26-4(b) cleanser spray, and large bottles of hand sanitizer refills. At 9:45 a.m., the surveyor observed the Electrical Closet door, which was closed and at that time. The surveyor turned the door handle and was able to open the door because the door was unlocked. The surveyor opened the Electrical closet door and observed three large gray panels, a screwdriver, a small tub of spackling, a 4.5 gallon of sheet rock joint compound, wasp and hornet bug spray, a circle vacuum with tubing and accessories, and a cardboard box of various metal objects. The surveyor also observed two gray and clear colored three drawer plastic containers which contained various items that	R 365		

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R 365	Continued From page 4 included a box cutter, with the blade exposed, light bulbs, extension cords, nails, bolts, and chalking. At 9:49 a.m., the surveyor observed that the Laundry room door was completely open. At 10:02 a.m., the surveyor interviewed a Home Health Aide (HHA) #1, who stated that the Laundry room and Electrical Closet should be locked at all times. During continued surveyor interview, HHA #1 stated that the Laundry room was open because the staff frequently were going back and forth. HHA #1, further stated that she did not know why the Electrical Closet was not locked. At 10:10 a.m., the surveyor interviewed HHA #2 who stated that the facility's Laundry room and Electrical Closet should have been locked. 2. On 3/19/2025 at 9:51 a.m., during the tour, the surveyor observed a blue, two-door cabinet located near a sitting area, next to resident room number 8. At that time the surveyor opened the cabinet, which revealed a 1-quart bottle of liquid glue, and 11 labeled clear containers that had green lids. One of the clear containers was labeled "tape, scissor, strings", which contained multiple safety scissors, a wire cutter and a single handheld hole puncher. At 10:00 am., the surveyor observed a black shopping bag full of paint bottles located on top, of a scale, behind the activity white board, in the television sitting area of the facility. At 10:40 a.m., the surveyor interviewed the Activity Aide (AA), who stated that the activity cabinet was unlocked and denied that there was	R 365		

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R 365	Continued From page 5 a wire cutter inside of the cabinet. The surveyor then with the AA, inspected the activity cabinet which revealed the scissors, glue, and wire cutter. The AA stated that "maybe the cabinet should have a latch" and that the scissors were safety scissors, and would be hard to cut oneself with. During continued interview, the AA stated that no one went into the cabinet, and that liquid should not be in the cabinet. In addition, the AA stated that she did not know who put the bag of paint in the resident area, and that it should not have been there. 3. On 3/19/2025 at 9:37 a.m., the surveyor observed in the Kitchenette electronic kitchen appliances located on a countertop. The appliances were within arm's reach to residents. The electronic kitchen appliances included two blenders (one missing a lid), a microwave, a crockpot, a four compartment toaster, an electric can opener, an electric tea kettle, and an ice maker. At 10:02 a.m., the surveyor interviewed HHA #1, who stated that the Kitchenette did not have a way to cut off the gas and electricity to the Kitchenette. The HHA also stated that the electronic items that were on the countertop, in arm reach of residents, were used by facility staff. In addition, the surveyor observed two-panel swinging doors to the left and the right entrances to the Kitchenette. The surveyor then interviewed HHA #1, who stated that the swinging doors did not lock. At 10:28 a.m., the surveyor interviewed HHA #2, who stated that the facility did not have a way to shut of the electricity and gas to the Kitchenette, but that the gas had to be turned on prior to the	R 365		

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R 365	Continued From page 6 use of the gas stove. During continued surveyor interview, HHA#2 stated that the Kitchenette gas could not be shut off once turned on, and that the gas turned off approximately 5 minutes after the user turned the gas stove off. Surveyor interview with HHA #2 revealed that the stove was unable to be turned off. During continued interview, HHA #2 stated that the two-panel swinging doors did not lock and that the facility administration removed the ropes because the residents were lifting the ropes in attempt to enter the Kitchenette. At 10:35 a.m., the surveyor toured the Kitchenette, which revealed drawers that contained non-safety scissors, a large two-pronged fork, a large cheese grater, four large chef knives and metal dinner knives. During continued surveyor tour of the Kitchenette, the surveyor observed multiple cleaning chemicals under the Kitchenette one part sink, and a box of hair dye. On 3/20/25 at 12:00 p.m., the surveyor reviewed an undated facility policy titled, "Resident Bill of Rights", which revealed the following: "Resident Bill of Rights ...12. You have the right to a safe and decent living environment..." On 3/19/25, the surveyor requested a Removal Plan to correct the imminent dangers identified during the survey. On 3/20/25, the Administrator provided the surveyor with an acceptable Removal Plan.	R 365		
R1296	8:37-7.4(d) Physical Plant-Ligthing & Electrical Service	R1296		

