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 08/22/2023

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 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		9/30/23

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

Electronically Signed | 09/08/2023

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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E 037	Continued From page 1 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037		

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E 037	Continued From page 2 (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of the Emergency Preparedness Program binder and interviews with administrative staff it was determined that the facility failed to provide emergency preparedness training to all new and existing staff annually. This deficient practice affected all residents and was evidenced by the following: On 8/17/2023 at 8:50 AM, the surveyor began review of the facility's Emergency Preparedness Policies and Procedure manual which did not include evidence that the facility was providing emergency preparedness training to all new and existing staff annually. On 8/18/2023 at 12:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who was currently	E 037	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility staff were educated on emergency preparedness. No residents were adversely affected by the deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE	

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E 037	Continued From page 5 overseeing the Emergency Preparedness (EP) Manuel. At that time, the surveyor requested documentation for the training of all new and existing staff for Emergency Preparedness. On 8/21/2023, at 12:49 PM, the surveyor in the presence of the LNHA, the Director of Nursing, and the Clinical Vice President of Nursing (CVP) requested evidence that all new and existing staff were trained on Emergency Preparedness. On 8/22/2023 at 8:52 AM, the CVP brought a list of staff with incomplete signatures and stated that she was working on getting staff to sign off on EP training however she did not believe that she would be able to get all signatures before the end of the survey. At that time the CVP stated that she did not think that there was evidence of EP training for the previous year. A review of a facility policy titled "Staff Education" with a Plan date of 02/01/2022 revealed under the "Intent" section: "It is the policy of the facility to provide a Staff Education Plan in accordance with State and Federal Regulations." Under the "Procedure" section: 3. "The facility will ensure the staff education plan includes both pre-service and annual requirements." 4. "The staff education plan shall ensure that education is conducted annually for all facility employees at a minimum, in the following areas: ... b. Fire Prevention, emergency procedures-life safety, and disaster preparedness; d. Accident prevention and safety awareness programs; e. Resident Rights to include Advanced Directives; f. Osha Training-Biomedical Waste Plan and Blood borne pathogens." N.J.A.C. 8:39-31.2(e)	E 037	DOES NOT RECUR: Emergency preparedness training will be included in the yearly facility education fair. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or designee will conduct audits weekly for 4 weeks and then monthly for 2 months to ensure that all newly hired employees receive emergency preparedness training. The results of the audits will be presented by QAPI Committee for review to ensure continued compliance.	

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F 000	INITIAL COMMENTS Standard Survey C/O # NJ 147804, NJ 152356, NJ 153946, NJ 156511, NJ 158380 Census: 112 Sample Size: 25 + 3 closed records 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to provide reasonable accommodation of resident needs specifically by failing to ensure call devices were in reach of 2 of 6 residents (Residents #68 and Resident #23) reviewed under the Environmental Task. The deficient practice was evidenced by the following: A.) On 8/14/2023 at 9:44 AM, during the initial tour of the facility, Surveyor #1 observed Resident #68 asleep in bed. At that time, Surveyor #1 observed the call device on the floor adjacent to	F 558	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Residents # 68 and # 23 call bells were placed within their reach. Residents # 68 and # 23 were not adversely affected from this deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the deficient practice of not having call bells within reach. An initial	9/30/23

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F 558	Continued From page 7 the bed. On 8/15/2023 at 11:33 AM, Surveyor #1 observed Resident #68 asleep in bed. At that time, Surveyor #1 observed the call device on the floor adjacent to the bed. On 8/16/2023 at 8:40 AM, Surveyor #1 observed Resident #68 asleep in bed. At that time, Surveyor #1 observed the call device on the floor adjacent to the bed. On 8/17/2023 at 9:56 AM, Surveyor #1 observed Resident #68's call device on the floor adjacent to the bed. On the same date at 11:45 AM, Surveyor #1 in the company of the facility's Clinical Vice President (CVP) observed Resident #68 awake in bed. At that time, Surveyor #1 observed the call device on the floor. At that time, the CVP retrieved the call device from the floor and placed it on Resident #68's bed. Resident #68 said he/she had an additional call device. At that time, Resident #68 pointed towards the wall behind his/her bed near the privacy curtain. Surveyor #1 observed an additional call device attached via clip to the call device cord protruding from the wall input. The call device appeared out of reach from Resident #68. A review of Resident #68's Care Plan provided by the facility revealed a focus that Resident #68 was at Ex Order 26. 4B1 related to Ex Order 26. 4B1 during transition. The Care Plan included an intervention that revealed, "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to	F 558	audit was conducted to determine that all residents have a call bell within their reach. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Staff were in-serviced on the importance of ensuring that all residents always have their call bell within reach. The Director of Nursing, Administrator, and or supervisor will conduct inspections every morning to ensure all residents' call bells are within reach. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or designee will audit 5 residents□ rooms weekly for 4 weeks and then monthly for two months to ensure all residents□ call bells remain within reach. 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.	

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F 558	Continued From page 8 all requests for assistance." B.) On 8/14/2023 at 9:43 AM, during initial tour of the facility, Surveyor #2 observed Resident #23 in bed. At that time, Surveyor #2 observed the call device on the floor, and out of Resident #23's reach. On 8/16/2023 at 8:39 AM, Surveyor #2 observed Resident #23 in bed. At that time, Surveyor #2 observed the call device on the floor, and out of Resident #23's reach. On 8/17/2023 at 9:56 AM, Surveyor #2 observed Resident #23's call device on the floor, and out of his/her reach. On 8/16/2023 at 9:21 AM, during an interview with Surveyor #2, Resident #23 stated that he/she '*Ex Order 26. 4B1* [redacted] " On 8/21/2023 at 12:52 PM, during an interview with Surveyor #2, the Director of Nursing (DON) stated, "No" when asked if call device should be placed on the floor. When asked why a call device should not be on the floor, the DON replied, "Because it is not within patient's reach." A review of undated facility policy titled, "Call Lights" under the section "Procedure" indicated that, "6. Always position call light conveniently for use and within the reach of the resident." N.J.A.C. § 8:39-31.8 (c) (9)	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		9/30/23

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F 584	Continued From page 9 §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 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	F 584		

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F 584	Continued From page 10 sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to provide a A.) sanitary and orderly environment for 3 of 39 rooms on the second floor and various areas on the 3rd floor and B.) a homelike dining atmosphere for 2 of 2 floors, 2nd and 3rd. This deficient practice was evidenced by the following: A.) On 8/14/2023 at 9:44 AM, during the initial tour of the facility, Surveyor #1 entered room [NJ Exec. O]. A strong odor of [Ex Order 26.] emanated inside the room. Surveyor #1 observed a floor stain that appeared to be dried, brown liquid. On 8/14/2023 at 10:19 AM, during the initial tour of the facility, Surveyor #1 entered room [NJ Exec. O]. A strong odor of [Ex Order 26.] emanated from the room. On 8/15/2023 at 11:31 AM, Surveyor #1 entered room [NJ Exec. O]. A strong odor of [Ex Order 26.] continued to emanate from the room. At that time, Resident #27 who resides in the room told the surveyor that he/she was not wet with [Ex Order 26.]. On 8/16/2023 at 8:38 AM, Surveyor #1 entered room [NJ Exec. Ord]. A strong odor of [Ex Order 26.] continued to emanate from the room. At that time, Surveyor #1 observed Resident #27 who was in bed. Surveyor #1 did not observed any dampness to his/her bed sheets. On 8/16/2023 at 9:35 AM, Surveyor #1 entered room [NJ Exec. O]. Surveyor #1 observed dried, brown stains on the wall in the room. A single wheelchair leg rest was left on the floor near the bed. Behind	F 584	A. A. Sanitary and orderly environment 1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility worked on updating cleaning protocols, cleaning schedules, and educating the housekeeping department on proper cleaning procedures. The facility created a cleaning guide for all housekeepers to follow when cleaning common areas and residents' rooms. Rooms 252, 254, 258, and 361; the [Ex Order 26.] [redacted], and meditation cart identified were thoroughly cleaned immediately. The door post corners to rooms 352, 354, 356, 357, 358, 361, 362,363, and 364 were cleaned immediately. Third floor dining room window was cleaned, and screen was replaced. Over-bed-table missing side trim was removed from third-floor dining room. Side rails in room 359 were cleaned immediately. No residents were adversely affected by the deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. An initial audit was conducted to determine if other rooms are clean with equipment in good repair.	

