STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	**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
E 000	Initial Comments This facility is 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		
F 000	INITIAL COMMENTS Complaint #s: NJ173552, NJ173390, NJ170602, NJ166036, NJ163429 Survey Dates: 08/26/2024 through 8/30/2024 Census: 85 Sample Size: 18 + 2 closed records A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with the federal guidelines for 1 of 19 residents (Resident	F 641	How the corrective actions will be accomplished for those residents found to have been affected: Resident #75 had a modification completed for the MDS with ARD of [redacted] NJ Exec Order 26 .	9/22/24

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

Electronically Signed | 09/20/2024

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

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F 641	Continued From page 1 #75) reviewed for the accuracy of MDS completion. The deficient practice was evidenced by the following: On 08/26/24, at 09:05 AM, the surveyor observed Resident #75 seated in bed eating their meal. On 08/27/24 at 12:54 PM, the surveyor reviewed Resident #75's electronic medical record, which revealed the following information: According to the Admission Record (an admission summary), Resident #75 was admitted to the facility with diagnoses that included but were not limited to unspecified [redacted] A review of the Admission MDS (A/MDS), dated [redacted], reflected that the resident had a Brief Interview for Mental Status score of [redacted], indicating that the resident had [redacted] Further review of the A/MDS "Section N. Medications" under [redacted] Use and Indication 1. Is taking - Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days ...." 1. Is taking A. [redacted] was checked indicating that the resident used an [redacted]. Further review of the A/MDS under "Section [redacted] Review A. Did the resident receive [redacted] since admission or reentry or the prior OBRA assessment, whichever is more recent?" indicated [redacted] were not received."	F 641	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. An audit was conducted of the MDS section N0450 for all current residents with clinical record reviews during the most recent look back period to ensure accuracy. No issues with MDS accuracy were noted during the facility audit of section N0450. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The corporate MDS nurse re-inserviced the [redacted] on the importance of the accuracy of assessments. Prior to closing of the MDS, the MDS coordinator will validate the accuracy of section N0450 with a clinical record review during the look back period to ensure accuracy. The MDS coordinator/Designee will perform a QAPI reviewing the accuracy of section N0450 with a clinical record review during the look back period to ensure 100% accuracy. The audit will be done weekly for 4 weeks until there is 100% compliance, then 50% of MDS will be audited for 4 weeks, until there is 100% compliance, then 25% of the MDS will be audited for 4 weeks. If there is not 100% compliance, the QAPI will be continued.	

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F 641	Continued From page 2 A review of the NJ Exec Order 26.4b1 Order Summary Report revealed a physician's order (PO) dated NJ Exec Order 26.4 for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) Give 1 tablet by mouth at bedtime" which was an NJ Exec Order 26.4b1 . A review of the NJ Exec Order 26.4b1 Medication Administration Record revealed a PO indicating a start date of NJ Exec Order 26.4 for, 'NJ Exec Order 26.4b1 give 1 tablet by mouth at bedtime". The medication was signed as administered on NJ Exec Order 26.4b1 . On 08/28/24 at 11:30 AM, the surveyor interviewed the U.S. FOIA (b)(6) who worked part-time as a U.S. FOIA (b)(6) The part-time U.S. FOIA (b)(6) stated that she missed to code the medication to reflect in the U.S. FOIA (b)(6) . The U.S. FOIA (b)(6) added that they follow the Resident Assessment Instrument (RAI) Manual for guidance. The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) RAI Version 3.0 Manual, updated October 2023. The RAI manual revealed under Chapter 3, page N-14, "Any medication that has a pharmacological classification or therapeutic category of NJ Exec Order 26.4b1 medication must be recorded in this section, regardless of why the medication is being used." On 08/29/24 at 01:07 PM, the survey team met with the U.S. FOIA (b)(6) and discussed the above concern. No further information was provided.	F 641	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The MDS coordinator/Designee will report the outcome of the audits to the QAPI team quarterly, with follow up as necessary.	

