STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401**

(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 Standard Survey 11/19/2024 Census: 115 Sample Size: 27 + 3 closed records C/O # NJ 168041, 169404, 173880, 174304, 175943, 179337 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.	F 577		1/3/25

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

Electronically Signed | 12/12/2024

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

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F 577	Continued From page 1 (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to make State of New Jersey inspection results in a place readily accessible to facility residents. This deficient practice was evidenced by the following: On 11/12/2024 at approximately 9:00 AM, the surveyor observed the state survey results binder in the facility reception area upon entry. The results were on top of the receptionist desk in a black plastic binder. During the Resident Council Meeting on 11/13/2024 at approximately 10:30 AM, 4 of 4 alert and oriented residents in attendance stated to the surveyor that they were not aware of the location of State Survey results. The residents indicated that they would like to be able to have access to the results upon completion of the survey. On 11/13/2024 at 11:01 AM, after completion of the Resident Council meeting, the surveyor again observed the State Survey results binder on the lobby receptionist desk. The binder was clearly labeled and visible, however, it was determined that residents could not easily access the results without asking for staff assistance. Residents cannot access the lobby as the door leading to the lobby has a code for access and the code is not provided to facility residents. Therefore, residents would have to ask staff for assistance to review the State Survey results book.	F 577	1. " The most recent state inspection results were immediately relocated to a prominent and easily accessible area within the facility. Results have been placed in each nurses station and library station for easy access. " Residents were notified of the new practice. " Facility staff were informed of the new location to guide residents and visitors as needed. 2. " All residents were affected by this practice. 3. " The facility policy on posting inspection results was reviewed and revised to specify designated locations where inspection results must be posted. " Timeframes for updating the posted documents following receipt of new reports. " All department heads and designated staff were educated by Administrator on the revised policy, emphasizing the importance	

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F 577	Continued From page 2 On 11/18/2024 at 11:05 AM, the [US FOIA (b)(6)] told the surveyor that the survey results are now located on the nursing units and accessible to residents. The [US FOIA (b)(6)] told the survey team, "We (facility administration) made sure they (survey results) were on the units on Friday. The surveyor then asked the [U.S. FOIA (b)] if the survey results were accessible to residents without having to ask when they were only located in the facility lobby area behind a locked door. The [US FOIA (b)(6)] told the surveyor, "I agree that the results weren't accessible to the residents prior because they do not have access to the lobby without having a code to the door. They would have to ask staff for access to the lobby copy." NJAC 8:39-9.4(b)	F 577	of timely posting and accessibility of inspection results. " Residents were notified during a council meeting about the location of the inspection results. 4. "The Administrator or designee will monitor the presence and accessibility of inspection results weekly for 6 months. " Results of the monitoring will be reviewed during QAPI meetings quarterly for 6 months, and additional corrective action will be implemented if deficiencies are identified.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		1/3/25

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F 584	Continued From page 3 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: C/O # NJ 168401, NJ# 174304 Based on observation, interview and review of other facility documentation, the facility failed to ensure the facility was maintained in a safe, clean and homelike environment. This deficient practice was identified for 2 of 3 units, 2nd and 3rd floor and was evidenced by the following: 1. On 11/14/24 at 08:29 AM the surveyor conducted an interview and observation with Resident #70 while he/she was lying in bed. The	F 584	1. "Resident #70 sheets were changed to sheets in good condition. "Room [redacted] a broken drawer was fixed immediately. "Room [redacted], residents clothes were sent to laundry and deep cleaning was done in the room. "Room [redacted] wallpaper was repaired Bed B[redacted]	

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F 584	Continued From page 4 sheet covering the mattress was observed to have holes in it at the lower end of the bed towards the foot board and exposed the mattress underneath. Resident #70 expressed to the surveyor that he/she would prefer a sheet that did not have holes. On 11/15/2024 at 09:28 AM the surveyor observed Room [NJ Exec O]. The surveyor observed that the [NJ Exec Order] bottom dresser drawer was broken, with the right side of the drawer face hanging on the floor. Resident who occupied [NJ Exec Order] was not present in the room at time of observation. The surveyor observed several flies around [NJ Exec Order] and observed a black fly on a red sweatshirt which was placed on top of the [NJ Exec Order 26.4b1]. (photo). The surveyor also observed the wall paper peeling from the upper wall and down between [NJ Exec Order 26.4b1]. On 11/15/2024 at 09:52 AM the surveyor observed Room. The surveyor observed a hole in the wall between the window sill and baseboard molding. On 11/18/2024 10:24 AM the surveyor interviewed the [US FOIA (b)(6)] The surveyor inquired whether the facility had a system in place for staff to report concerns to the maintenance department for repairs. The [US FOIA (b)(6)] told the surveyor that he believed that they have a communication book on the unit for staff or residents to report issues to the maintenance department. Upon showing the [US FOIA (b)(6)] photographs of the above listed concerns the [US FOIA (b)(6)] told the surveyor, "I agree if I find it in that condition it needs to be repaired. I agree all of these concerns should be repaired. I will take a look and get back to you."	F 584	"The surveyor observed a hole in between the windowsill and baseboard molding, the room number was not specified in FORM CMS-2567. " Bathroom vents in rooms 241C, 343, 352, 361 were cleaned. "The facility communicated to company providing laundry services about issues related to bed linen. 2. "All residents have the potential to be affected by the deficient practice. 3. "Training and communication; all staff received training on maintaining a clean, safe and homelike environment. Training included cleaning schedules, reporting unsafe conditions, or enhancing resident comfort. Education completed by Administrator. "Staff were educated promptly reporting and resolving environmental concerns and completing maintenance workbook logs for needed repairs. Education completed by Administrator. "Director of Maintenance (DOM) to check logs daily and address concerns in a timely manner. "Director of Housekeeping or designee will check the quality of bed linen before distributing to the floors.	

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F 584	Continued From page 5 On 11/18/2024 at 10:44 AM the surveyor conducted an interview with the facility [US FOIA (b)(6)] [redacted]: The surveyor asked the showed the [US FOIA (b)] [redacted] of the damaged linens observed on Resident #70's bed. The surveyor then asked the [US FOIA (b)] [redacted] what the facility process was for linens that were in disrepair. The [US FOIA (b)] [redacted] explained, "Linens that are in disrepair are sent back to our contract company. That linen should not have been put on the bed and that is the type of linen that should be returned to the contractor because it is in disrepair." 2. During the initial tour of the 2nd floor on 11/12/2024 at 11:38 AM, Surveyor #2 observed the bathroom vent in room [NJ Exec Order 2] [redacted]. There was large amount of dust observed on each louver of the vent. On 11/13/2024 at 08:37 AM, Surveyor #2 observed the bathroom vent in room [NJ Exec O] [redacted] to have louvers covered with dust. On 11/14/2024 at 08:19 AM, Surveyor #2 observed the bathroom vent in room [NJ Exec O] [redacted] and it had a moderate amount of dust on the louvers.	F 584	4. "The Director of Maintenance or designee will audit 5 rooms weekly for 4 weeks then monthly for 3 months to inspect furniture, beds, walls and the physical aspect of the room. Findings will be discussed with the team and repairs will be made immediately. "Director of Housekeeping or designee will audit linen quality weekly for 4 weeks then monthly for 3 months. Linen in disrepair will be sent back to laundry services company. "Results of the monitoring will be reviewed during QAPI meetings quarterly for 6 months, and additional corrective action will be implemented if deficiencies are identified.	