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F 584	Continued From page 11 the head board of the bed was an insect glue trap on the floor. The glue trap had numerous insect carcasses on it. Also behind the head board was a hole in the dry wall. Underneath the bed on the floor was a partial piece of an Ex Order 26. 4B1 brief and an empty medicine cup. On 8/17/2023 at 11:06 AM during an interview with Surveyor #1, the housekeeper (HK #1) assigned to room NJ Exec. O and room NJ Exec. O said she cleans those rooms in the morning. She stated that a resident in room NJ Exec. O Ex Order 26. 4B1 behind the dresser and under the bed. She also stated that the residents from room NJ Exec. O and NJ Exec. O share a bathroom. She concluded saying the residents Ex Order 26. 4B1 "all over the bathroom." On 8/17/2023 at 11:40 AM during an interview with Surveyor #1, the Clinical Vice President (CVP) of the facility told the surveyor that two residents in room NJ Exec. O contribute to the smell in the room. The CVP informed the surveyor that Resident #27 refuses Ex Order 26. 4B1 care. On 8/21/2023 at 12:47 PM during an interview with Surveyor #1, the Licensed Nursing Home Administrator replied, "yes" when the surveyor asked if it was reasonable that room NJ Exec. O is not a sanitary environment. During the initial tour of the NJ Exec. Order 26:4.b.1 on 8/14/2023 at 10:28 AM, resident room NJ Exec. O had a strong Ex Order 26.1 odor. The floors were observed with black marks and debris. During a tour of the 3rd floor on 8/16/2023, Surveyor #2 observed the following: * observed in 3rd floor dining room window	F 584	3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The facility Administrator and Director of Housekeeping are actively seeking to hire staff to complete the housekeeping team. Systemic changes listed below: • Carbonization schedule for rooms was revised and updated. • Room cleaning guide implemented. Rooms cleaning guide as follows: o The facility will increase the frequency of cleaning rooms with residents who are known to have episodes of incontinence in not common areas. o The Housekeeping Director will conduct inspections every morning before morning meetings to identify cleanliness issues. o The facility will train staff in proper cleaning techniques, the use of cleaning products and the importance of infection control. Will train staff regularly to keep staff informed about the latest guidelines and best practices. o The Director of Housekeeping will keep detailed records of cleaning schedules, inspections, and any incidents related to cleanliness. 4. MONITORING OF CORRECTIVE ACTIONS Administrator or designee will conduct weekly audits of 6 rooms, for 4 weeks and then monthly for two months, to ensure that the facility remains sanitary and a homelike environment for the residents. The results of the audits will be presented	

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F 584	Continued From page 12 screen in last windows was ripped and the windows were observed to have white dry dots on them. * an over bed table in the dining room was observed to be missing side trim. The radiator cover had chipped wood and stained. * doorway corner for rooms 352, 354, 356, 357, 358, 361, 362, and 363 were dirty and had dust debris. * Geri chair in hallway with dust along bottom edge, arm rests ripped, upper top ripped bottom was dirty, hair was wound around wheels. * door frame room 364 was observed to be rusted where it meets the floor. The base board also had a rusted looking area. A pipe in the corner had chipped tile around base with rust marks on floor. * wheels on mechanical lift was observed with hair and debris wrapped around, medication cart wheels had hair wrapped around them. * elevator floor chipped at entrance. * room 361, 363, 365 had window blinds that were broken and bent. * room 354 and 359 floors had black marks. * room 359 side rails observed with dried tan debris. During an interview with the surveyor on 8/18/2023 at 11:54 AM, Licensed Practical Nurse (LPN #3) said we a have schedule for carbolization (deep cleaning of a room) of every room at least monthly. The wheelchairs are cleaned at least monthly and Geri chairs are also cleaned monthly. A review of the facility policy titled, "Resident Room Cleaning Procedure" under "Policy" revealed, "All rooms on all floors will be cleaned and disinfected using Pomona spray and	F 584	to the QAPI Committee quarterly for one quarter. The QAPI committee will determine if further audits are necessary. B. Homelike Dining Atmosphere 1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility implemented a homelike dining atmosphere immediately. The facility educated the dietary, recreation and nursing departments on homelike dining environment. The residents in the dining areas were served all items on the tray directly on the table. Meals were removed from the hot plates and placed directly on the table. All residents in dining rooms were provided with place mats. No residents were adversely affected by the deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the deficient practice. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The facility reviewed and updated the Dining Assistance/Observation policy to reflect changes to the dining experience for all residents participating in communal dining. Other systemic changes listed below: • Homelike dining experience	

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F 584	Continued From page 13 Disinfectant cleaner bathrooms, dressers, overbed tables, walls, will be cleaned and disinfected using the Pomona Spray." The policy further revealed under, "Procedure" that, "An AM tour will be conducted daily for each residents room on each floor in the facility, all rooms will be inspected to ensure that room is presentable before initially being cleaned (All trash will be pulled, floors will be checked for cleanliness, bathrooms, will be checked for soap, paper towel, and toilet paper, and bathroom will be checked for cleanliness." A review of the facility policy titled, "Safe Environment" dated 2/01/2023 revealed that, "It the policy of the facility to provide a safe and clean environment in accordance to State and Federal regulations." The policy further revealed, "5. The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public." B.) On 08/14/2023 at 12:19 PM, during lunch meal observation in the 3rd floor dining room, the surveyor observed 9 of 9 resident were served their meal on the tray and remained on the tray throughout the meal. On 08/16/2023 at 8:24 AM, during breakfast meal observation in the 3rd floor dining room, 6 of 6 residents in dining room were served meal on their tray and remained on the tray through out the meal. On 08/18/2023 at 8:20 AM, during breakfast meal observation in the 3rd floor dining room, 11 of 11 residents in dining room, were served their meal on the tray and the food remained on the tray through out the meal.	F 584	implemented in all dining areas. • Education provided to all departments involved in dining experience: • Serving all items in the tray directly on the table. • Assisting residents opening items as needed. • Proper hand wash for staff and residents during mealtimes. • Providing residents with proper chinaware and silverware. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or designee will conduct weekly audits for 4 weeks and then monthly for 2 months to ensure that proper dining experience is followed in all dining areas. 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.	