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R1296	Continued From page 7 An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement to the facility that the electrical circuits and wiring in the facility are satisfactory and in safe condition. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide documentation of electrical inspection. This deficient practice was evidenced by the following: On 3/20/25 at 12:02 p.m., the surveyor interviewed the Administrator and requested the documentation for the annual electrical inspection by a licensed electrician. The Administrator was not able to provide documentation to show there was an annual electrical inspection by a licensed electrician.	R1296		
R1424 SS=E	8:37-7.7(f) Physical Plant-Maintenance Every facility shall be free from rodents, vermin and insects. This STANDARD is not met as evidenced by: Based on interview and record review it was determined that the facility failed to conduct the following required mandatory inspections: fire alarm and detection system annual inspection, and failed to conduct 1 of 2 semi-annual kitchen fire suppression system inspections which had the potential to affect 14 of 14 residents. This	R1424		

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R1424	Continued From page 8 deficient practice was evidenced by the following: On 3/20/25 at approximately 9:15 a.m., during the survey entrance conference with the Administrator (Admin), the surveyor requested all the mandatory inspections from 1/1/23 through 3/19/25 for later review. At approximately 12:02 p.m., the surveyor reviewed the mandatory inspections and identified the following: 1. There was no evidence of the building's fire alarm and detection system inspection. 2. The facility provided, Vendor #2 semi-annual (every 6 months) kitchen fire suppression, dated 12/4/24. At that time the surveyor requested the Admin to provide any additional mandatory inspections. The Admin then provided Vendor #1 semi-annual (every 6 months) kitchen fire suppression, dated 1/13/23. The facility went 18 months between the semi-annual (every 6 months) inspections. The surveyor interviewed the Admin, who acknowledged that only 1 of 2 semi-annual kitchen fire suppression inspections was performed for 2024.	R1424		



3
POC received +
accepted 6/19/25

Peaceful Pines Residence

Memory Care Community

Peaceful Pines Residence
1288 NJ-34
Aberdeen, NJ 07747
Email: Info@peacefulpinesnj.com
732-858-3741

Tag R0365 – Physical Plant – Laundry and Electrical Room Doors, Activity closet and Kitchen access

1. Corrective Action for Cited Deficiency:

The laundry room door and electrical closet door, activity closets and Kitchen access were immediately closed and secured once the issue was identified. Staff present at the time were reminded of the requirement to keep these areas locked when not in use.

2. All residents at risk for the safety concern.

3. Systemic Changes:

Interventions Implemented:

1. Activity Cabinet:

- All materials that could pose a choking or ingestion hazard have been removed.
- The cabinet is now locked when not in supervised use, and access is restricted to staff only.

2. Kitchenette Access:

- Kitchenette doors have been secured with an automatic locking mechanism.
- Access is limited to authorized staff only.

3. General Safety Measures:

- All hazardous materials, including sharp objects, chemicals, and appliances, have been secured in locked cabinets or removed from common areas.
- Daily environmental rounds are conducted by each shift staff to ensure these safety protocols are maintained.

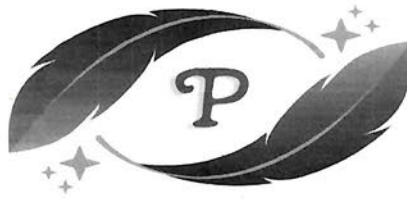
All staff were re-educated via in service on the requirement that all laundry rooms and electrical closets remain locked when unattended. Signage has been posted on both doors as a visual reminder. A key check system has also been implemented to ensure only authorized personnel have access.

Key Check and Access Control System

• Key Access Control:

A key inventory and access log system has been implemented to manage access to locked Laundry and Electrical room doors.

LICENSING



Peaceful Pines Residence

Memory Care Community

- **Key Responsibility:**

- **Shift Leads** will be responsible for holding the keys during their shift.
- Keys must be returned and logged at the end of each shift in a secure key box located in the staff office.
- The **Administrator** or **designee** will audit the key log **weekly** to ensure compliance.

- **Lost/Missing Key Protocol:**

Any lost or unreturned keys must be reported immediately to the Administrator. Replacement keys will only be issued with proper documentation, and locks will be changed if necessary.

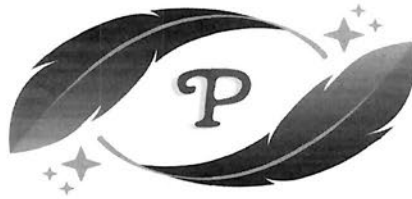
4. Monitoring:

The Administrator or designee will conduct daily safety rounds to verify that all restricted access doors remain closed and locked. Any violations will be addressed immediately and reviewed during the monthly QA meeting.

5. Completion Date:

March 21, 2025

LICENSING



Peaceful Pines Residence

Memory Care Community

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Tag R1296 – Physical Plant – Annual Electrical Inspection

1. Corrective Action for Cited Deficiency:

A licensed electrician was contacted immediately, and a full annual electrical inspection of the facility was completed. The inspection report is now filed in the facility's maintenance binder.