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F 584	Continued From page 6 On 11/14/2024 at 11:23 AM, Surveyor #3 observed room [NJ Exec D] dust buildup on vent in bathroom. A review of a grievance form dated 5/29/24 provided to the surveyor for room [NJ Exec D] indicated that the facility addressed a concern regarding the dust on the bathroom vent and was resolved. During an interview with Surveyor #2 on 11/18/2024 at 10:08 AM, the [US FOIA (b)(6)] said that housekeeping performs a monthly deep clean of the entire room. Resident needs to be out of bed, staff pack all personal belongings, and we clean mattress, bed, move furniture, clean inside drawers, closet, sweep and mop. We also dust blinds and change privacy curtains. In the bathroom we the clean toilet, sink, lights and make sure paper towels and soap are stocked. They clean the garbage can in the room and in the bathroom. The [US FOIA (b)] went on to say we wipe walls if they need to be wiped, clean bed side tables, legs on the table, windows, call bell, remotes, telephone, wipe TV and behind the TV. The air conditioner is cleaned on outside for dust on the grates. The staff have a check list for this. The [US FOIA (b)] said "We clean vents and normally check twice a week and clean weekly as part of daily bathroom cleaning." We may need to take the vent off to clean. [US FOIA (b)] said yes this was a concern when surveyor #2 reviewed evidence of the bathroom vent having large amount of dust accumulation. The [US FOIA (b)] confirmed "No it should not look like that if it was being cleaned once a week."	F 584		

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F 584	Continued From page 7 The [US FOIA (b)] confirmed that surface dusting is completed during monthly carbolization (deep cleaning) and weekly during cleaning. On 11/18/2024 at 10:44 AM, Surveyor #2 reviewed a facility policy titled Surface Dusting undated revealed Under Procedure for Wall & Ceiling Dusting 7. Dust walls once ceiling is complete. Always dust from top to bottom, including vents, ledges & exposed pipe.	F 584		
F 658 SS=D	NJAC 8:39-31.4(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: NJ 173880 Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to notify a physician of a resident's [NJ Exec Orde] [redacted] (Resident #173) in accordance with professional standards of practice. This deficient practice was identified for 1 of 1 residents reviewed for [NJ Exec Order 2] usage. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse	F 658	1. " Resident #173 was discharged from the facility. MD was notified of the findings on 11/13/2024. 2. "All residents with an order for insulin with parameters have the potential to be affected by the deficient practice. 3. "Policy for Physician Medication Orders was reviewed and updated to include instructions for following physician□s orders. " All licensed nursing staff were	1/3/25

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F 658	Continued From page 8 Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 11/13/2024 at 9:17 AM, the surveyor reviewed the closed medical record of Resident #173. A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1 A review of the quarterly Minimum Data Set (MDS), an assessment tool NJ Exec Order 26.4b1, reflected a brief interview for mental status (BIMS) score of NJ Exec out of 15; which indicated a NJ Exec O NJ Exec Order 26.4b1.	F 658	re-educated on the revised policy by Director of Nursing, focusing on monitoring and documentation of blood sugar levels. Notifying physician when levels are outside of established parameters. " All orders for residents with insulin with parameters were audited to ensure parameters have been followed. 4. "The Director of Nursing or designee will be responsible for ensuring ongoing compliance with physician notification protocols. " The Director of Nursing or designee will audit 3 residents with insulin orders with parameters and blood sugar level weekly for 4 weeks and then monthly for 3 months to ensure physician is notified if blood sugar level is outside of the parameters. " Audit results will be reviewed at monthly QAPI quarterly meeting for 6 months, and additional corrective action will be implemented if compliance falls below 100%.	

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F 658	Continued From page 9	F 658		

A review of the Order Summary Report with a order date range of NJ Exec Order 26.4b1 included a physician orders (PO) dated NJ Exec Order 26.4b1:

NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 , if NJ Exec Order 26.4b1 is NJ Exec Order 26.4b1 call MD; NJ Exec Order 26.4b1 if NJ Exec Order 26.4b1 is NJ Exec Order 26.4b1 than NJ Exec Order 26.4b1 call MD, NJ Exec Order 26.4b1 before meals for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 . Check NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 before meals. Give with NJ Exec Order 26.4b1 when following NJ Exec Order 26.4b1 , as needed. Call MD if NJ Exec Order 26.4b1

NJ Exec Order 26.4b1 before any NJ Exec Order 26.4b1 administration, call if NJ Exec Order 26.4b1 before meals and at bedtime related to NJ Exec Order 26.4b1 .

A further review of the Order Summary report revealed PO dated NJ Exec Order 26.4b1:

NJ Exec Order 26.4b1 before meals for IDDM related to NJ Exec Order 26.4b1 . Administer an additional NJ Exec Order 26.4b1 , Call MD if NJ Exec Order 26.4b1 is NJ Exec Order 26.4b1

A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected the following:

From NJ Exec Order 26.4b1 , the resident's NJ Exec Order 26.4b1

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F 658	Continued From page 10 were recorded [redacted] on 34 occasions: 7:30 AM, [redacted] 11:30 AM, [redacted]. 4:30 PM, [redacted] A review of the corresponding Progress Notes for [redacted] did not include documentation that the resident's [redacted] was recorded as [redacted] or that the resident's physician had been notified of the resident's [redacted] recorded as [redacted]. A review of the corresponding [redacted] Medication Administration Record (MAR) reflected the following: From [redacted] the resident's [redacted] were recorded [redacted] on 17 occasions: 7:30 AM, [redacted]. 11:30 AM, [redacted] 4:30 PM, [redacted] 10:00 PM, [redacted]. A review of the corresponding Progress Notes for [redacted] did not include documentation that the resident's [redacted] was recorded as [redacted] or that the resident's physician had been notified of the resident's [redacted] was recorded as [redacted]	F 658		

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F 658	Continued From page 11 On 11/18/2024 at 11:12 AM, the surveyor interviewed the US FOIA (b)(6)) as well as the US FOIA (b)(6) and together reviewed the medical record including the NJ Exec Order 26.4b1 MAR and the corresponding nursing progress notes for Resident #173. The US FOIA (b) acknowledged there were numerous incidences of NJ Exec Order 26.4b1 and further acknowledged she had previously reviewed the corresponding progress notes for that time period and acknowledged there was no documentation indicating the physician had been made aware of the NJ Exec above the indicated NJ Exec Order 26.4b1 . The US FOIA (b) stated nurses had to call the physician to notify if the NJ Exec Order 26.4b1 than the NJ Exec Order 26.4b1 according to the physician's orders. The US FOIA (b)(6) confirmed the nurses should have documented in the resident's medical record, in the nursing progress notes the MD had been notified regarding the resident's NJ Exec Order 26.4b1 . A review of the facility's "Physician Medication Orders" policy dated NJ Exec Order 26.4b1 , did not include instructions for following a physician's orders. A review of the facility's undated "Charting and Documentation" policy revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. NJAC 8:39-27.1(a)	F 658		

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EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401**

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review and review of other facility documentation, it was determined that the facility failed to implement NJ Exec Order 26.4b1 measures for the handling and storage of NJ Exec Order 26.4b1 equipment for 1 of 4 residents (Resident #70) reviewed for NJ Exec Order 26.4b1. This deficient practice was evidenced by the following: On 11/12/2024 at 10:56 AM, during the initial tour of the facility the surveyor observed that Resident #70 was not present in the room. The surveyor observed a NJ Exec Order 26.4b1 placed on top of the NJ Exec Order 26.4b1 while not in use. The NJ Exec Orde was uncovered and exposed to contamination. On 11/14/2024 at 08:25 AM Resident #70 was observed lying in bed. The surveyor observed Resident #70's NJ Exec Order 26.4b1 not in use and placed in the opened top drawer of the bedside table. The surveyor asked Resident #70 if he/she had received a NJ Exec Order 26.4b1 treatment this AM, and the resident responded not yet. The surveyor asked if the last treatment he/she had received was last night and the resident confirmed that they last received a NJ Exec Order 26.4b1 treatment last night.	F 695	1. The NJ Exec Order 26.4b1 equipment for resident #70 was immediately replaced and stored according to infection control guidelines. 2. All residents who use a nebulizer treatment mask have the potential to be affected by the deficient practice. 3. All nursing and respiratory therapy staff were re-educated on the facility□s infection control policies and procedures specific to the handling and storage of respiratory equipment. Training included: proper cleaning and disinfection protocols for respiratory equipment, appropriate storage methods to prevent contamination, monitoring and documentation procedures to ensure compliance. 4. The Infection Preventionist or Designee will perform weekly audits of respiratory equipment storage for four weeks for 4 weeks, followed by monthly audits for	1/3/25