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F 641	Continued From page 3 NJAC 8:39-33.2(c)2, (d)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		9/22/24

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F 656	Continued From page 4 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a person-centered comprehensive care plan (CP) to meet the resident's needs. This deficient practice was observed for 2 of 19 residents reviewed, Resident #30 and #15, as evidenced by the following: 1. On 08/26/24 at 08:22 AM, the surveyor observed Resident #30 in the dining room eating, using their NJ Exec Order 26.4b1 The resident stated to the surveyor that their NJ Exec Order 26.4b1. The resident further stated that the facility provided something for their NJ Exec Order 26.4b1, but they NJ Exec Order 26.4 to wear it. On 08/27/24 at 10:05 AM, the surveyor interviewed the Certified Nurse Assistant #2 (CNA#2) who was assigned to Resident #30. CNA #2 stated the resident used the NJ Exec Order 26.4b most of the time due to the NJ Exec Order 26.4b1 On 08/27/24 at 12:01 PM, the surveyor interviewed the Licensed Practical Nurse #3 (LPN#3) assigned to Resident #30, who stated	F 656	How the corrective actions will be accomplished for those residents found to have been affected: Resident #30 had a care plan completed for NJ Exec Order 26.4b1. Resident #15 had a care plan completed for use of NJ Exec Order 26.4b1. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. An audit was conducted for all current residents using splints to ensure appropriate care plans were in place. No other residents were missing care plans for splints. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: Education on developing comprehensive care plans was conducted for all nurses who complete, revise, or update care plans.	

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F 656	Continued From page 5 that the resident NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the electronic record medical record which revealed the following: According to the Admission Record (an admission summary) (AR), Resident #30 was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of the Quarterly Minimum Data Set (an assessment tool used to facilitate the management of care) (Q/MDS), dated NJ Exec Order 26.4 [redacted], revealed in Section C. NJ Exec Order 26.4b1 that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 [redacted], indicating NJ Exec Orde [redacted]. Further review of Q/MDS revealed "Section GG - NJ Exec Order 26.4b1 [redacted], A. NJ Exec Order 26.4b1 [redacted] 1. NJ Exec Order 26.4b1 . B. NJ Exec Order [redacted] 1. 1. [redacted] The surveyor reviewed Resident #30's comprehensive CP which did not reflect the resident's NJ Exec Order 26.4b1 [redacted] 2. On 08/26/24 at 08:40 AM, the surveyor observed Resident #15 in bed with eyes closed. On 08/28/24 at 11:11 AM, the surveyor interviewed CNA#1, who stated that the resident	F 656	All splint use will be discussed at clinical care meetings, and appropriate care plan will be initiated or updated at that time. The Director of Nursing/Designee will perform a QAPI reviewing the care plans for all residents with orders for splints, and all residents refusing to use splints. The audit will be done weekly for 4 weeks, then monthly for 3 months, then quarterly thereafter until there is 100% compliance. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of nursing/Designee will report the outcome of the audits to the QAPI team quarterly, with follow up as necessary.	

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F 656	Continued From page 6 had a NJ Exec Order 26.4b1 and CNA #1 removed it at the start of her shift at 7AM. On 08/28/24 at 11:20 AM, the surveyor interviewed LPN#1, who confirmed to the surveyor that the resident had a physician's order for a NJ Exec Order 26.4b1 . The surveyor reviewed the electronic record medical record that revealed the following: According to the AR, Resident #15 was admitted to the facility with diagnoses that included but were not limited to other NJ Exec Order 26.4b1 A review of the Q/MDS, dated NJ Exec Order, revealed in Section NJ Exec Order 26.4b1 the resident had a BIMS score of NJ Exe, indicating NJ Exec Order 26.4b1 . A review of the NJ Exec Order 26.4b1 Order Summary Report revealed a PO dated NJ Exec Order 26.4b to "Apply NJ Exec Order 26.4b1 to wear up to NJ Exec Order 26.4b1 Monitor NJ Exec O daily and remove if NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1. Every night shift for NJ Exec Order 26.4b1." A review of the Progress Notes dated NJ Exec Order 26.4b, documented NJ Exec Order 26.4b1 in place per orders." The surveyor reviewed the residents' comprehensive CP which did not reflect the resident's use of NJ Exec Order 26.4b1 . A review of the facility's policy and procedure with a review date of 01/2024 titled "Care Plans" under	F 656		