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F 584	Continued From page 14 During an interview with Surveyor #2 on 08/18/2023 at 8:34 AM, Certified Nursing Assistant (CNA #1) said was asked if the meal is left on the tray replied "all I can say always serve meal on tray and eat meal off tray in the dining room." During an interview with the surveyor on 8/18/2023 at 9:01 AM, Licensed Practical Nurse (LPN #2) when asked if residents are served their meal on trays and if the residents eat their meal off the tray responded "Yes." On 8/18/2023 at 9:08 AM, during a breakfast meal observation in 2 east dining room, 5 of 5 residents were served their meal on the tray and remained on the tray through out the meal. During an interview with Surveyor #2 on 8/18/2023 at 9:50 AM, the Director of Nursing (DON) said the process for serving meals in the dining rooms is when trays come up distribute tray in front of the patient. We offer assistance if they need. When asked if residents eat their meals off the trays, the DON responded "Yes, the residents eat their meal off the tray." A review of a facility policy titled Dining Assistance/Observation undated, did not include documentation regarding removing meal from the tray. NJAC 8:39-31.4 (a) NJAC 8:39-4(a)(12)	F 584		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		9/30/23

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F 689	Continued From page 15 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident's environment is free from accident hazards specifically by having unattended, unpackaged medications left in 2 of 2 rooms reviewed for Accidents. The deficient practice was evidenced by the following: On 8/14/2023 at 9:46 AM during the initial tour of the facility, the surveyor observed two tablets and one capsule left on the night stand between two resident beds in room [redacted]. On 8/16/2023 at 9:26 AM, the surveyor again observed two tablets and one capsule left on the night stand between two resident beds in room [redacted]. At that time, the surveyor showed Licensed Practical Nurse (LPN #1) the tablets and capsule. LPN #1 stated that she believed one of the tablets may be *Ex Order 26. 4B1* [redacted]. LPN #1 was unsure if the tablet and capsule belonged to a specific resident in room [redacted] On 8/18/2023 at 9:35 AM while in room [redacted], the surveyor observed an unattended, unpackaged white tablet on the top of a cabinet across from	F 689	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Medications were removed from bedside of resident #21 and room [redacted]. Resident #21 and residents in room [redacted] were not adversely affected from this deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. An initial audit was conducted to determine that no medications are left at bedside. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Nursing Staff were in-serviced and trained on the proper medication Administration process, with a focus on safety, emphasizing the need to keep medications out of reach from others who should not have access to them. The Director of Nursing will keep detailed records of medication administration	

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F 689	Continued From page 16 the resident's bed. Resident #21 who resided in the room, told the surveyor that the white tablet was medication that was dropped in the room at one point in time. On 8/21/2023 at 12:47 PM during an interview with the surveyor, the Director of Nursing replied, "No" when asked by the surveyor if medications should be left near the bedside. Further, the DON replied, "If it's left there." when the surveyor asked if she would consider medications left at the bedside a potential hazard. A review of the undated facility policy titled, "Medication Administration-General Guidelines" revealed under subheading, "Administration" that, "u. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR (Medication Administration Record), and action is taken as appropriate." N.J.A.C. § 8:39-29.4 (h)	F 689	competencies, inspections, and any incidents related to medication left at unattended. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or Designee will audit 5 residents□ rooms weekly for 4 weeks and then monthly for 2 months to ensure that no medication is left at bedside. 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.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to identify and	F 698	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY	9/30/23

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F 698	Continued From page 17 monitor a resident's Ex Order 26. 4B1 treatment access site. This deficient practice was identified for 1 of 1 residents reviewed for Ex Order 26. 4B1 (Resident #161) and was evidenced by the following: According to the Admission Record Resident # 161 was admitted to the facility with diagnoses including but not limited to: Ex Order 26. 4B1 . According to the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care, dated Ex Order 26. 4B1 revealed Resident #161 had a Ex Order 26. 4B1 score of /15 indicating Resident #161 was Ex Order 26. 4B1 . The MDs section indicated the Resident received Ex Order 26. 4B1 while a resident. A review of the Physician Order summary on Ex Order 26. 4B1 did not include a physician order to monitor the Ex Order 26. 4B1 . There was no documentation in the medical record that Resident #161's Ex Order 26. 4B1 was monitored. A review of the Care Plan did not indicate that the residents Ex Order 26. 4B1 was to be monitored. During an interview with the surveyor on 8/16/2023 at 9:24 AM, Resident # 161 said he/she goes to Ex Order 26. 4B1 three (3) times a week. During an interview with the surveyor on 8/17/2023 at 11:02 AM, Licensed Practical Nurse (LPN #2) said Ex Order 26. 4B1 residents have their	F 698	THE DEFICIENT PRACTICE: A new order was received and carried out to monitor Resident #161's Ex Order 26. 4B1 site every shift. Resident #161 was not adversely affected by this deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents on hemodialysis have the potential to be affected by this deficient practice. An initial audit was conducted to determine that all patients on hemodialysis have a physician's order and care plan to monitor the hemodialysis access point. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Comprehensive training was provided to all Nurses on the importance of monitoring hemodialysis access points on each shift for signs of infection, redness, swelling, or tenderness. Check for bruits and thrills to ensure proper blood flow. Ensure that the access site dressing is clean, intact, and dry. 4. MONITORING OF CORRECTIVE ACTIONS: DON or designee will conduct weekly audits of 2 hemodialysis patients for four weeks and then monthly for two months to ensure that all hemodialysis patients have physician's orders and care plans to monitor their dialysis access points. The	

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F 698	Continued From page 18 schedule and we have Ex Order 26. 4B1 communication book we give to the patient or ambulance driver. LPN #2 said we check when they come back if they have it (communication book) and this is where the Ex Order 26. 4B1 would write any recommendations. We have every shift vitals and Ex Order 26. 4B1 puts in vitals. LPN #2 further said Ex Order 26. 4B1 does resident weights and we have monthly weights but we go by Ex Order 26. 4B1 weights. We would also have a physician order to monitor access site. This would be done every shift. During an interview with the surveyor on 8/18/2023 at 10:40 AM, the Director of Nursing (DON) was asked what care do you provide for a Ex Order 26. 4B1 resident. The DON replied they (nurses) prepare them for schedule and it depends on time of schedule and we send brown bag meal if they leave early. They bring note book for communication and we instruct Ex Order 26. 4B1 to write any information and recommendations and labs. We transcribe the requests to the chart. When asked what are your expectations regarding *Ex Order 26. 4B1*, the DON responded "a physician order for patient to go to Ex Order 26. 4B1 and their schedule days and times. During assessment the admission nurse notes the Ex Order 26. 4B1 on the assessment. This also goes into physician orders and care plans to be clean, monitored, how often change the dressing." When asked if there should have been a physician order to check Resident #161's Ex Order 26. 4B1, the DON replied " Yes, It should have been in physician order and baseline care plan to monitor the Ex Order 26. 4B1." During a follow up interview withe the DON on 8/21/2023 at 1:04 PM, the DON confirmed that "Yes there should have been a physician order to	F 698	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.	

