

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

PRINTED: 09/29/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2022
NAME OF PROVIDER OR SUPPLIER PINE ACRES CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 51 MADISON AVE MADISON, NJ 07940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>Survey date: 1/21/2022</p> <p>Census: 83</p> <p>Sample: 5</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

01/26/2022

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061413	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2022
NAME OF PROVIDER OR SUPPLIER PINE ACRES CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 51 MADISON AVE MADISON, NJ 07940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities, infection control regulations and has implemented Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 1/21/22 Census: 83	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview 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 10 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ The staffing coordinator was educated on the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. ¿ The facility will continue to reach out to existing staff to see if they want to pick up overtime shifts and continue to try and staff accordingly	2/28/22

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

TITLE

(X6) DATE

Electronically Signed

01/26/22

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061413	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2022
NAME OF PROVIDER OR SUPPLIER PINE ACRES CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 51 MADISON AVE MADISON, NJ 07940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	<p>Continued From page 1</p> <p>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:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>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</p> <p>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.</p> <p>During entrance conference on 1/21/22 at 9:41 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), informed the survey team that the facility was currently experiencing no staffing shortages and that the facility used Agency contracted staff as needed to cover shifts.</p> <p>On 1/21/22 at 12:30 PM, the DON in the presence of the LNHA, informed the surveyor that the facility also used waivers for Temporary Nursing Assistants (TNA) to aide with CNA staffing.</p> <p>As per the "Nurse Staffing Report" completed by the facility for the weeks of 1/2/22 to 1/8/22 and 1/9/22 to 1/15/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as</p>	S 560	<p>How the Facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>¿ All residents have the ability to be affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur?</p> <p>¿ The facility will continue to post job openings on job sites to promote CNA openings</p> <p>¿ The facility is offering a sign on bonus</p> <p>¿ The facility has contracted with agency to assist with our staffing needs</p> <p>¿ The staffing coordinator/designee will offer staff the ability to pick up more shifts by placing a "pick up shift sheet" on each unit.</p> <p>¿ The facility has partnered with a cna school to use the facilities as a training site and to recruit new grads.</p> <p>¿ The administrator/designee will review the daily staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter.</p>	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061413	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2022
NAME OF PROVIDER OR SUPPLIER PINE ACRES CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 51 MADISON AVE MADISON, NJ 07940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 documented below: 01/02/22 had 7 CNAs for 83 residents on the day shift, required 11 CNAs. 01/03/22 had 9 CNAs for 82 residents on the day shift, required 11 CNAs. 01/04/22 had 9 CNAs for 82 residents on the day shift, required 11 CNAs. 01/09/22 had 9 CNAs for 83 residents on the day shift, required 11 CNAs. 01/10/22 had 8 CNAs for 83 residents on the day shift, required 11 CNAs. 01/11/22 had 8 CNAs for 83 residents on the day shift, required 11 CNAs. 01/12/22 had 10 CNAs for 83 residents on the day shift, required 11 CNAs. 01/13/22 had 10 CNAs for 83 residents on the day shift, required 11 CNAs. 01/14/22 had 9 CNAs for 80 residents on the day shift, required 10 CNAs. 01/15/22 had 7 CNAs for 80 residents on the day shift, required 10 CNAs. NJAC 8:39-5.1(a)	S 560	How the Facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place? ¿ The Administrator/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	