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F 656	Continued From page 7 "Policy" revealed that: "A comprehensive care plan will be developed for each resident within seven (7) days of completion of resident assessment. The care plan must include measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs as identified in the comprehensive assessment. The Interdisciplinary Team shall develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on comprehensive assessment." On 08/29/24 at 01:07 PM, the survey team met with the[U.S. FOIA (b)(6) [redacted] and discussed the above concern. No further information was provided.	F 656		
F 836 SS=C	NJAC 8:39-11.2 (e) License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	F 836		9/22/24

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F 836	Continued From page 8 §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. 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 notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in facility name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and	F 836	How the corrective actions will be accomplished for those residents found to have been affected: The building has started the process and has filled out CMS 855A to ensure that the CMS license matches our logo, and all signage. No residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure the	

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F 836	Continued From page 9 maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location.	F 836	deficient practice will not recur: The VP of Operations educated the US FOIA (b)(6) on ensuring the proper licensing credentials are in place for the facility. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Administrator/designee will conduct an audit of all licensing credentials for the facility monthly. The results of the Administrators audits will be brought to the QAPI team quarterly	

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F 836	Continued From page 10 (2) All other changes in enrollment must be reported within 90 days." On 8/26/24 at 7:30 AM, upon arrival of the surveyors to the facility, the surveyor observed a signage outside the facility that stated, "Pine Acres Rehab + Healthcare" outside the building and had a name that did not correspond with the CMS licensed, approved name and provider registered name "Pine Acres Convalescent Center." On 08/26/24 at 09:44 AM, the surveyor met with the U.S. FOIA (b)(6) [redacted] ng for Entrance Conference. On 8/26/24 at 11:30 AM, the surveyor reviewed various documents and facility policies that were provided by the [redacted] that were titled, "Pine Acres Rehab + Healthcare." A review of the facility Admission agreement revealed under the facility name section as "Pine Acres Rehabilitation and Health Care Center". The Business cards provided to the surveyors upon entrance reflected the facility name as "Pine Acres Rehab + Healthcare." On 08/29/24 1:06 PM, the surveyor met with the U.S. FOIA (b)(6) [redacted] to discuss the above noted documents did not match the documentation according to what they were licensed for. On 8/30/24 at 9:10 AM, the surveyor met with the	F 836		

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F 836	Continued From page 11 NJ Exec Order who explained that the facility is called Pine Acres Convalescent Center, and the facility didn't change their name. The surveyor asked if the facility had filed a 855B form to CMS and the U.S. FOIA (b)(6) explained that they have not done the 855B form. A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of June 11, 2024, and an expiration date of August 31, 2025 revealed the name licensed to operate was "Pine Acres Convalescent Center" and not "Pine Acres Rehab + Healthcare."	F 836		
F 880 SS=D	NJAC 8:39-5.1 (a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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	F 880		9/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	**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 880	Continued From page 12 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 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	F 880		

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F 880	Continued From page 13 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to a.) follow appropriate hand hygiene practices to prevent the potential spread of infection observed during care for Resident #15 and b.) provide [redacted] in a sanitary manner for 1 of 2 for Resident #59. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site for the same patient, After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. A review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Clean Hands Count for Healthcare Providers, reviewed 1/8/2021, included, "When cleaning your hands	F 880	How the corrective actions will be accomplished for those residents found to have been affected: CNA #1 was immediately re-in-serviced by the Infection prevention nurse on hand hygiene. CNA #1 was immediately re in-serviced by the Infection prevention nurse on the proper storage of [redacted] when not in use. Resident #15 had [redacted] from above. Resident #59 was given a [redacted] and had no negative effect. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: All staff have been re-in-serviced on the hand hygiene and infection control protocols by the Infection prevention nurse All staff have been re-in-serviced by the infection prevention nurse on the proper	