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F 698	Continued From page 19 monitor the *Ex Order 26. 4B1* ." NJAC 8:39-27.1(a)	F 698		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of 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 8/15/2023 from 8:25 to 9:03 AM, the surveyors, accompanied by the Food Service Director (FSD) and Regional Manager (RM),	F 812	1.1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All defrosted items that were not properly labeled and dated were discarded immediately. Expired food items found in the walk-in freezer were removed immediately. All other items were checked for expiration date. All food items in the walk-in freezer were labeled with proper	9/30/23

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F 812	Continued From page 20 observed the following in the kitchen: 1. On a middle shelf in the walk-in refrigerator a sheet pan contained 17 defrosted house shakes. The shakes had no pull date or manufacturer expiration date. The RM stated that the "shakes are good for 14 days after pulling from freezer to defrost." The RM agreed that there was no way to determine how long the house shake supplements were in the refrigerator. 2. On an upper shelf, an unopened gallon of whole milk had a "best if used by" date of 07/19/23. The FSD removed the expired gallon of milk to the trash. 3. On an upper shelf in the walk-in freezer (2) boxes covered with clear plastic contained frozen biscuits, according to the FSD and RM. The biscuits were removed from their original container and had no dates. On interview the FSD agreed that the biscuits should be dated when removed from the original container. On 08/16/2023 from 08:42 AM to 8:52 AM, the surveyor accompanied by Registered Nurse (RN #1), observed the following on the 2 West nurses station resident designated refrigerator: 1. Observation of the inside of the refrigerator designated for resident food and supplements revealed a plastic bag filled with what appeared to be chunks of watermelon. The watermelon appeared mushy, and the bag had no dates. In addition, a jar of Sauteed Shrimp Paste had been previously opened. The shrimp paste jar had no name, no dates and no manufacturers use by date. On the same shelf a plastic container, previously opened, contained strawberries. The	F 812	date. All food items in the refrigerator designated for residents were discarded immediately. Immediate education was provided to the dietary department staff regarding food labeling and checking expiration dates on all items on delivery dates. Immediate education was provided to the nursing department about food labeling for any food items placed in resident designated refrigerators. Labeling should include date and resident's initials. Dietary staff were educated immediately on the use of facial hair coverings. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the deficient practice. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Director of Dietary will review the DATING AND LABELING POLICY with all dietary staff. The Director of Dietary will audit labeling of all items in the walk-in fridge weekly. The Director of Dietary will review the HEALTHSHAKE STORAGE POLICY with all dietary staff. The Director of Dietary will inspect expiration dates on all food items on delivery date. The Director of Nursing or designee will review the OUTSIDE FOOD BROUGHT IN BY FAMILY/VISITOR TO PATIENTS/RESIDENTS POLICY with the nursing department. The Director of	

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F 812	Continued From page 21 strawberries had no date. On interview RN #1 stated that nursing staff were responsible for monitoring of the contents of the refrigerator. RN #1 removed all food products involved to the trash in the presence of the surveyor. On 08/16/2023 from 08:53 AM to 9:01 AM, the surveyor accompanied by Licensed Practical Nurse (LPN #1 and RN #2), observed the following on the 2 East nurses station designated resident refrigerator: 1. On a middle shelf a clear plastic bag contained an unidentified food substance. The unidentified food was double bagged and had no name and had no dates. According to RN #2 assigned to the 2 East nurses' station during an interview, "All food should be labeled with name and date. I will try and find out who this belongs to." On 8/17/2023 at 11:46 AM, the surveyors observed a kitchen dietary aide (DA) in the kitchen during the lunch meal tray line. The DA was observed to have a lengthy beard. The DA did not don a beard guard and the beard was exposed. On interview the RM agreed that the DA should don a beard guard while in the kitchen and handling food. The surveyor reviewed the facility policy titled [company name] DATING AND LABELING POLICY, date reviewed/revised 1.20.23. According to the POLICY, "The kitchen will ensure food safety by maintaining proper dates and labels for all ready-to-eat foods. The following was revealed under the heading PROCEDURE:	F 812	Nursing or designee will audit all resident designated fridges weekly to ensure resident food items are labeled and dated properly. The Director of Dietary and Administrator will review the UNIFORM POLICY with all departments regarding the/ use of hair nets and facial coverings when entering and exiting the kitchen area. 4. MONITORING OF CORRECTIVE ACTIONS: The Director of Dietary or designee will conduct weekly audit for 4 weeks and then monthly for 2 months to ensure proper labeling of all items in the walk-in fridge. The Director of Dietary or designee will conduct weekly audit weekly for 4 weeks and then monthly for 2 months to ensure all defrosted items are labeled properly. The Director of Nursing or designee will conduct weekly audit for 4 weeks and then monthly for 2 months to ensure all items in the refrigerators designated for residents are labeled and dated properly. 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.	

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F 812	Continued From page 22 2. All food items will be labeled with a received date upon acceptance of delivery. The vendor delivery date sticker on the case can also be used to identify when the product was delivered to the facility. 3. Follow the "CCS Labeling and Dating System Protocol" for all dating other than received date of all products. 4. Use a date gun, address label, or Black marker with legible writing to date and label products in accordance with the "CCS Labeling and Dating System Protocol." 5. Discard all foods that expire immediately. The surveyor reviewed the facility policy titled Health Shake Storage Policy, Rev 4.2023. The following was revealed under the heading Policy: "To ensure that all Health Shakes are properly stored and consumed within the proper period." The following was revealed under the heading Procedure: 3. All Health Shakes will be stickered with a 14-day usage sticker during the nourishment/snack production. 4. Once that 14th day is reached, if any Health Shakes are left, they will be discarded. The surveyor reviewed the facility policy titled Outside Food Brought in by Family/Visitor to Patients/Residents, effective date: 1/24/18. The following was revealed under the PROCEDURE heading: 1.2 Food items that require refrigeration must be	F 812		

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F 812	Continued From page 23 labeled with the patient/resident's name and the date the food was brought in. 1.4 Foods considered unsafe for human consumption or beyond the expiration date will be discarded by staff upon notification to patient/resident. 1.5 Food will be held in the refrigerator for three (3) days following the date on the label and will be discarded by staff upon notification to patient/resident. The surveyor reviewed the facility policy titled UNIFORM POLICY; date revised 5/27/2023. The following was revealed under the heading PROCEDURE: Facial hair coverings will be worn to cover any and all facial hair and to be taken off before leaving to transport or going into any other areas in the facility.	F 812		
F 880 SS=D	N.J.A.C. 18:39-17.2(g) 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	F 880		9/30/23

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F 880	Continued From page 24 program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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 §483.70(e) 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	F 880		

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F 880	Continued From page 25 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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, record review, and review of pertinent facility documentation, it was determined that the facility failed to use appropriate precautions to store respiratory equipment in order to prevent the risk of infection, specifically by not containing a Ex Order 26. 4B1 [redacted] mask and a Ex Order 26. 4B1 [redacted] mask in the appropriate manner increasing the risk of potential infection. The deficient practice was evident for 2 of 7 residents (Resident #21, #6) reviewed for Ex Order 26. 4B1 . The deficient practice was evidenced by the following: On 08/16/2023 at 09:35 AM while inside Resident #21's room, the surveyor observed a mask connected to a Ex Order 26. 4B1 left on top of a night stand adjacent to the resident's bed. The mask was not contained in a bag and left	F 880	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #21 is no longer in the facility, as he/she was discharged. The Ex Order 26. 4B1 mask and tubing for resident #21 were discarded. The Ex Order 26. 4B1 for resident #6 was cleaned. The Ex Order 26. 4B1 mask and tubing for resident #6 were replaced with new ones and placed in a new bag. Residents #6 and #21 were not adversely affected by this deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents on BiPAP/CPAP have the potential to be affected by this deficient practice. An audit was conducted to	

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F 880	Continued From page 26 exposed to the environment. The top of the nightstand contained a variety of items including but not limited to a dentures container, container of margarine/butter, batteries, and a cellular phone. On 08/18/2023 at 09:24 AM while inside Resident #21's room, the surveyor observed the mask connected to a *Ex Order 26. 4B1* left on top of a night stand adjacent to the resident's bed. The mask was not contained in a bag and left exposed to the environment. The top of the nightstand still contained a variety of items including but not limited to a dentures container, container of margarine/butter, batteries, and a cellular phone. A review of Resident #21's Discharge - Return Anticipated Minimum Data Set (MDS, an assessment tool) dated *Ex Order 26. 4B1* revealed under section "[redacted]" that Resident #21 had *Ex Order 26. 4B1* when sitting at rest. A review of Resident #21's Annual MDS dated *Ex Order 26. 4B1* revealed under section "[redacted]" that Resident #21 used a *Ex Order 26. 4B1* [redacted]. A review of Resident #21's physician's orders revealed an order dated *Ex Order 26. 4B1* for *Ex Order 26. 4B* [redacted] with *Ex Order 26. 4B1* mask at bedtime. A review of Resident #21's Care Plan with an initialed date of *Ex Order 26. 4B1* revealed a focus that stated, "*Ex Order 26. 4B1* [redacted]."	F 880	determine the cleanliness and proper storage of BiPAP/CPAP machines, masks, and tubing. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The nursing staff were in-serviced on the importance of maintaining BiPAP/CPAP cleanliness, proper mask, and tubing storage. The Director of Nursing will inspect daily for proper BIPAP/CPAP cleanliness and storage. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or designee will conduct audits of 5 BiPAP/CPAP weekly for 4 weeks and then monthly for two months to ensure that all respiratory equipment is stored properly. 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.	