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F 695	Continued From page 13 The [NJ Exec Orde] was unprotected between uses and exposed to contamination. According to the Admission Record, Resident #70 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted] and [NJ Exec O] [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool dated [NJ Exec Order 26.4b1], revealed that Resident #70 had a Brief Interview for Mental Status score of [NJ Exec Orde], indicating NJ Exec Order 26.4b1 [redacted]. Section [NJ] of the MDS indicated that Resident #70 had an [NJ Exec Order] [redacted]. Section [NJ S] indicated that Resident #70 received NJ Exec Order 26.4b1 for [NJ] days in the last [NJ] days of the observation period. A review of the Order Summary Report with active orders as of: [NJ Exec Order 26.4b1] revealed that Resident #70 had the following physician order(s): NJ Exec Order 26.4b1 [redacted] four times a day for NJ Exec Order 26.4b1 Order date: [NJ Exec Order 26.4b1]. On 11/15/2024 at 12:31 PM, the surveyor interviewed Licensed Practical Nurse (LPN #2) assigned to Resident #70. The surveyor asked LPN #2 what the facility procedure was for the storage of [NJ Exec Order 26.4b1] equipment when not in use. LPN #2 told the surveyor that the [NJ Exec Order 26.4b1] was to be rinsed after treatment and then we place it in the bag after it dries. The surveyor asked LPN #2	F 695	three months to ensure continued compliance. Audit findings will be reviewed during the QAPI meetings quarterly for 6 months and corrective actions will be implemented as needed.	

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F 695	Continued From page 14 what the purpose was of bagging the [NJ Exec Orde] after drying and LPN #2 told the surveyor, "We do that to keep it clean, don't let it collect dust. It should be bagged when not in use." On 11/15/2024 at 01:10 PM, during an interview with facility administration the surveyor asked what the facility practice was for [NJ Exec Order 26.4b1] equipment ([NJ Exec Order 2] when not in use. The facility US FOIA (b)(6) replied, "The facility practice is to put the [NJ Exec Order 26.4b1] mask in a plastic bag when not in use to keep it clean. It is an infection control concern to not protect the [NJ Exec Orde] while not in use." The facility failed to provide the surveyor with a policy or procedure pertaining to [NJ Exec Order 26.4b1] equipment.	F 695		
F 812 SS=F	NJAC 8:39 -27.1 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		1/3/25

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F 812	Continued From page 15 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 11/12/2024 at 09:32 AM, the surveyor, accompanied by the US FOIA (b)(6) [redacted], observed the following in the kitchen: 1. On a lower shelf a one (1) gallon container of Deli Mustard was dated received "11/21/22." The mustard had a manufacturer's "BEST BY" date of "10/25/23." On interview the [redacted] agreed that the mustard was expired and should have been removed from stock. The [redacted] then removed the mustard from storage. 2. On a lower shelf in the walk-in freezer two (2) bags of frozen French fries were removed from their original container. The French fries had no dates. The [redacted] told the surveyor that all products should be dated when removed from the original container. In addition, an apple pie on a middle shelf was removed from its original container and had no dates. 3. On a middle shelf in the walk-in refrigerator four (4) clear plastic bags of shredded lettuce had received dates of "10/15/24." The lettuce was observed to be browned and slimy on	F 812	1. All expired items from dry storage, walk-in refrigerator and walk-in freezer were removed and discarded. Undated items from dry storage, walk-in refrigerator and walk-in freezer were removed and discarded. An internal thermometer was placed inside the milk box. The stand-up mixer was cleaned and sanitized once again. The metal cage surrounding the blades was cleaned and sanitized. The stand-p mixer was covered with a plastic bag once cleaned and dry. The faucet mounted on the steam table was cleaned and sanitized. Hand wash competency completed with the cook. 2. All residents have the potential to be affected by the deficient practice. 3. The Director of Dietary or designee reviewed the dating and labeling policy with all dietary staff. Education was provided to all kitchen staff regarding labeling of all food products	

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F 812	Continued From page 16 appearance. The [US FOIA (b)] stated they were old and removed the four (4) bags of spoiled lettuce to the trash. In addition, on an upper shelf an opened cardboard box contained a plastic bag with six (6) heads of ice berg lettuce. The lettuce was observed to be brown and slimy. The [US FOIA (b)] agreed that the lettuce was spoiled and removed to the trash. 4. The surveyor reviewed the Milk Box Temperature log which revealed that all temperatures were up to date and the temperatures were within normal parameters. Upon opening the milk box, the surveyor was unable to find an internal thermometer to monitor the internal temperature of the milk box. The [US FOIA (b)] then searched the internal milk box and could not find an internal thermometer. The [US FOIA (b)] told the surveyor that it must have been lost because it had been there earlier. On 11/15/2024 at 10:00 AM, the surveyor, accompanied by the [US FOIA (b)] and the [US FOIA (b)(6)] made the following observations in the kitchen: 1. A stand-up mixer was on top of a prep table. The mixer was cleaned and sanitized after being used to make crumb cakes this morning, according to the [US FOIA (b)] The mixing bowl was observed to have a wet/watery substance in the bottom of the bowl. The metal cage that surrounds the mixing blade was covered with unidentified tan/brown food debris. The mixer was also uncovered and exposed while not in use and after being cleaned and sanitized. The [US FOIA (b)] stated to the surveyor that the mixer will be recleaned and stated we cover it with a plastic bag when not in use.	F 812	in the dietary department as well as proper cleaning and sanitation of kitchen equipment and surface areas. Education and hand wash competency completed with all dietary department staff. 4. The Director of Dietary or Design will conduct a weekly audit for 4 weeks and then monthly for 2 months to ensure proper labeling of all items in the walk-in freezer and refrigerator. The Director of Dietary or designee will audit the presence of thermometer in the milk box weekly for 4 weeks and then monthly for 2 months to ensure temperature logs are completed appropriately. The Infection Preventionist or designee will complete 5 hand wash competencies weekly for 4 weeks then monthly for 2 months. The results of the audits will be presented to the QAPI Committee by the Director of Dietary or designee quarterly for six months. The QAPI Committee will determine if further audits are necessary.	

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F 812	Continued From page 17 On 11/15/2024 at 11:43 AM, the surveyor, accompanied by the [redacted] observed the following in the kitchen: 1. Observation of the faucet mounted on the steam table revealed an abundance of unidentified food debris around the faucet and gas line. The [redacted] agreed that the area needed cleaning and instructed the [redacted] to have it cleaned after completion of the lunch tray line. The [redacted] agreed that the unidentified food debris was not fresh and had been there for an extended period. 2. Prior to the lunch tray line the surveyor observed the cook doff (remove) his disposable gloves and place them in the trash receptacle. The cook then proceeded to walk to the designated hand washing sink and pulled on the handle of the paper dispenser and pulled on it several times. The cook then turned on a water faucet with their left hand and put hand soap on their right hand that was not under the faucet and was dry. The cook then proceeded to wash their hands after only applying water to the left hand and soap to the dry right hand. The cook washed their hands for approximately 18 seconds then rinsed their hands and dried with a hand towel. The cook then grabbed an additional hand towel and turned off the faucets and then placed the hand towel in the garbage. On 11/18/2024 at 9:00 AM, the surveyor reviewed a facility policy titled Equipment Cleaning Policy, undated. The policy revealed the following under POLICY: The Director of Dining or designee will ensure that all equipment is maintained, kept clean, and in a sanitary condition before and after	F 812		

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F 812	Continued From page 18 each use. In addition, the following was documented at 9. Steam table: a. After each meal service, drain water from the steam table. b. It must be cleaned after each use both inside and out using soap and water before you refill it with clean water. c. For heavy scale build up, use Delimer and allow it to soak for 30 minutes. Follow the instruction label for cleaning measurements and safety. d. Use stainless steel polish around the outside and leg bases. On 11/18/2024 at 9:00 AM, the surveyor reviewed a facility policy titled DATING AND LABELING POLICY, undated. The following was revealed under POLICY: All foods are to be labeled and dated appropriately to ensure food safety regulations are followed. In addition, the following was documented under PROCEDURE: 1. Upon receiving and storing, all items must be labeled with the name of food and received date. Once opened, the label must be updated with the current date and a use by date of 3 days (including date opened) unless indicated on Labeling and Dating Protocol. 2. Prepared ready-to-eat foods are to be tightly wrapped and labeled with the name of food and 3 days use by date (including date prepared) prior to being placed in refrigerator. 3. All items with an expired use by date must be discarded immediately. The surveyor reviewed the facility policy titled Infection Control-Food Handling, date:	F 812		