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F 880	Continued From page 14 with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry." 1. On 8/28/24 at 11:11 AM, the surveyor in the presence of the Certified Nursing Assistant #1 (CNA#1) went inside the resident's room to see Resident #15. CNA #1 donned a new pair of clean gloves and touched resident's blanket. After CNA #1 put the blanket in place, CNA#1 then removed her used gloves and discarded them in the garbage bin. The surveyor observed CNA #1 walked outside the resident's room without performing any hand hygiene or use of ABHR. The surveyor also observed CNA #1 placed her hand inside her pocket. CNA#1 went inside another resident's room to perform hand hygiene when the surveyor observed CNA #1 lathered her hands for a total of eight (8) seconds. During the interview, CNA #1 stated to the surveyor that handwashing must be at least 40-60 seconds. CNA #1 further stated that she should have performed hand hygiene after removing the gloves. On 08/29/24 at 09:25 AM, the surveyor interviewed the facility's [redacted], who stated that the staff were in serviced regarding hand washing. The [redacted] confirmed that CNA #1 should have performed hand hygiene after removing the gloves. On 08/29/24 at 01:07 PM, the survey team met	F 880	storage of urinary catheter bags when not in use. The Infection Prevention Nurse/Designee will perform 3 hand hygiene observations on each shift at least once per week The Infection Prevention Nurse/Designee will report the trends from these observations to the Director of Nursing, with follow up as necessary The infection prevention nurse/designee will report the trends from these observations to the QAPI team quarterly. The Infection prevention nurse/designee will perform audits 3 days per week including all three shifts on proper storage of urinary catheter bags The Infection prevention nurse/designees will report the trends from these observations to the Director of nursing monthly with follow up as necessary. The Infection prevention nurse/designee will report the trends from these audits to the QAPI team quarterly. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Infection Prevention Nurse/Designee will report trends and any necessary follow up actions quarterly to the Quality Assurance Committee, with further follow up actions	

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F 880		F 880		

Continued From page 15

with the[U.S. FOIA (b)(6) redacted] and discussed the above concern. No further information was provided.

A review of the facility's Policy titled, "Handwashing/Hand Hygiene" with a review date of 01/2024 provided by LNHA revealed under procedure: "1. d. After removing gloves" and under Washing Hands" stated "1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for twenty (20) seconds under a moderate stream of running water, at a comfortable temperature."

2. On 8/26/24 at 9:00 AM, the surveyor observed Resident #59 in their room seated in a wheelchair eating breakfast. The surveyor observed the bathroom and found a[NJ Exec Order 26.4b1 redacted] with[NJ Exec Order redacted] present in the[NJ Exec Order redacted] hanging on to the rail next to the toilet. The[NJ Exec Order redacted] was not in a plastic bag and the end of the[NJ Exec Order 26.4b1] was[NJ Exec Order 26.4b1 redacted].

A review of the AR reflected Resident #59 was admitted to the facility on[NJ Exec Order redacted], with diagnoses that included[NJ Exec Order 26.4b1 redacted]

A review of the Annual Minimum Data Set, an assessment tool dated[NJ Exec Order redacted], reflected a brief interview for mental status (BIMS) score of[NJ Exec Order redacted] which indicated[NJ Exec Order 26.4b1]. Further