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F 880	Continued From page 27 On 08/21/2023 at 09:55 AM during an interview with Surveyor #1, the Infection Preventionist (IP) stated, "Should be in a plastic bag" when asked by Surveyor #1 how should a *Ex Order 26. 4B1* be stored. During the same interview, the IP stated, "for infection" when asked by Surveyor #1 why should the *Ex Order 26. 4B1* be stored in a bag. On 08/21/2023 at 12:47 PM during an interview with Surveyor #1, the Director of Nursing (DON) stated, "Should be inside a zip-locked bag" when asked by Surveyor #1 how should a *Ex Order 26. 4B1* be stored when not in use. During the same interview, the DON stated, "Has to be in a zip-locked bag" when asked by Surveyor #1 if the *Ex Order 26. 4B1* should be uncovered on top of a night stand. Lastly, the DON replied, "To prevent infection" when Surveyor #1 asked why should the *Ex Order 26. 4B1* be covered and contained when not in use. A review of the facility policy titled, "CPAP/BiPAP Support" with a revised date of April, 2007 did not reveal information about storage of the equipment. N.J.A.C. § 8:39-19.4 (a) B.) On 08/15/2023 at 11:21 AM, Surveyor #2 observed a *Ex Order 26. 4B1* standing on Resident #6's night stand. The machine appeared to be dusty. *Ex Order 26. 4B1* mask and tubing were stored in a plastic bag dated *Ex Order 26. 4B1*. The *Ex Order 26. 4* mask appeared to	F 880		

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F 880	Continued From page 28 have discolored stains within the mask. An additional [redacted] mask with black head straps was hanging behind the headboard of Resident #6's bed. The mask was also appeared to be dust and not contained in a bag, and was exposed to the environment. On 08/16/2023 at 08:37 AM, Surveyor #2 observed the *Ex Order 26. 4B1* remining on Resident #6's night stand. The machine continued to appear dust. *Ex Order 26. 4B1* tubing and [redacted] mask were contained in a plastic bag dated *Ex Order 26. 4B1*. The [redacted] mask that was behind the headboard continued to appear dusty, not containd in a bag, and was exposed to the environment. On 08/17/2023 at 10:36 AM, Surveyor #2 observed the *Ex Order 26. 4B1* remining on Resident #6's night stand. The machine continued to appear dust. *Ex Order 26. 4B1* tubing and [redacted] mask were contained in a plastic bag dated *Ex Order 26. 4B1*. The [redacted] mask that was behind the headboard continued to appear dusty, not containd in a bag, and was exposed to the environment. On 08/18/2023 at 08:27 AM while inside Resident #6's room, Surveyor #2 observed the [redacted] remaining on the night stand. The machine continued to appear dusty. Equipment tubing and the [redacted] mask were contained in a plastic bag still dated *Ex Order 26. 4B1*. The [redacted] mask that was behind the headboard and continued to appear dusty, not containd in a bag, and was exposed to the environment. Additionally, clear liquid was noticed on the surface of the night stand, and underneath the *Ex Order 26. 4B1*.	F 880		

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F 880	Continued From page 29 On 08/21/2023 at 08:59 AM, the Ex Order 26. 4B1 remained on the resident's nightstand and continued to appear dusty. The tubing and Ex Order 26. 4 mask were stored in a plastic bag dated Ex Order 26. 4B1. The Ex Order 26 mask that was behind the headboard and continued to appear dusty, not containd in a bag, and was exposed to the environment. A review of Resident #6's Quarterly Minimum Data Set (a standardized assessment tool) dated Ex Order 26. 4B1 indicated in section "Ex O" that Resident #6 required Ex Order 26. 4B1. A review of Resident #6's Medical Diagnosis located in electronic medical record (EMR) revealed that Resident #6 had a diagnosis of Ex Order 26. 4B1 . A review of Resident #6's Physician's Orders located in the EMR revealed orders dated Ex Order 26. 4B1 for Ex Order 26. 4B1 settings and Ex Order 26. 4B1 at Ex Order 26. 4B1 via Ex Order 26. 4B1. A review of Resident #6's Care Plan located in the EMR dated Ex Order 26. 4B1 revealed a focus of 'Ex Order 26. 4B1 " On 08/15/2023 at 11:21 AM during an interview with Surveyor #2, Resident #6 stated that he/she was using the Ex Order 26. 4B1 at the Ex Order 26. 4B1, and currently he/she uses it at night. On 08/21/2023 at 09:03 AM, during an interview with Surveyor #2, the Infection Preventionist (IP) stated, "Ex Order 26. 4B1 should be in a plastic bag. It's for infections" when asked about how the facilty	F 880		

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F 880	Continued From page 30 stores [redacted] equipment. On 08/21/2023 at 09:06 AM, during an interview with Surveyor #2, Registered Nurse (RN) #3 stated, "[redacted] plastic bag should be changed every Sunday" when asked by Surveyor #2 how often the storage bag should be changed. RN #3 then stated that, "It is important to keep microorganisms away" when asked by Surveyor #2 why was it important to change the storage bag. At that time in Resident # 6's room, Surveyor #2 showed the *Ex Order 26. 4B1* to RN #3 along with the masks and tubing. At that time, RN #3 removed the [redacted] mask located behind the headboard and disposed of it in the trash container. RN #3 then stated, "He is not using the [redacted] mask anymore. He uses a *Ex Order 26. 4B1* mask now." RN#3 acknowledged that *Ex Order 26. 4B1* was dusty. On 08/21/2023 at 12:47 PM during interview with Surveyor #2, the Director of Nursing (DON) replied, "We don't have too many BiPAP patients. If resident needs it, it should be check if is clean enough to use. It should be cleaned probably three (3) times per week" when asked how often should the BiPAP mask, machine and filter be cleaned. The DON stated, "It should be inside a zip lock bag" when asked where should the mask be stored. Lastly, the DON replied, "Every Monday or as needed" when asked how often should the bag be changed. A review of the facility policy with a revision date of April 2007, and titled "CPAP/BiPAP Support" did not address storage, cleaning, or maintenance of BiPAP/CPAP equipment. A review of the 03/2023 dated facility policy titled	F 880		

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F 880	Continued From page 31 "Infection Control, Prevention and Surveillance Plan" revealed under "Mission and Goal", "1. Provide a safe, sanitary, and comfortable environment for residents, visitors, and staff." The policy further revealed under section titled "Scope", that "2. Implementation of Control Measures and Precautions: Basics such cleaning procedures, hand hygiene practices, and standard and transmission-based precautions."	F 880		
F 947 SS=D	N.J.A.C. § 8:39-19.4(k) Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility	F 947	1. 1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS	9/30/23