2. All residents at risk for the safety concern.

3. Systemic Changes:

A recurring annual task reminder was created in the facility's digital compliance calendar to ensure timely scheduling of all future electrical inspections. The Administrator has access to the calendar and receives alerts when inspection due dates approaching. The administrator or designee will be responsible for scheduling inspections and ensuring that the inspection is completed and documented annually.

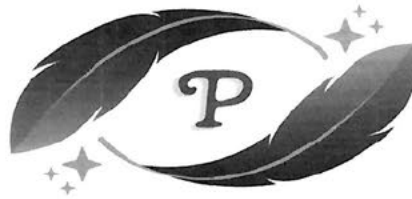
4. Monitoring:

The Administrator will review the facility's compliance calendar monthly to ensure that all scheduled maintenance inspections, including the electrical inspection, are completed and documented on time. Compliance will be reviewed quarterly in QA meetings.

5. Completion Date:

May 15, 2025

LICENSING



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Tag R016 – Personnel Files – Tuberculosis Testing Documentation

1. Corrective Action for Employees Identified:

We obtained the tuberculosis (PPD) test results for Employees #1, 2, 5, 6, and 7 from their previous employers and re-screened them for NJ Ex Order 26.4(b)(1) as a precautionary measure. The results are now documented and filed in their respective employee binders.

2. All residents are at risk for the safety concerns.

3. Systemic Changes:

We developed a New Hire Documentation Checklist that will be implemented by the administrator or designee to ensure that all required health screening and certification documents, including PPD results and CPR cards, are collected and filed prior to the employee's first day of work.

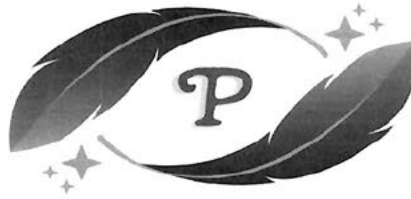
4. Monitoring:

The Administrator will audit new employee files within one week of hire to confirm all required documents are present. A quarterly review of all employee charts will be conducted to ensure continued compliance with health and certification requirements. The monthly schedule will be monitored by the Administrator or designee to ensure every shift has a staff member who is certified in cardio pulmonary resuscitation.

5. Completion Date:

May 20, 2025

LICENSING



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2. All residents are at risk for the safety concerns.

3. Systemic Changes:

We developed a New Hire Documentation Checklist that will be implemented by the administrator or designee to ensure that all required health screening and certification documents, including PPD results and CPR cards, are collected and filed prior to the employee's first day of work.

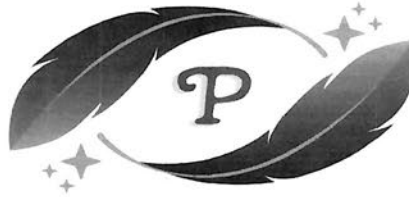
4. Monitoring:

The Administrator will audit new employee files within one week of hire to confirm all required documents are present. A quarterly review of all employee charts will be conducted to ensure continued compliance with health and certification requirements. The monthly schedule will be monitored by the Administrator or designee to ensure every shift has a staff member who is certified in cardio pulmonary resuscitation.

5. Completion Date:

May 20, 2025

LICENSING



Peaceful Pines Residence

Memory Care Community

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1288 NJ-34
Aberdeen, NJ 07747
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Tag R1424 – Life Safety Code – Fire Alarm and Kitchen Suppression System Inspections

1. Corrective Action for Cited Deficiency:

The annual fire alarm and detection system inspection, which was scheduled for April 4, 2025, has since been completed. Documentation of the inspection is filed in the facility's life safety compliance binder.

Regarding the kitchen fire suppression system, we acknowledge that only one of the two required semi-annual inspections was completed. This was due to a misunderstanding that the system required only annual inspection. This has now been corrected, and we will be conducting inspections twice a year moving forward.

2. All residents at risk for the safety concern.

3. Systemic Changes:

The facility has updated its compliance calendar to reflect the correct frequency of required inspections:

- Fire alarm and detection system: Annually every April.
- Kitchen fire suppression system: Semi-annually every June and December.

The administrator or designee will be responsible for scheduling and oversight of inspections.

4. Monitoring:

The Administrator or designee will review the compliance calendar monthly to ensure all inspections are scheduled in advance and completed on time. Documentation of inspections will be reviewed quarterly during QA meetings.

5. Completion Date:

April 10, 2025

LICENSING

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 25316	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/19/2025
NAME OF FACILITY PEACEFUL PINES RESIDENCE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1288 RT 34 ABERDEEN, NJ 07747	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix R0016	Correction	ID Prefix R0365	Correction	ID Prefix R1296	Correction
Reg. # 8:37-1.1(b)	Completed	Reg. # 8:37-3.1(a)(12)	Completed	Reg. # 8:37-7.4(d)	Completed
LSC	05/20/2025	LSC	03/21/2025	LSC	05/15/2025
ID Prefix R1424	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:37-7.7(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/10/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 3/20/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			