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F 880	Continued From page 16 review revealed in Section H. NJ Exec Order 26.4b1 the resident had an NJ Exec Order 26.4b1 . A review of the NJ Exec Order 26.4b1 Physician Orders Summary Report revealed a physician's order dated NJ Exec Order 26, to NJ Exec Order 26.4b1 to a NJ Exec Order 26.4b1 while out of bed daily. A review of the individual person-centered care plan CP revealed that the resident was at risk for NJ Exec Order 26.4b1 and was placed on an enhanced barrier precautions (NJ Exec Order 26.4b1 in nursing homes) related to the use of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 reflected a goal which included, the resident would not contract NJ Exec Order 26 Some of the CP interventions included but not limited to implement the use of gown and gloves for high contact care activities such as NJ Exec Order 2 care for NJ Exec Order 26.4b1 . On 8/26/24 at 9:20 AM, the surveyor interviewed Resident #59's CNA#1 who stated that she performed the resident's care. CNA #1 further stated that the resident had an NJ Exec Order 26.4b1 , and she removed the NJ Exec Order 26.4b1 , placed a NJ Exec Order 26 on the resident and stored the NJ Exec Order 26.4b1 in the bathroom. The surveyor showed CNA #1 the NJ Exec Order 26.4b1 and she stated that she omitted the plastic bag and the NJ Exec Order 26 bag should not be hung in the bathroom that way. On 8/26/24 at 9:30, the surveyor interviewed Licensed Practical Nurse (LPN#2) who stated that the NJ Exec Order 26.4b1 should not be NJ Exec Orc on the	F 880		

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F 880	Continued From page 17 handrail in the bathroom and must be placed in a plastic bag when removed. On 8/28/24 at 12:50 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated the [NJ Exec Order 26.4b1] was changed weekly, washed daily and stored in a plastic bag in the bathroom. The [U.S. FOIA (b)(6)] further stated that the [U.S. FOIA (b)] must clean the [NJ Exec Order 26.4b] with an alcohol pad and then place a blue cap at the end of the [NJ Exec Order 26.4b] to prevent any contamination. On 08/29/24 at 01:07 PM, the survey team met with the [US FOIA (b)(6)] and discussed the above concern. No further information was provided. The surveyor reviewed the facility's policy titled, "Care and Maintenance of Foley Drainage System" dated 11/23, which revealed when the drainage bag was not it use the facility will clean the bag by rinsing the bag out with water and capped and place in a plastic bag and be hung in the resident's bathroom for later use. NJAC 8:39-19.4(a) (n)	F 880		

New Jersey Department of Health

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	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: Complaint #'s: NJ166036 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18	S 560	How the corrective actions will be accomplished for those residents found to have been affected: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Facility will utilize staffing agencies to fill open positions. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. The Administrator re-educated the staffing manager on the importance of being in	9/22/24

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

Electronically Signed | 09/20/24

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S 560	Continued From page 1 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than	S 560	compliance with S560. Continuous efforts will be made to hire and fill the open positions. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: A QAPI was started to address ongoing staffing challenges for the day shift Contracts with additional staffing agencies have been secured to supplement facility staff. Hiring and recruitment efforts continue, including job fairs, sign on bonuses, referral bonuses, weekend bonuses, and differentials. Pine Acres is working with multiple CNA schools to direct hire after they complete their clinicals. Pine Acres is working with various colleges to make nursing students aware they are able to work as CNA's after completing nursing 101. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of nursing/designee will review staffing schedules weekly to ensure adequate staffing is maintained for all shifts. The results of the Director of nursing reviews will be brought to the QAPI team quarterly	

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S 560	Continued From page 2 a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period of complaint staffing beginning on 7/23/2023 and ending 7/29/2023 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 7 of 7-day shifts, as follows: -07/23/23 had 8 CNAs for 80 residents on the day shift, required at least 10 CNAs. -07/24/23 had 7 CNAs for 80 residents on the day shift, required at least 10 CNAs. -07/25/23 had 8 CNAs for 79 residents on the day shift, required at least 10 CNAs. -07/26/23 had 8 CNAs for 79 residents on the day shift, required at least 10 CNAs. -07/27/23 had 8 CNAs for 79 residents on the day shift, required at least 10 CNAs. -07/28/23 had 7 CNAs for 79 residents on the day	S 560		