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F 812	Continued From page 19 04/01/2024. The following was listed under PROCEDURE: 10. Food should be properly labeled and expired foods will be discarded. The surveyor reviewed a facility policy titled Hand Washing Policy provided by the [redacted] The following was documented under PROCEDURE: 1. Wet hands with warm water 2. Apply soap from the dispenser. 3. lather hands and wrists with soap for 20 seconds. 4. Clean thoroughly underneath fingernails and between fingers. 5. Rinse hands thoroughly with warm water. 6. Turn off faucet with a paper towel - not with your clean hands. 7. Dry hands with disposable towel or under air dryer-never use an apron or kitchen towel. NJAC 18:39-17.2(g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		1/3/25

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F 880	Continued From page 20 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 21 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to follow appropriate infection control practices and perform proper hand hygiene (HH) a.) during medication administration task on 1 of 4 units, the NJ Exec Order 26.4b1 unit for 2 of 7 resident (Resident #3 and Resident #61) and b.) follow appropriate infection control practices and perform hand hygiene during NJ Exec Order 26.4b1 care (NJ Exec Order 26.4b1) for 1 of 1 residents reviewed for NJ Exec Order 26.4b1. This deficient practice was evidenced by the following: 1. During medication pass on the NJ Exec Order 26.4b1 unit on 11/13/2024 at 9:45 AM, the surveyor observed the following: a.) Licensed Practical Nurse (LPN #1) administered medication to Resident #3 via the NJ	F 880	1. "An immediate evaluation was conducted to ensure no adverse outcomes resulted from these lapses. Resident #3 and resident #61 NJ Exec Order 26.4b1 "LPN #1 was educated on medication administration policy and procedure, and a hand wash competency was completed. Education and competency was completed by nursing leadership. "A medication administration competency was completed on LPN #1 by a pharmacy consultant. 'US FOIA (b)(6) was educated on infection control policies and procedures, hand washing policy and a hand was competency was completed. Education was completed by nursing leadership.	

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F 880	Continued From page 22 NJ Exec Order 26.4b1 LPN #1 disconnected the NJ Exec Order used to administer the medications and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . LPN #1 then covered Resident #3 and doffed (removed) gloves and placed NJ Exec Order 26.4b1 in plastic bag. At 9:46 AM, LPN #1 donned (put on) clean gloves and no hand hygiene was performed. LPN #1 then proceeded to administer NJ Exec Order 26.4b1 to each NJ Exec for Resident #3. At 9:48 AM LPN #1 doffed gloves and went to the bathroom to perform hand washing. The surveyor observed LPN #1 wet her hands, lathered less than 10 seconds, rinsed, and dried her hands. LPN #1 then used the same towel that she used to dry her hands to turn off the water faucet. b.) At 9:56 AM, LPN #1 prepared Resident #61's medication. LPN #1 went to the unit refrigerator to obtain a NJ Exec Order 26.4b1 for Resident #61. LPN #1 then donned gloves and opened the capsule and poured the contents into a medication cup and discarded the NJ Exec Orde NJ Exec Order 26.4b LPN #1 then doffed the gloves and proceed to crush Resident #61' medication without performing hand hygiene. LPN #1 then proceeded to don a gown and enter Resident #61's room to administer the medications. At 10:15 AM, LPN #1 had spilled Resident #61's NJ Exec Order 26.4b1 and she doffed her gown, then left the room to obtain more NJ Exec Order 26.4b1 At 10;16 AM LPN #1 returned to the room, donned the gown and gloves, and did not perform hand hygiene prior to donning her gloves.	F 880	"A tracheostomy care competency was completed on the US FOIA (b)(6) Competency was completed by the Director of Respiratory Department. "All staff nursing staff and RRTs received immediate retraining on infection control practices including CDC guidelines for hand hygiene, proper use of personal protective equipment and specific protocols for medication administration and tracheostomy care. 2. "All residents in the vent unit have the potential to be affected by this deficient practice. LPN#1 and RRT are only designated to work in the vent unit. 3. " Nursing staff were in-serviced on the importance of hand hygiene and donning and doffing of PPE. Education completed by nursing leadership. " Respiratory Therapists were in-serviced on the importance of hand hygiene and donning and doffing of PPE. Education completed by nursing leadership. " Tracheostomy care guidelines were reviewed with all Respiratory Therapists. Education completed by Director of Respiratory Department. " Medication administration guidelines were reviewed with the nursing staff by nursing leadership.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401**

(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 880	Continued From page 23 During an interview with the surveyor on 11/13/2024 at 10:22 AM, the surveyor asked LPN #1 what the facility policy was regarding when to perform hand hygiene. LPN #1 replied coming out of the room from giving meds and before starting meds again. The surveyor asked to explain when HH was performed and she replied anytime coming out of the room after meds, after cleaning the cart, tray and before going back in the room. When asked by the surveyor if the policy was to perform HH between glove changes LPN #1 replied "that is not our policy." At the same time the surveyor asked what the process was to perform handwashing LPN #1 said I put water on, pull paper towels down, soap in your hand and lather outside the water for 30 seconds. I sing a song. Then I rinse then dry hands. At 10:26 AM, when asked if she performed HW for 30 seconds between glove change for Resident #3, LPN #1 replied "No, I did not. I was just washing from my hand being inside the glove so I could put the [redacted]." 2. On 11/14/2024 at 09:55 AM, the surveyor observed [redacted] care with the [redacted] as follows: The [redacted] walked into the hall from a back room with gloves on prior to entering Resident #61's room and there was no HH observed. The [redacted] changed the [redacted] and doffed his gloves. The [redacted] then applied sterile gloves to clean around the [redacted]. There was no hand hygiene observed between glove change. At 9:59 AM, the [redacted] completed [redacted] care. He	F 880	4. " The Director of Respiratory therapy will observe tracheostomy care practices on 3 residents weekly x 4 weeks and then monthly for 3 months to ensure tracheostomy care is done following proper infection control practices. " The Infection Preventionist will conduct hand wash observations in the vent unit with 5 staff weekly for 4 weeks and then monthly for 3 months to ensure hand wash is done per the facility hand wash policy. " The results of the audits will be presented to the QAPI Committee quarterly for one quarter. The QAPI committee will determine if further audits are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401**

(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 880	Continued From page 24 collected all used supplies and discarded them in the trash. The [US FOIA (b)] then doffed his gloves and used ABHR (alcohol based hand rub) upon exit of the room. During an interview with the surveyor on 11/14/2024 at 10:00 AM the surveyor asked if the [US FOIA (b)] performed hand hygiene prior to donning gloves before entering the resident room. The [US FOIA (b)] replied "No." When asked what the facility policy is regarding hand hygiene between glove changes, the [US FOIA (b)] replied "No, hand hygiene is not required, and I don't need to as I used the regular gloves for the dirty work then applied the sterile gloves." During an interview with the surveyor on 11/14/2024 at 11:01 AM, the US FOIA (b)(6) [redacted]) was asked what the facility policy for hand hygiene was. The [US F] replied it is important to use proper hand hygiene before going into a resident room with ABHR and if in room apply gloves. After doffing gloves, they should wash hands or use sanitizer, if not in contact with bodily fluids. I also recommend after 3 times of ABHR, to wash with soap and water. I do competencies with all staff for hand washing. When asked what about between glove changes the [US F] replied," Absolutely, staff is to wash their hands between glove changes." The [US F] went on to say staff should wash hands after doffing dirty gloves and prior to donning sterile gloves. The surveyor asked what the facility policy/process for handwashing is. The [US F] replied I tell them to prep paper towels, turn on the water, check temperature of water lukewarm to hot, wet hands, apply soap away from water, and scrub hands for 20 seconds on all surface and crevices	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401**