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F 947	Continued From page 32 failed to ensure 2 of 5 Certified Nursing Assistants (CNA #2 and CNA #3) received 12 hours of education annually. This deficient practice was evidenced by the following: The surveyor requested five (5) random CNA education files for the year 2022. A review of a facility form titled 2022 In-Service Log revealed the following; CNA #2 completed 11.5 hours. CNA #3 completed 8.5 hours. During an interview with the surveyor on 8/21/2023 at 1:09 PM, the Director of Nursing (DON) said the CNA should have 12 hours of education annually. When asked what topics are required to be covered, the DON responded we have a list. She further said "yes, Resident rights, abuse and neglect, Infection Control should be included. The surveyor asked who is responsible to ensure the CNA completes 12 hours of education annually and the DON replied Human Resources tracks to ensure they (CNA's) are getting 12 hours. A review of a facility policy titled Staff education with a Plan date of 02/01/2022 revealed under the Intent section: It is the policy of the facility to provide a Staff Education Plan in accordance with State and Federal Regulations. Under the Procedure section: 3. The facility will ensure the staff education plan includes both pre-service and annual requirements. NJAC 8:39-43.17(b)	F 947	FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: CNA #2 received the necessary education to complete 12 hours of mandatory education. CNA #3 received the necessary education to complete 12 hours of mandatory education. The facility reviewed the current process to ensure all nurses' aides are receiving the annual mandatory education. All nurse aides' education files were reviewed to ensure all 12 hours of mandatory education was completed. No residents were adversely affected by the deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The facility completed a comprehensive plan to include an education packet, the education packet covers all necessary topics to complete all 12 hours of mandatory education as per state regulations. An annual education fair will be held yearly to ensure completion of all mandatory education. 4. MONITORING OF CORRECTIVE ACTIONS: The Director of Nursing or designee will audit 5 nurse aides education files weekly for 4 weeks and then monthly for 2	

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(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 947	Continued From page 33	F 947	months to ensure all mandatory education is up to date. 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.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060103	A. BUILDING: _____ B. WING _____	C 08/22/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each 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: C/O # NJ158380, NJ156511 Based on interviews and review of pertinent 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.) 14 of 14 day shifts for the period of 07/30/2023 to 08/12/2023 and 2.) 3 of 7 day shifts for the period of 9/25/2022 to 10/1/2022 AND 3.) 5 of 7 day shifts for the period of 07/17/2022 to 07/23/2022. 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	S 560	1. 1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 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 hire CNA's, direct nursing staff include Aggressively running ads through various social media platforms, Utilization of employment application websites, and fostering partnerships with recruitment and employment agencies. No residents have been adversely affected by the deficient practice.	9/30/23

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

Electronically Signed | 09/08/23

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S 560	Continued From page 1 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. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (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. 1.) The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows for the period 07/30/2023 to 08/12/2023: -07/30/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -07/31/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/01/23 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/02/23 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/03/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/04/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/05/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/06/23 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs.	S 560	2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this situation. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Facility's 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 media platforms and employment application websites. • Flexible shifts and schedules. • Working with C.N.A. schools to recruit new grads. 4. MONITORING OF CORRECTIVE ACTIONS: The HR Director or designee will provide weekly reports to the Administrator regarding all efforts made to try to comply with the State's Staffing Ratios. Reports will be presented to the QAPI Committee quarterly for one quarter. The QAPI committee will determine if further reports	

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S 560	Continued From page 2 -08/07/23 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/08/23 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/09/23 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/10/23 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/11/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/12/23 had 8 CNAs for 112 residents on the day shift, required at least 14 CNAs. 2.) The facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows for the period of 9/25/2022 to 10/1/2022: -09/25/22 had 7 CNAs for 97 residents on the day shift, required at least 12 CNAs. -09/30/22 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -10/01/22 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. 3. The facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows 5 of 7 day shifts for the period of 07/17/2022 to 07/23/2022. : -07/17/22 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/18/22 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/19/22 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/20/22 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/22/22 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs.	S 560	are necessary.	

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S 560	Continued From page 3 On 8/18/23 at 8:28 AM, the surveyor interviewed the facility person responsible for staffing. The surveyor asked the staffing person if she was familiar with the minimum staffing requirements for nursing homes. The staffing person replied, "I am familiar. Day shift is 1 CNA to 8 residents, evening is 1 to 10 and night shift requires 1 employee for every 14 residents. Someday's we meet the requirement and some days we do not. We try our best." On 8/18/2023 at approximately 1:19 PM, the surveyor met with the facility administrative staff. The surveyor asked the administrative staff if they were meeting the minimum staffing requirements for nursing homes. The facility Director of Nursing stated, "Not regularly."	S 560		
S1160	8:39-13.4(c)(3) Mandatory Communication (c) At least one education training program each year shall be held for all employees on each of the following topics: 3. Resident rights; and This REQUIREMENT is not met as evidenced by: Based on interview and review of facility employee inservices records, it was determined that the facility failed to provide evidence that Certified Nursing Assistants (CNAs) received annual inservice training on the mandatory topic of resident rights. This deficient practice was identified for 5 of 5 CNA education files reviewed, and was evidenced by the following:	S1160	1. 1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were adversely affected by the deficient practice. The facility staff were educated on residents' rights.	9/30/23

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S1160	Continued From page 4 The surveyor requested five (5) random CNA education files for the calendar year of 2022. A review of the five education files did not include documentation that the CNA's received annual training for Resident Rights. During an interview with the surveyor on 08/21/23 at 1:09 PM, the Director of Nursing replied when asked what topics are required to be covered for CNA training, the DON responded we have a list. She further said "yes, Resident rights, abuse and neglect, Infection Control should be included. A review of a facility policy titled Staff education with a Plan date of 02/01/2022 revealed under the Intent section: It is the policy of the facility to provide a Staff Education Plan in accordance with State and Federal Regulations. Under the Procedure section: 3. The facility will ensure the staff education plan includes both pre-service and annual requirements. 4. The staff education plan shall ensure that education is conducted annually for all facility employees at a minimum, in the following areas: ... b. Fire Prevention, emergency procedures-life safety, and disaster preparedness; d. Accident prevention and safety awareness programs; e. Resident Rights to include Advanced Directives; f. Osha Training-Biomedical Waste Plan and Blood borne pathogens.	S1160	2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this situation. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Resident rights training will be included in the yearly facility education fair. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or designee will conduct audits weekly for 4 weeks and then monthly for 2 months to ensure that all employees receive resident' rights training. 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.	
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to	S1405		9/30/23

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S1405	Continued From page 5 complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files, it was determined that the facility failed to ensure that new employees had a physical examination during the required time frame. This deficient practice was identified for 1 of 10 new employee records reviewed and was evidenced by the following: Employee #9 was hired on Ex Order 26. 4B1. A review of the file revealed that Employee #9 did not receive a physical examination as required as part of the new hire process. During an interview with administration on 8/18/2023 at 8:21 AM, the surveyor asked if new employees and rehired employees require a physical examination as part of the new hire	S1405	1. 1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents have been adversely affected by the deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents in the facility have the potential to be affected by this deficient practice. Employee #9 received physical on Ex Order 26. 4B1. In addition, all files of Employees hired since Ex Order 26. 4B1 were reviewed for compliance.	