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S 560	Continued From page 3 shift, required at least 10 CNAs. -07/29/23 had 7 CNAs for 81 residents on the day shift, required at least 10 CNAs. 6. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week staffing prior to survey beginning 8/11/2024 and ending 08/24/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 13 of 14 day shifts as follows: -08/11/24 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs. -08/12/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -08/13/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -08/14/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -08/15/24 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs. -08/16/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -08/17/24 had 6 CNAs for 77 residents on the day shift, required at least 10 CNAs. -08/18/24 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs. -08/19/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -08/20/24 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -08/21/24 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -08/23/24 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs. -08/24/24 had 7 CNAs for 83 residents on the day	S 560		

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S 560	Continued From page 4 shift, required at least 10 CNAs. On 8/29/24 at 1:06 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing, Infection Preventionist and Operations regarding the above concerns.There was no additional information provided by the facility.	S 560		
S2235	8:39-31.6(c) Mandatory Physical Environment (c) Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/27/2024 and 08/28/2024 in the presence of the Senior Director of Facilities (SDOF), Director of Facilities (DOF) and Maintenance Director (MD), it was determined that the facility failed to ensure that a written evacuation diagram was posted on a wall in each resident care unit and/or department throughout the facility. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/28/24 at 12:10 PM,	S2235	How the corrective actions will be accomplished for those residents found to have been affected: A written evacuation diagram was posted on the third floor. No Residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.	9/22/24

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S2235	Continued From page 5 revealed that an evacuation diagram was not provided on the third floor. In an interview at the time of the observation, the surveyor asked the SDOF and DOF if there was an evacuation diagram posted anywhere on the 3rd floor. The DOF stated that he believed so but was unable to locate an evacuation diagram after checking the unit. In an interview at 12:13 PM, the SDOF and DOF confirmed the observations. The SDOF and DOF were informed of the deficient practice at the Life Safety Code exit conference on 08/28/2024.	S2235	The building was audited, and there is a written evacuation diagram posted throughout the facility and in each resident care unit and department throughout the facility. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Director of Maintenance/Designee will perform monthly observations to ensure appropriate signage is maintained. The Director of Maintenance/Designee will report the trends from these observations to the Administrator, with follow up as necessary How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Maintenance will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly.	

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
315053 Y1	A. Building B. Wing Y2	10/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	51 MADISON AVE MADISON, NJ 07940

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 F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0836	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.70(a)-(c)	Completed
LSC	09/22/2024	LSC	09/22/2024	LSC	09/22/2024
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/22/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/30/2024	☐ 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)
061413	A. Building B. Wing	10/18/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	51 MADISON AVE MADISON, NJ 07940

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/22/2024	ID Prefix S2235 Reg. # 8:39-31.6(c) LSC	Correction Completed 10/18/2024	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 8/30/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061413 Y1	A. Building B. Wing Y2	10/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	51 MADISON AVE MADISON, NJ 07940

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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 09/22/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING **01** B. WING _____	**08/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	**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
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 08/14/2024 and 08/15/2024. Pine Acres was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Pine Acres is a 3-story building that was constructed in the late 1960's. When asked the construction type they were unable to confirm what type it was. It appears to be Type III -Protected. According to the US FOIA (b)(6), they have a 180 KW diesel powered generator that supply's 100 percent of the building in an emergency. They utilize a domestic water supply for their fire sprinkler system.	K 000		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and	K 223		10/2/24