(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 880	Continued From page 25 including top of hands, nails up to the wrist and then rinse hands under water, wash all soap off, grab paper towel dry hands thoroughly dispose of paper towel. Then they are to grab new paper towel and turn off the water and dispose of that paper towel. When questioned if it was allowable to use the same paper towel, they dried their hands on to turn off the water. The [US FOIA (b)] replied, "No do not use same paper towel they used to dry hands." During an interview with the surveyor on 11/15/2024 at 01:16 PM, the [US FOIA (b)(6)] was questioned what the facility policy for hand hygiene is. The [US FOIA (b)] said they should wash hands after medication if they use [NJ Exec Order 26.4b] for administration and they can use sanitizer between glove changes. They must wash hands before using sterile gloves. When asked what the facility policy/process for handwashing is the [US FOIA (b)] said they go to sink, turn faucet on, wash for 20 seconds, rinse and dry hands then turn off the faucet. They get another towel to turn off the faucet. On 11/15/2024 at 08:29 AM, a review of a facility policy titled Infection Control-Hand Hygiene with date of 04/01/2024 revealed under the Intent section: It is the policy of the facility to perform hand hygiene in accordance with national standards from the Centers of for Disease Control and Prevention and the World Health Organization. Under Procedure section: 2. Alcohol-based hand rub may be used for all other hand hygiene opportunities (e.g. when soap and water is not indicated per #1 above). According to the World health Organization, hand hygiene is to be	F 880		

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	315317	A. BUILDING _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401**

(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 880	Continued From page 26 performed: a. Prior to caring for a resident; d. after caring for a resident including after removing gloves. 3. The Centers for Medicare and Medicaid Operations Manual indicates that hand hygiene should be performed: b. before and after performing any invasive procedure; f. before and after handling peripheral vascular catheters and other invasive devices; o. after removing gloves or aprons. NJAC 8:39-19.4(a)	F 880		

New Jersey Department of Health

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	060103	A. BUILDING: _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

(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
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 1. For the week of Complaint staffing from 11/26/2023 to 12/02/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts 2. For the week of Complaint staffing from 06/02/2024 to 06/08/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 3. For the week of Complaint staffing from 07/21/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in CNAs to total staff on 1 of 7 day shifts, deficient in total staff for residents on 1 of 7 evening shifts,	S 560	1. " The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls being made by the shift supervisor to fill the shift. Recruitment efforts by the facility to hirs CNAs, direct nursing staff include aggressively running ads through various social media platforms, utilizing of employment application websites and fostering partnerships with recruitment and employment	1/3/25

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

Electronically Signed — 12/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 and deficient in total staff for residents on 1 of 7 overnight shifts, 4. For the 2 weeks of staffing prior to survey from 10/27/24 to 11/09/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility as documented below:	S 560	agencies. " No residents have been adversely affected by the deficient practice. 2. " All residents have the potential to be affected by this situation. 3. Facility recruitment and retention strategies and efforts will remain in progress, which include but are not limited to the following: "Offer sign-on bonuses to attract staff. "Recruitment bonus to encourage referrals from current staff. "Make attempts to attract overtime or PRN staff shifts. "Regularly meet with staff to boost morale. "Conduct staff appreciation programs and activities to promote staff retention. "Aggressively run ads in various social medial platforms and employment application websites. "Flexible shifts and schedules. "Work with CNA schools to recruit new graduates. "The administrator, staffing coordinator and nursing leadership will meet daily to review/monitor CNAs schedules to ensure ratios are met. CNA staffing needs will be posted on the agency website. 4. "The HR Director or designee will provide weekly reports to the Administrator regarding all efforts made to try to comply with the States staffing ratios. "Reports will be presented to the QAPI committee quarterly for one quarter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

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S 560	Continued From page 2 1. For the week of Complaint staffing from 11/26/2023 to 12/02/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -11/26/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -11/27/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -11/29/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -11/30/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -12/01/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -12/02/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. 2. For the week of Complaint staffing from 06/02/2024 to 06/08/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -06/02/24 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -06/03/24 had 9 CNAs for 117 residents on the day shift, required at least 15 CNAs. -06/04/24 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -06/05/24 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -06/06/24 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -06/07/24 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -06/08/24 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. 3. For the week of Complaint staffing from	S 560	The QAPI committee will determine if further reports are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 07/21/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in CNAs to total staff on 1 of 7 day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -07/21/24 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -07/21/24 had 10 total staff for 117 residents on the evening shift, required at least 12 total staff. -07/21/24 had 4 CNAs to 10 total staff on the evening shift, required at least 5 CNAs. -07/22/24 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. -07/23/24 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -07/24/24 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -07/25/24 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/26/24 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/27/24 had 7 CNAs for 114 residents on the day shift, required at least 14 CNAs. -07/27/24 had 7 total staff for 114 residents on the overnight shift, required at least 8 total staff. 4. For the 2 weeks of staffing prior to survey from 10/27/24 to 11/09/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -10/27/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/28/24 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -10/30/24 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -10/31/24 had 12 CNAs for 116 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 4 day shift, required at least 14 CNAs. -11/01/24 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -11/02/24 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -11/03/24 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -11/05/24 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/06/24 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/07/24 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/08/24 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/09/24 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. During an interview with the surveyor on 11/15/2024 at 10:20 AM, the staffing Coordinator was asked if she was familiar with the minimum staffing requirements for CNA's. The SC replied It is 1 CNA to 8 residents on day shift, for 4pm-12 midnight 1 CNA to 10 residents and 12midnight-8 am is 1 CNA to 14 residents. When asked are you meeting the requirements and the SC said Yes, we are meeting those requirements. If we don't have aides we use agency. On 11/15/2024 at 11:07 AM, the surveyor reviewed facility policy titled Staffing Policy with Effective Date 5/1/24 which revealed under Policy Guideline section: 1. Staffing levels ... Minimum staffing ratios will comply with New Jersey Law. 8. Compliance The facility will adhere to all state and federal staffing regulations, including those outlined in the New Jersey Administrative Code (N.J.A.C.) and CMS guidelines.	S 560		

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
315317 (Y1)	A. Building B. Wing (Y2)	4/1/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 01/03/2025	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 01/03/2025	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

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 11/19/2024	☐ 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
315317 Y1	A. Building B. Wing Y2	4/1/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0577	Correction	ID Prefix F0584	Correction	ID Prefix F0658	Correction
Reg. # 483.10(g)(10)(11)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025
ID Prefix F0695	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/19/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
060103	A. Building B. Wing	4/1/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/03/2025	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: DAHL12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING **01** B. WING _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(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 This facility is not in substantial 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 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		1/3/25

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

Electronically Signed | 12/12/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(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 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents on 11/19/24, it was determined the facility failed to establish and maintain the facility transfer contracts and agreements at least annually in accordance with Appendix Z, §483.73(a): Emergency Plan. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility documents at 10:05 AM, revealed that facility contracts and transfer agreements were not updated at least annually. The following contracts and transfer agreements not annually updated: 1. Shore Memorial Hospital dba Shore Medical Center 2. AtlantiCare Regional Medical Center: 4/8/22 3. Milford Manor	E 004	1. The Administrator reviewed and contacted all contracts via call to ensure compliance with annual review requirements and confirmed that all contractors have active status. Copy of executed agreements will be kept in an emergency plan binder. The transfer agreements that included Milford Manor, Pine Brook Care Center and Lourdes Specialty Hospital of Southern New Jersey are no longer in effect. They have been replaced by aggreeemnets wityh ExcelCare at Egg Harbor; ExcelCare at Dover and ExcelCare at Wayne 2. All residents have the potential to be affected by the deficient practice.	