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S1405	Continued From page 6 process. Administration replied, "Of course, a new hire requires a physical as part of the new hire process. Even if an employee leaves employment and is rehired after 1 year it is considered a new hire and would require a physical as part of the new hire process."	S1405	3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR On 08/18/23, Administrator educated HRD on NJ 8:39-19.59(a). A new hire check list was developed to establish criteria for determining the timely completeness of physical examinations for employees. 4. MONITORING OF CORRECTIVE ACTIONS Administrator or designee will audit new hire files weekly for 4 weeks and then monthly for 2 months to ensure timely completeness of physical examinations. 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.	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:	S1410		9/30/23

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S1410	Continued From page 7 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that new employees consistently received the Mantoux tuberculin skin test (a test to check if a person has been infected with TB bacteria) upon hire as required. This deficient practice was identified in 1 of 10 new employee files reviewed (Employee #9) and is evidenced by the following: A review of Employee #9's file did not include documentation that she received step 1 or step 2 of the test upon hire on [redacted]. On interview on 8/18/2023 at 8:30 AM, the staff responsible for new hires was asked if new employees are required to have a 2-step Mantoux test. The staff responded, "Of course, a new hire requires a ppd (purified protein derivative, a skin test that determines if you have tuberculosis) and physical as part of the new hire process. Even if an employee leaves employment and is rehired after 1 year it is considered a new hire and would require a physical and 2 step ppd as part of the new hire process."	S1410	1. 1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents have been adversely affected by the deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents in the facility have the potential to be affected by this deficient practice. Employee #9 received [redacted] test on [redacted]. In addition, the files of Employees hired since [redacted] were reviewed for compliance. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR On 08/18/23, Administrator educated HRD on NJ 8:39-19.59(a). A new hire check list was developed to establish criteria for determining the timely completeness of employees' Mantoux testing.	

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S1410	Continued From page 8	S1410	4. MONITORING OF CORRECTIVE ACTIONS Administrator or designee will audit the new hire files weekly for 4 weeks and then monthly for 2 months to ensure timely completeness of Mantoux testing. 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.	

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	10/2/2023 Y3

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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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0689	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	09/30/2023	LSC	09/30/2023	LSC	09/30/2023
ID Prefix F0698	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	09/30/2023	LSC	09/30/2023	LSC	09/30/2023
ID Prefix F0947	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.95(g)(1)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/30/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/22/2023	☐ YES ☐ NO

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 09/30/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/22/2023	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315317	A. Building B. Wing	10/2/2023

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 E0037 Reg. # 483.73(d)(1) LSC	Correction Completed 09/30/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 8/22/2023	☐ 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	10/2/2023 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 E0037 Reg. # 483.73(d)(1) LSC	Correction Completed 09/30/2023	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 8/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060103	A. Building B. Wing	10/2/2023

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/30/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
8/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: G08G12

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060103 Y1	A. Building B. Wing Y2	10/2/2023 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 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	Correction	ID Prefix S1160	Correction	ID Prefix S1405	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-13.4(c)(3)	Completed	Reg. # 8:39-19.5(a)	Completed
LSC	09/30/2023	LSC	09/30/2023	LSC	09/30/2023
ID Prefix S1410	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-19.5(b)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/30/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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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?
8/22/2023	☐ YES ☐ NO

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 _____	**08/22/2023**

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	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/16/2023 and 08/17/2023 and Excel Care at the Pines was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupanci Excel Care at the Pines is a three story building that was built in 90's, It is composed of Type II protected. The facility is divided into 8- smoke zones. The facility currently has 2 generators. .	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/16/2023 and 08/17/2023, in the presence of facility management, it was determined that the facility failed to: Provide a battery backup emergency light above the two (2) emergency generator's transfer switches location, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following:	K 291	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A vendor will install a proper battery backup emergency light above the 2-emergency generator transfer switch in accordance with NFPA 101:2012-7.9,19.2.9.1 on September 30, 2023. 2. IDENTIFICATION OF RESIDENTS	9/30/23

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

Electronically Signed | 09/08/2023

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 _____	**08/22/2023**

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 291	Continued From page 1 On 08/16/2023 (day one of survey) during the survey entrance at approximately 8:46 AM, a request was made to the Senior Maintenance Director (SMD) if the facility had an Emergency Generator. The SMD told the surveyor, yes we have two Diesel Generators. On 08/17/2023 (day two of survey,) during the building tour at approximately 9:17 AM, an inspection outside of the building where the two emergency generator switches were located was performed. The surveyor observed no evidence of a battery backup emergency light that was independent of the generator's for the two generator transfer switches. At that time the surveyor asked the SMD, do you have a battery back up emergency light out here for the transfer switches. The SMD told the surveyor, no. The SMD confirmed the finding at the time of observation. On 08/17/2023 during the survey exit at approximately 10:50 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9 emergency generator's transfer switches location, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1.	K 291	WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents, staff and visitors have the potential to be affected by the deficient practice. Director of Maintenance will ensure that Battery backup emergency lighting will be installed in accordance with NFPA 101 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Director was educated by the Administrator on K921 definition and details. Director of Maintenance or designee will include observation of the designated emergency generators transfer switch locations to ensure safety and compliance when conducting weekly environmental rounds. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or Designee will conduct audits of all designated emergency generator transfer switches weekly for 4 weeks, then monthly for 2 months, to ensure that the continuous lighting need to meet code is in place. 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.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101	K 351		9/30/23

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 _____	**08/22/2023**

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 351	Continued From page 2 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 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 review of facility provided documentation on 08/16/2023 and 08/17/2023, in the presence of facility management it was determined that the Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 08/16/2023 (day one of survey) during the survey entrance at approximately 8:46 AM, a request was made to the Senior Maintenance	K 351	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE The Maintenance director installed the 1 escheon wring to sprinkler head inside closet of the 2nd floor Activities room. The Maintenance director corrected the 1-inch gap to the folding attic stairs inside the second-floor activities room to be sealed to not let heat bypass the fire sprinkler and for the sprinkler to function properly. The maintenance director mounted the 2x3 foot ceiling tile is in place in the vent unit staff lounge. This ensures the heat does not bypass the sprinkler and for the sprinkler to function properly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 3 Director (SMD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are two (2) buildings that are connected together the "East and West" buildings. The "East" building has three (3) floors with 46 Resident sleeping rooms and the "West" building has two (2) floors with 19 Resident sleeping rooms . Starting on 08/16/2023 at approximately 9:17 AM and continued on 08/17/2023, in the presence of the facility's SMD a tour of the facility was conducted. During the two (2) day tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 08/16/2023: 1) At approximately 11:16 AM, inside the 2nd. floor Activities room, the surveyor observed the one fire sprinkler inside the closet that was missing an escheon cap. This left an approximately one inch gap in the plywood ceiling. In the event of a fire this would allow the heat to by-pass the fire sprinkler and not function properly. 2) At approximately 11:18 AM, inside the second floor Activities room, the surveyor observed a set of folding attic stairs that did not close into its frame. This left an approximately one (1) inch gap in the ceiling. In the event of a fire this would allow the heat to by-pass the fire sprinkler and not function properly. On 08/17/2023:	K 351	2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents, staff and visitors have the potential to be affected by the deficient practice. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Administrator educated the Maintenance Department to ensure that automatic fire sprinkler system protection is functioning properly and that there no penetration in any areas throughout the building. The Maintenance Director will audit the presence of escheon wrings throughout the building monthly. The Maintenance Director will audit for gaps to be sealed to not let heat bypass the fire sprinkler throughout the facility monthly. The Maintenance Director will audit ceiling tiles monthly throughout the facility to ensure that heat does not bypass the sprinkler and for the sprinkler to function properly. 4. MONITORING OF CORRECTIVE ACTIONS: Maintenance Director or Designee will conduct monthly rounds for 5 months to ensure that automatic fire sprinkler system protection is installed with no interference. Findings will be presented to the QAPI Committee quarterly for one quarter. 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 _____	**08/22/2023**