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

Electronically Signed | 09/20/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING 01 B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 223	Continued From page 1 * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/27/2024 and 08/28/2024 in the presence of the[redacted] it was determined that the facility failed to ensure that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position in accordance with NFPA 101 (2012) Sections 19.2.2.2.7 and 7.2.1.8.2 and NFPA 80 Section 5.2.4.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 8/28/2024 at 1:35 PM, revealed that the latching hardware was missing on the fire rated door assembly for the dining room stairway enclosure on the first floor. This would prevent the door from closing and latching in the event of an emergency when the controlled access device is de-energized by the fire alarm system. In interviews at the time of the observations, the [redacted] confirmed the observations. The [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 08/28/2024. N.J.A.C 8:39-31.2(e) NFPA 80	K 223	How the corrective actions will be accomplished for those residents found to have been affected: Latching hardware was installed on the fire rated door assembly for the dining room stairway on the first floor. No residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: All other fire rated door assemblies were audited to ensure latching hardware is installed where appropriate. No other doors were affected. All residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The[redacted] was in-serviced on Latching Hardware on the Fire Rated Door Assembly. The Director of Maintenance/Designee will perform monthly x3 months and quarterly x3 observations to ensure doors have the appropriate functional latching hardware. The Director of Maintenance/Designee will report the trends from these observations to the Administrator, with follow up as necessary How the facility will monitor its corrective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING **01** B. WING _____	**08/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	**51 MADISON AVE** **MADISON, NJ 07940**

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K 223	Continued From page 2	K 223	actions to ensure that the deficient practice is being corrected and will not recur: The Director of Maintenance will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly.	
K 233 SS=F	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/27/2024 and 08/28/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that the means of egress accesses are in accordance NFPA 101: 2012 Edition, Sections 19.2.1, 19.2.2.2, 19.2.5.6.1, 7.1.10.1 and 7.2.1.2.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/27/24 at 1:16 PM, revealed that resident room 206 was provided with a pair of swinging door leaves in which neither door provided a clear width opening of not less than 32	K 233	How the corrective actions will be accomplished for those residents found to have been affected: The exit doors affected will be replaced with doors that provide at least 32 inches in clear width. No Residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: All exit access doors were audited to ensure they all provide at least 32 inches in clear width. Any door that does not meet K223 will be replaced. All residents have the potential to be	10/18/24

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	315053	A. BUILDING **01** B. WING _____	**08/30/2024**

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PINE ACRES REHABILITATION AND HEALTHCARE	**51 MADISON AVE** **MADISON, NJ 07940**

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K 233	Continued From page 3 inches. Both doors were approximately 23 inches wide. The inactive leaf is secured in place with a latching mechanism that is controlled by an attached chain that must be pulled down from the egress side of the door. An observation at 1:20 PM, revealed that 16 other resident rooms on the second floor were provided with a pair of swinging door leaves in which neither door provided a clear width opening of not less than 32 inches. An observation on 8/28/24 at 11:00 AM revealed that 10 resident room doors on the first floor were provided with a pair of swinging door leaves in which neither door provided a clear width opening of not less than 32 inches. In interviews at the time of the observations, the U.S. FOIA (b)(6) confirmed the observations. TheU.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 08/28/2024. N.J.A.C 8:39-31.2(e)	K 233	affected. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Director of Maintenance/Designee will perform weekly observations to ensure the exit doors and exit access doors are at least 32 inches in clear width. The Director of Maintenance/Designee will report the trends from these observations to the Administrator, with follow up as necessary How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Maintenance will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly.	
K 255 SS=F	Suite Separation, Hazardous Content, and Subd CFR(s): NFPA 101 Suite Separation, Hazardous Content, and Subdivision All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided	K 255		10/2/24

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	315053	A. BUILDING **01** B. WING _____	**08/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	**51 MADISON AVE** **MADISON, NJ 07940**

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K 255	Continued From page 4 they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/27/2024 and 08/28/2024 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that corridor were separated from all other areas in accordance with NFPA 101:2012 Edition, Section 19.3.6.1 through 19.3.6.5. This deficient practice had the potential to affect all residents and is evidenced by the following: An observation on 8/28/2024 at 12:02 PM, revealed that the corridor wall separating the U.S. FOIA (b)(6) office from the corridor was not continuous from the floor to the underside of the floor or roof deck above, leaving an approximately 4-foot by 10-foot opening between the two spaces. In an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the observations. The U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 08/28/2024. N.J.A.C 8:39-31.2(e)	K 255	How the corrective actions will be accomplished for those residents found to have been affected: The wall separating the Assistant director of nursing office from the corridor was constructed to be continuous from floor to the roof deck above. No Residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: The building was audited, and there are no other instances where the walls are not continuous from the floor to the roof deck. All residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Director of Maintenance/Designee will perform monthly observations to ensure there are no other areas that have suite separation.. The Director of Maintenance/Designee will report the trends from these observations to the Administrator, with follow up as necessary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING **01** B. WING _____	**08/30/2024**