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	315317	A. BUILDING **01** B. WING _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(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 004	Continued From page 2 4. Pinebrook Care Center 5. Lourdes Specialty Hospital of Southern New Jersey: 10/17/14 In an interview at the time of document review, the corporate staff member indicated the transfer documents that were not dated were on an auto-renewal basis. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.2(e), 31.6(i)	E 004	3. The Administrator/Designee in-serviced the Admission and Maintenance staff to ensure that facility is in compliance with regulations governing maintain annual review of transfer agreements at least annually in accordance with Appendix Z 483.73 (a). 4. Maintenance Director/Designee will conduct yearly audits. Any issues will be reported to the Administrator immediately for corrective actions. Findings will be submitted to the Quality Assurance Committee x 2 annually. The Quality Assurance Committee will determine the need for further action plans if necessary.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/18/24 and 11/19/24. Excel Care at the Pines was found to not be in compliance 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. Excel Care at the Pines is a three story building that was built in 90's. It is composed of Type II protected construction. The facility is divided into 8- smoke zones.	K 000		

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	315317	A. BUILDING **01** B. WING _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 3 There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The facility currently is utilizing a rental generator since July 2024. The U.S. FOIA (b) (6) indicated on 11/18/24 that the rental generator is tied to the fire alarm control panel, cross corridor doors hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility is licensed for 151 certified beds and is currently occupying 115.	K 000		
K 222 SS=E	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	K 222		1/3/25

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	315317	A. BUILDING 01 B. WING _____	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

(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 4 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 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 observation and interviews on 11/19/24 in the presence of the U.S. FOIA (b) (6)	K 222	1. The Maintenance staff left signage on the egress doors in place that indicates	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

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K 222	Continued From page 5 U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the 15-second delayed egress feature on 2 of 3 exit discharge doors (with this feature) would activate properly when tested in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1(3)C. This deficient practice had the potential to affect 25 residents and was evidenced by the following: 1). At 10:00 AM, the surveyor and U.S. FOIA (b) (6) observed that the exit/egress door across from resident room 254 was provided with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds". The U.S. FOIA (b) (6) tried to activate the door delayed device as indicated on the sign, but the door was not equipped with a 15 second delayed device. 2). At 10:40 AM, the surveyor and U.S. FOIA (b) (6) observed that the vent unit exit/egress door was provided with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds". The U.S. FOIA (b) (6) tried to activate the door delayed device as indicated on the sign, but the door did not open when the U.S. FOIA (b) (6) tried to activate the system to open the door. An interview was conducted with the U.S. FOIA (b) (6) during the observations. The U.S. FOIA (b) (6) indicated he was not sure why the delayed devices were not working. The U.S. FOIA (b) (6) was notified of the findings at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.2(e)	K 222	"Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds" The system was activated achieving life and safety code (2012 edition) Section 7.2.1.6.1(3) mandate on the following egress doors: 2 exit discharge exit door across from resident room 254; 3 exit discharge exit door and by the door for exit/egress on Floor #1 Vent unit 2. This situation potentially affected 25 residents. The director of maintenance audited doors signage mounted on the doors to correspond to the actual locking setup of each door and ensured that system was active. 3. The Administrator educated the Maintenance staff to ensure that proper signage is mounted according to the actual locking set up of each door and that the delayed device is active . Audit log was developed. Audits will be performed monthly by Director of Maintenance / designee. Monthly logs will be submitted to the Administrator for review. 4. The Maintenance Director/ designee will perform observation audits monthly x 6 months, to ensure that exit doors locked with a delayed egress device are provided with instructional signage as required by regulation (Signs with 1-inch letters	

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K 222	Continued From page 6	K 222	indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds). Findings will be submitted to the Quality Assurance Committee quarterly and will be incorporated in the Facility Quality Assurance Program to ensure on-going compliance.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/18/24 and 11/19/24 in the presence of the NJ Ex Order 26.4(b)(1) and U.S. FOIA (b) (6)), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Section 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 4 of 4 occupied areas, had the potential to affect all residents, and was evidenced by the following: 1. Observations on 11/18/24 at 1:55 PM, revealed in the 3rd floor dining/day/activities room that 2 wall light switches shut off all 10 ceiling light fixtures. 2. Observations on 11/19/24 at 10:00 AM,	K 281	1. The light control setup in the following spaces was corrected to provide emergency illumination that would operate automatically along with the means of egress: (1) 3rd floor dining/day/activities room lighting corrected to provide emergency illumination that operates automatically along with the means of egress (2) 2nd floor dining/day/activities room lighting corrected to provide emergency illumination that	1/10/25

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EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(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 281	Continued From page 7 revealed in the 2nd floor dining/day/activities room that 2 wall light switches shut off all 10 ceiling light fixtures. 3. Observations on 11/19/24 at 10:19 AM, revealed in the 1st floor dining/day/activities room that 2 wall light switches shut off all 8 ceiling light fixtures. 4. Observations on 11/19/24 at 10:50 AM, revealed in the 1st floor Physical Therapy room that 2 wall light switches shut off all 5 ceiling light fixtures. The areas were not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The US FOIA (b)(6) both confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code survey exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.2(e)	K 281	operates automatically along with the means of egress (3) 1st floor dining/day/activities room lighting corrected to provide emergency illumination that operates automatically along with the means of egress (4) 1st floor physical therapy room lighting corrected to provide emergency illumination that operates automatically along with the means of egress 2. All residents who have access to the dining/day/activities rooms and physical therapy have the potential to be affected by the deficient practice. 3. The Maintenance staff audited all spaces to ensure that there was emergency illumination that would operate automatically along the means of egress. 4. The Maintenance Director or designee will perform observation audits monthly x 6 months, to ensure that all paths to a means of egress have emergency illumination that would operate	

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K 281	Continued From page 8	K 281	automatically. Findings will be submitted to the QAPI Committee q quarterly x2 quarters and will be incorporated in the Facility QAPI Program to ensure on-going compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 11/18/24 and 11/19/24 in the presence of the U.S. FOIA (b) (6) it was determined that the facility failed to a) ensure a smoke detector sensitivity test was being performed and b) provide and maintain complete and accurate documentation, manufacturer's acceptable sensitivity range and testing of the fire alarm system in accordance with NFPA 101: 2012 Edition, Sections 19.3.4.3.1, 9.6, NFPA 70:2011 Edition and NFPA 72:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: On 11/18/24 the U.S. FOIA (b) (6)	K 345	1. Maintenance obtained the fully detailed sensitivity report from the fire alarm vendor. The report includes the itemized inspection and the test. 2. All residents, staff and visitors have the potential to be affected by the deficient practice. The Maintenance Director will review all future sensitivity reports to ensure all requisite information is included on the fire alarm inspections.	1/10/25

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K 345	Continued From page 9 U.S. FOIA (b) (6)), provided a Sensitivity testing certificate dated 9/27/24. The sensitivity indicated 3.5% passed only and did not provide an itemized inspection and testing did not include the required information including the make/model, method of testing and manufacturer's acceptable smoke sensitivity range as per 'Sensitivity Test per ST-22394'. The finding was verified by the US FOIA (b)(6) at the time of the observation. The US FOIA (b)(6) and was notified of the findings at Life Safety Code survey exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70,72	K 345	3. US FOIA (b)(6) in-serviced the Maintenance Director to review all future sensitivity reports to ensure all requisite information is included on the fire alarm inspections. 4. Maintenance Director/Designee will conduct quarterly reviews x 6 months to ensure that requisite reports are on file. Findings will be submitted to the QAPI Committee quarterly basis x 2 Quarters. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and	K 351		12/1/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

(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 351	Continued From page 10 sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/19/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all residents and was evidenced by the following: At 12:15 PM, the surveyor and U.S. FOIA (b) (6 observed on floor #1 that a facility sign was fully blocking an "out of service" elevator. The sign was removed and a window was observed approximately 10-inches by 10-inches. The surveyor observed the interior of the locked, out of service elevator with a flashlight that showed combustible cardboard boxes were being stored and the interior of the elevator did not have a fire sprinkler head. The U.S. FOIA (b)(6 indicated he was unaware the facility was using the unsprinklered elevator for hazardous storage. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	1. On floor #1 The combustible cardboard boxes that were being stored on the interior of the elevator that is unsprinklered were removed by the Maintenance Staff. 2. All residents, staff and visitors have the potential to be affected by the deficient practice. 3. US FOIA (b)(6) in-serviced the Maintenance Department to ensure that the interior of the service elevator is not used for storage of any type. Director of Maintenance/Designee will ensure the interior of elevetor of the service elevator remains empty, in accordance with NFPA 13 by conducting weekly audits of the elevator interior. 4. Maintenance Director/Designee will conduct monthly rounds x 6 months to ensure that the interior of the of service elevator remains empty. Findings will be submitted to the QAPI Committee quarterly basis x 2 Quarters. QAPI	