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K 351	Continued From page 4 3) At approximately 9:33 AM, inside the Vent unit's staff lounge, the surveyor observed one two (2) feet by three (3) feet ceiling tile missing from the drop ceiling tracking. In the event of a fire this would allow the heat to by-pass the fire sprinkler in the room and the sprinkler would not function properly. The SMD confirmed the findings at the time of observations. On 08/17/2023 at approximately 10:50 AM during the survey exit , the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	QAPI committee will determine if further audits are necessary.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K 363		9/30/23

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K 363	Continued From page 5 with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 08/16/2023 and 08/17/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 34 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 08/16/2023 (day one of survey) during the survey entrance at approximately 8:46 AM, a request was made to the Senior Maintenance Director (SMD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.	K 363	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The maintenance director fixed the door latch on the door to room 357. This ensures the 7-inch gap is closed to not allow fire, smoke and poisonous gases to pass. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the deficient practice. Director of Maintenance made rounds to ensure	

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K 363	Continued From page 6 A review of the facility provided lay-out identified there are two (2) buildings that are connected together the "East and West" buildings. The "East" building has three (3) floors with 46 Resident sleeping rooms and the "West" building has two (2) floors with 19 Resident sleeping rooms . Starting on 08/16/2023 at approximately 9:17 AM and continued on 08/17/2023 in the presence of the facility's SMD, a tour of the facility was conducted. During the two (2) day tour of the facility the surveyor performed closure tests of the thirty-four (34) doors in the corridors with the following results, On 08/16/2023 at approximately 9:36 AM, in the East building 3rd. floor during a closure test of the corridor door leading into Resident room #357, the door did not latch into it's frame. This left an approximately seven (7) inch gap between the door and the frame. This test was repeated two additional times with the same results. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The SMD confirmed the finding at the time . The Administrator was informed of the findings at the Life Safety Code Exit conference on 08/17/2023 at approximately 10:50 AM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	that all room doors will close and latch. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The administrator educated the Maintenance Department to ensure that the facility is compliant in properly confining fire and smoke products and in properly defending occupants in place by making sure that all room doors will close and latch. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or Designee will conduct audits weekly for four weeks and then monthly for two months to ensure that all room doors will close and latch, so they are able to resist the passage of smoke, properly confine fire and smoke products and to properly defend occupants in place. 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.	
K 371 SS=E	Subdivision of Building Spaces - Smoke Compar	K 371		9/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 371	Continued From page 7 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 0816/2023, it was determined that the facility failed to provide at least two smoke compartments on each floor that did not exceed 22,500 square feet. This deficient practice was evidenced by the following: On 08/16/2023 (day one of survey) during the survey entrance at approximately 8:46 AM, a request was made to the Senior Maintenance Director (SMD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are two (2) buildings that are connected together the "East and West" buildings. The "East" building has three (3) floors with 46 Resident sleeping rooms between the three (3) floors and the "West" building has two (2) floors with 19 Resident sleeping rooms on the second floor. There are 8 smoke compartments in the facility.	K 371	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Maintenance director installed self-closing bars for the 2-bathroom doors in room # 217 and #219 to seal off as a smoke compartment. Residents were not adversely affected by the deficient practice. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents, staff and visitors have the potential to be affected by the deficient practice. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Administrator in-serviced the Maintenance Department	

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 _____	**08/22/2023**

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 371	Continued From page 8 Starting on 08/16/2023 at approximately 9:17 AM in the presence of the facility's SMD, a tour of the facility was conducted. During a test of the corridor double smoke doors between Resident rooms #217 and #219 the surveyor observed that the Resident room #217 was located one one side of the smoke doors and Resident room #219 was located on the other side. Further inspection identified that Resident rooms #217 and #219 shared a bathroom. The surveyor also observed that the two (2) corridor doors leading into the resident rooms and two (2) bathroom doors had no means to self-close. In the event of a fire in one smoke compartment the fire, smoke and poisonous gasses would pass through Resident rooms #217 and #219 into the other smoke compartment. The SMD confirmed the finding at the time of inspection. On 08/17/2023 at approximately 10:50 AM during the survey exit , the surveyor informed the Administrator of the deficiency.	K 371	on NFPA101; 19.3.71, 19.3.7.2 to ensure that all smoke compartment doors seal to ensure no smoke, fire, or poisonous gasses pass. The Maintenance Director audited the facility for two smoke compartments on each floor that did not exceed 22,500 square feet. 4. MONITORING OF CORRECTIVE ACTIONS: Administrator or designee will conduct audits weekly for four weeks and then monthly for two months to ensure that Smoke compartment doors close properly. 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.	
K 911 SS=D	NJAC 8:39 -31.1 (c) -31.2 (e) Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 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	K 911		9/30/23

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	315317	A. BUILDING **01** B. WING _____	**08/22/2023**

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K 911	Continued From page 9 citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 08/16/2023 and 08/17/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 6 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 08/16/2023 (day one of survey) during the	K 911	1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The maintenance director replaced the outlet to a GFCI hospital grade outlet in room # 212. 2. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents, staff and visitors have the potential to be affected by the deficient practice. 3. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Director was educated by the Administrator on K911 definition and details. The Director of Maintenance and/or designee will include observation of GFCI outlets to ensure safety and proper performance of all resident's rooms GFCI outlets when conducting daily environmental rounds. The Maintenance Director checked all the residents' rooms GFCI outlets to ensure safety and compliance with NFPA 10. 4. MONITORING OF CORRECTIVE ACTIONS: The Administrator or Designee will conduct audits of 5 residents' rooms GFCI	

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	315317	A. BUILDING **01** B. WING _____	**08/22/2023**

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K 911	Continued From page 10 survey entrance at approximately 8:46 AM, a request was made to the Senior Maintenance Director (SMD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are two (2) buildings that are connected together the "East and West" buildings. The "East" building has three (3) floors with 46 Resident sleeping rooms and the "West" building has two (2) floors with 19 Resident sleeping rooms . Starting on 08/16/2023 at approximately 9:17 AM and continued on 08/17/2023 in the presence of the facility's SMD, a tour of the facility was conducted. During the two (2) day building tour the of the facility the surveyor observed and tested six (6) electrical outlets in wet (with-in 6 feet of a sink) locations with one electrical outlet that failed to de-energize when tested in the following location. On 08/16/2023: 1. At approximately 10:41 AM, inside the West building 2nd. floor Nursing supply room (#212), one Quad electrical outlet located thirty-six (36) inches to the left of the sink when tested with a GFCI tester to de-energize, the Quad electrical outlet did not de-energize as required by code. The SMD confirmed the findings at the time of observations. On 08/17/2023 at approximately 10:50 AM during the survey exit, the surveyor informed the Administrator of the deficiency.	K 911	outlets weekly for 4 weeks then monthly for 2 months, to ensure that the residents CFCI outlets de-energize. 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 **01** B. WING _____	**08/22/2023**

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K 911	Continued From page 11 NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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	10/2/2023 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 K0291	09/30/2023	LSC K0351	09/30/2023	LSC K0363	09/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0371	09/30/2023	LSC K0911	09/30/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/22/2023	☐ YES ☐ NO