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	315317	A. BUILDING **01** B. WING _____	**11/19/2024**

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EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

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K 351	Continued From page 11	K 351	Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 11/18/24 and 11/19/24, in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that corridor walls were constructed to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Sections 8.3.4.1, 19.3.6.2 and 19.3.6.2.7. This deficient practice	K 362	Please see the photos attached of the completed Dampers installation. The dampers were successfully installed on 3/18/2025. The fusible link was serviced on 3/18/2025.	3/18/25

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K 362	Continued From page 12 had the potential to affect all residents and was evidenced by the following: Observations on 11/19/24 from approximately 09:45 AM to 12:30 PM,revealed in the floor #3 corridor that an approximately 18-inch by 18-inch wall vent was installed. The wall vent was observed on floor #2 and floor #1 in the same area. The inside of the vents were provided with a fusible link system, but it was undetermined if a smoke damper was installed to prevent a smoke condition from involving all floors. In an interview at the time, the US FOIA (b)(6) indicated that he would look for a damper inspection report from the facility vendor. No further documentation was provided. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.2(e)	K 362	1. A mechanical contractor was contacted to determined if a smoke damper was installed to prevent a smoke condition from involving all floors i.e.. the #1 floor; #2 floor and #3 corridor. The 18x18 vents on the 1st and 2nd floors will have the fusible link system serviced. The contractor has been hired and will complete the installation of the dampers. 2. All residents, staff and visitors have the potential to be affected by the deficient practice. 3. THE RPOD educated the maintenance staff on the importance of ensuring monthly testing and maintenance are conducted in accordance with NFPA 101. Ventilation shafts in the facility will be inspected for compliant hardware and equipment. The Director of Maintenance/Designee will ensure monthly testing and maintenance are conducted in accordance with NFPA 101. Audit log was developed and audits will be conducted monthly. Any noted deficiencies will be forwarded to the administrator for review. 4. The maintenance Director/Designee will conduct monthly rounds x 6 months to ensure that ventilation servicing multiple floors resist the passage of smoke. Findings will be submitted to the Quality	

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K 362	Continued From page 13	K 362	Assurance committee quarterly basis x 2. Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and document review on	K 741	1. The maintenance director conducted	1/3/25

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K 741	Continued From page 14 11/19/24 in the presence of the Administrator and U.S. FOIA (b) (6)), the facility failed to maintain smoking areas and in accordance with NFPA 101: 2012 Edition, Section 19.7.4 by failing to prohibit the practice of mixing cigarette butts and ash in trash cans with other combustibles. This deficient practice was observed for 1 of 1 smoking areas, had the potential to affect 20 residents and was evidenced by the following: Observations at 11:39 AM in the presence of the US FOIA (b)(6) , revealed the occupied smoking courtyard had 8 oasis style plastic ashtrays with no metal buckets inside for 4 of 8 ashtrays. The plastic base of 4-units were filled with cigarette butts. An orange 5-gallon bucket was observed next to the building with mixed cigarettes and combustible paper products. The smoking area was not provided with an approved self-closing covered metal container for the disposal of cigarette butts and ashes in the area. The US FOIA (b)(6) provided a resident smoking policy that stated: "smoking area has been set up for smoking and appropriate cigarette disposal" and was dated 10/24/24. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 11/19/24 at 1:35 PM.	K 741	an audit to ensure that all ashtrays in the patio have metal receptable with self-closing lids. After audit results, all 8 ashtrays were replaced with compliant metal receptable with self-closing lid was placed in the smoking area for cigarette disposal 2. 20 residents were identified as being affected by the deficient practice. 3. RPOD educated the US FOIA (b)(6) and staff including the smoking monitor on standard NFPA 101:2012 Edition, Section 19.7.4. Weekly audit log will be completed by smoking monitor/designee to ensure proper metal receptable with self-closing lids are present. Findings will be submitted to the Administrator for review 4. The Maintenance Director/Designee will conduct weekly rounds x 6 months to ensure that the receptacle is used properly and that cigarette butts are not disposed of into plastic receptacles. Findings will be submitted to the Quality Assurance Committee quarterl x2.	
K 911 SS=F	NJAC 8:39-31.2(e) Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99	K 911		1/10/25

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K 911	Continued From page 15 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 11/18/24 and 11/19/24 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure the guarding of live parts of electrical equipment and controls within unlocked panels in resident accessible areas in accordance with NFPA 101: 2012 Edition, Section 19.5.1, 19.5.1.1, 9.1 and 9.1.2, NFPA 99: 2012 Edition, Sections 6.3.2.1 and 15.5.1.2 and NFPA 70: 2011 Edition, Sections 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas was observed for 3 of 7 open electrical panels, had the potential to 50 residents in the facility and was evidenced by the following: Observations on 11/18/24 from approximately 9:45 AM to 12:45 PM in the presence of the US FOIA (b)(6) revealed open electrical wall panels in the resident exit/egress corridors throughout the facility in the following areas: Floor #1 corridor by the Human Resources Office Floor #1 corridor by the elevator Floor #2 corridor by the ice machine across from RR 241 The observations were confirmed by the US FOIA (b)(6) during the tour of the facility.	K 911	1. Electrical panels that were not guarded against accidental contact have been secured. 2. All residents, staff and visitors have the potential to be affected by the deficient practice. Director of Maintenance or his designee will ensure that electrical wall panels located in resident exit/egress corridors are secured. 3. Administrator educated the Maintenance Staff to ensure that that electrical wall panels located in resident exit/egress corridors are secured and keys to properly lock the panels were purchased. 4. Maintenance Director/Designee will conduct monthly audits x 6 months of the of the electrical wall panels to ensure they are properly secured. Results of the audits will be reported in the quarterly QAPI Committee Meetings for 2 Quarters.	

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K 911	Continued From page 16 The Administrator was informed of findings at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 11/19/24 in the presence of the [redacted] it was determined that the facility failed to ensure that 1 of 10 electrical outlets located next to a water source was equipped with a Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and NFPA 99. This deficient practice had the potential to affect 10 residents was evidenced by the following: Observations at 12:02 PM, revealed in the Physical Therapy room that a Hydrocollator was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter	K 912	1. 1 of 10 electrical outlets, in the the physical therapy room that the Hydrocollator was plugged into was replaced with a 20-amp GCFI outlets by Miantenance staff 2. 10 residents have the potential to be affected by the deficient practice. 3. Administrator educated the Maintenance Staff to ensure that GFCI protected outlets	1/3/25

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K 912	Continued From page 17 (GFCI) electrical outlet for wet locations. The US FOIA (b)(6) confirmed the finding at the time of observation. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39 -31.2 (e) NFPA 70, 99	K 912	are installed in locations within 6 feet of a water source. Audit log was developed. The maintenance director will complete audit logs monthly to ensure GFCI outlets are located within 6 feet of a water source. Findings will be submitted to the Administrator for review. 4. Maintenance Director/Designee will conduct monthly audits x 6 months of outlets within 6 feet of water sources to ensure they are GFCI protected. Results of the audits will be reported in the quarterly Quality Assurance Committee X 2. The Quality Assurance Committee will determine the need for further action plans to ensure on-going compliance.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 11/19/24 in the	K 916	1. On 12/25/24 A contractor properly	12/25/24

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K 916	Continued From page 18 presence of the U.S. FOIA (b) (6) [redacted] it was determined that the facility failed to ensure that the facility's emergency rental generator since July 2024, was wired to the annunciator panel in accordance with NFPA 99: 2012 edition Sections 6.4.1.1.17 and 6.4.1.1.17.5. This deficient practice was observed for 1 of 1 rental generators, had the potential to affect all residents in the facility and was evidenced by the following: Observations at 11:45 AM revealed the generator annunciator panel at the floor-1 nurse station did not function when the U.S. FOIA (b) (6 activated the lamp test button. The panel remained blank. The U.S. FOIA (b) (6) was informed of the finding at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.2(e) NFPA 99	K 916	connected to a wired annunciator in a 24-hour monitored area in accordance with NFPA 99 2. All residents, staff and visitors have the potential to be affected by the deficient practice. 3. THe RPOD educated the US FOIA (b)(6) [redacted] on the importance to have annunciator present at all times. The Maintenance Director or designee will conduct monthly test of the annunciator panel to ensure proper communication and operation. Findings will be submitted to the Administrator for review 4. The Maintenance Director/Designee will conduct monthly conduct monthly audits x 6 months of the generator annunciator panels to confirm operation. Results of the audits will be reported in the quarterly Quality Assurance Committee x2. The Quality Assurance Committee will determine the need for further action plan(s) to ensure on- going compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		1/3/25

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K 918	Continued From page 19 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: Based on observation, interview and record review on 11/18/24 and 11/19/24 in the presence of the[redacted] it was determined the facility failed to ensure that the temporary rental generator was	K 918	1. The rental generator has received a wheel clamp lock on 1 wheel to ensure trailer remains in place at all times 2. All residents, staff and visitors have the	

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K 918	Continued From page 20 not installed on a mobile trailer in accordance with NFPA 70 and 110. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following: Observations on 11/18/24 at 10:45 AM, revealed on the exterior of the facility that there was a rental generator being used. The rental generator was wired into the main generator transfer switch and was observed to be on a 4-wheel mobile trailer. The trailer wheels were chocked in place to keep the generator from moving. In an interview at the time, the [redacted] indicated that the main facility generator was being serviced since July 2024. The [redacted] indicated he was unsure of the KW size of the rental generator. The [redacted] provided a "temporary generator use statement" dated 7/16/24 indicating the rental generator was in full compliance with state and federal regulations and was tied into the life-sustaining medical equipment as the facility has 10 vent beds. The [redacted] was informed of the finding at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39 -31.2 (c) NFPA 99, 110	K 918	potential to be affected by the deficient practice. 3. When the temporary generator is in use, wheels will be secured with locked wheel clampsto prevent unintended removal of the trailer. The maintenance director or designee will complete weekly audits while the temporary generator is present to ensure security measures are intact. Findings will be submitted to the Administrator for review 4. The Maintenance Director/designee will conduct weekly audits x 6 months (or until permanent generator is back in service [whichever comes first]) of the Temporary Generator security measures. Results of the audits will be reported in the quarterly Quality Assurance Committee Meetings x 2 . Quality Assurance Committee will determine the need for further action plans to ensure on-going compliance.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements	K 921		1/3/25

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K 921	Continued From page 21 The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 11/18/24 and 11/19/24 in the presence of the US FOIA (b)(6)), it was determined that the facility did not provide policies and protocols for patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record log of all required testing, test results and repairs in accordance with NFPA 99: 2012	K 921	1. Policies and protocols for Patient Care Related Electrical Equipment (PCREE) has been created, maintenance will be conducted annually of electrical equipment and facility will maintain a record log of all required testing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING **01** B. WING _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(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 921	Continued From page 22 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. The deficient practice had the potential to affect all residents and was evidenced by the following: In an interview, the inspection record and log of electric beds in the facility, policies and protocols for patient care related electrical equipment was requested. The US FOIA (b)(6) provided a log for patient care equipment, but no patient care equipment when observed had any stickers with the date of inspection. The US FOIA (b)(6) also stated that there were not policies and protocols for patient care related electrical equipment for the facility at this time. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 11/19/24 at 1:35 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	2. All residents, staff and visitors have the potential to be affected by the deficient practice. 3. Administrator in-serviced maintenance staff regarding the required testing and maintenance of PCREE. The Director of Maintenance will conduct monthly audits to test and label PCREE. The findings will be submitted to the Administrator for review 4. Maintenance Director/Designee will conduct monthly conduct monthly audits x 6 months to ensure all PCREE have been inspected and maintained per regulation. Results of the audits will be reported in the quarterly Quality Assurance Committee Meetings x2. The Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	

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
315317 Y1	A. Building B. Wing Y2	3/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

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 E0004 Reg. # 483.73(a) LSC	Correction Completed 01/03/2025	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	
11/19/2024	☐ 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
315317 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

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 K0222	01/03/2025	LSC K0281	01/10/2025	LSC K0345	01/10/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	12/01/2024	LSC K0741	01/03/2025	LSC K0911	01/10/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0912	01/03/2025	LSC K0916	12/25/2024	LSC K0918	01/03/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0921	01/03/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
11/19/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING 01 B. WING _____	R 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(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	{E 000}		
{K 000}	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction (POC) for the Life Safety Code Survey that was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/18/24 and 11/19/24. Excel Care at the Pines was found to not be in compliance 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. Excel Care at the Pines is a three story building that was built in 90's. It is composed of Type II protected construction. The facility is divided into 8- smoke zones. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The facility currently is utilizing a rental generator since July 2024. US FOIA (b)(6) [redacted] indicated on 11/18/24 that the rental generator is tied to the fire alarm control panel, cross corridor doors hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility was certified for 151 beds.	{K 000}		
{K 362} SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls	{K 362}		3/18/25

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

Electronically Signed | 04/01/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING **01** B. WING _____	R **03/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(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 362}	Continued From page 1 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on the offsite/desk review of the facility's Plan of Correction (POC) on 3/14/2025, it was determined that the facility failed to meet their POC compliance date of 1/28/2025 to ensure that corridor walls were constructed to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Sections 8.3.4.1, 19.3.6.2 and 19.3.6.2.7. The facility was cited during the 11/19/2024 Recertification survey that on the floor #3 corridor there was an approximately 18-inch by 18-inch wall installed. A wall vent was also observed on floor #2 and floor #1 in the same area. The inside of the vents were provided with a fusible link system, but it was undetermined if a smoke damper was installed to prevent a smoke	{K 362}	Please see the photos attached of the completed Dampers installation. The dampers were successfully installed on 3/18/2025. The fusible link was serviced on 3/18/2025. 1. A mechanical contractor was contacted to determined if a smoke damper was installed to prevent a smoke condition from involving all floors i.e.. the #1 floor; #2 floor and #3 corridor. The 18x18 vents on the 1st and 2nd floors will have the fusible link system serviced. The contractor has been hired and will complete the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. BUILDING **01** B. WING _____	R **03/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	**29 NORTH VERMONT AVE** **ATLANTIC CITY, NJ 08401**

(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 362}	Continued From page 2 condition from involving all floors. The facility submitted a POC on 12/12/2024 that alleged a mechanical contractor was hired and scheduled to be on-site to install smoke dampers and fusible links on 1/28/2025. The New Jersey Department of Health (NJ DOH) contacted the facility via email on 1/29/2025 to confirm the work was completed. The facility responded on 1/30/2025, via email, that they are awaiting a reply from the vendor because the part required needed to be custom built. The NJ DOH contacted the facility on 2/3/2025 regarding an estimated completion date. The facility responded on 2/14/2025 and stated that the parts were to be delivered on 2/17/2025 but that would not occur, and the facility did not know when the corrections would be completed.	{K 362}	installation of the dampers. 2. All residents, staff and visitors have the potential to be affected by the deficient practice. 3. THE RPOD educated the maintenance staff on the importance of ensuring monthly testing and maintenance are conducted in accordance with NFPA 101. Ventilation shafts in the facility will be inspected for compliant hardware and equipment. The Director of Maintenance/Designee will ensure monthly testing and maintenance are conducted in accordance with NFPA 101. Audit log was developed and audits will be conducted monthly. Any noted deficiencies will be forwarded to the administrator for review. 4. The maintenance Director/Designee will conduct monthly rounds x 6 months to ensure that ventilation servicing multiple floors resist the passage of smoke. Findings will be submitted to the Quality Assurance committee quarterly basis x 2. Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315317 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/1/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT THE PINES	29 NORTH VERMONT AVE ATLANTIC CITY, NJ 08401

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0362	Correction Completed 03/18/2025	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 11/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			