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K 255	Continued From page 5	K 255	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Maintenance will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/27/2024 and 08/28/2024 in the presence of the [redacted] it was determined that the facility failed to provide illumination of the means of egress that was either continuously in operation or capable of automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all residents and was evidence by the following: An observation on 08/28/2024 at 11:20 AM, revealed that all the lights in the dining room used as exit access were controlled by a manual light switch on the wall.	K 281	How the corrective actions will be accomplished for those residents found to have been affected: First floor exit access corridor lights were re-wired, and will remain on at all times. No Residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: All other exit access lighting was checked to ensure they remain on, and cannot be turned off with a light switch. All residents have the potential to be affected. What measures will be put into place or	10/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 281	Continued From page 6 An observation at 12:00 PM, revealed that all of the exit access corridor lights on the first floor were turned controlled by a manual light switch on the wall. In interviews at the time of the observations, the U.S. FOIA (b)(6) confirmed the observations The U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 08/28/2024. N.J.A.C 8:39-31.2(e)	K 281	systemic changes made to ensure the deficient practice will not recur: The Director of Maintenance/Designee will perform monthly x3 and quarterly x3 observations to ensure appropriate lightning is maintained. The US FOIA (b)(6) was in-serviced on appropriate exit access lighting. The Director of Maintenance/Designee will report the trends from these observations to the Administrator, with follow up as necessary How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Maintenance will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on	K 293	How the corrective actions will be	10/18/24

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PINE ACRES REHABILITATION AND HEALTHCARE	51 MADISON AVE MADISON, NJ 07940

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K 293	Continued From page 7 08/27/2024 and 08/28/2024 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that a sign with directional indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit is not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/27/2024 at 1:24 PM, revealed that upon exit of the elevator on the 3rd floor, there was no sign indicating the direction of travel to the nearest exit. An observation on 08/28/2024 at 11:10 AM, revealed that upon exit of the elevator on the 1st floor, there was no sign indicating the direction of travel to the nearest exit. In interviews at the time of the observations, the U.S. FOIA (b)(6) confirmed the observations The U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 08/28/2024. N.J.A.C 8:39-31.2(e)	K 293	accomplished for those residents found to have been affected: Exit signs will be installed outside of the elevator on the first and third floors indicating the direction of travel to the nearest exit. No Residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. The building was audited, and there is a sign with directional indicators showing the direction of travel to the nearest exit is posted in all appropriate areas. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Director of Maintenance/Designee will perform monthly x3 and quarterly x3 observations to ensure appropriate signage is maintained. The US FOIA (b)(6) was rein-serviced on appropriate exit signage. The Director of Maintenance/Designee will report the trends from these observations to the Administrator, with follow up as necessary How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Maintenance will review and analyze trends based on the observations and report findings and any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING **01** B. WING _____	**08/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	**51 MADISON AVE** **MADISON, NJ 07940**

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K 293	Continued From page 8	K 293	necessary follow up actions to the Administrator monthly.	
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/27/2024 and 08/28/2024 in the presence of the U.S. FOIA (b)(6) was determined that the facility failed to ensure that the operable part of each manual fire alarm pull station was not less than 42-inches and not more that 48-inches above the floor level in accordance with NFPA 72: 2010 Edition, Section 17.14. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/27/2024 at 1:00 PM, revealed that the manual fire alarm pull station near room 306 was 62-inches above the floor.	K 342	How the corrective actions will be accomplished for those residents found to have been affected: All pull stations will be lowered to ensure that the operable part of each manual fire alarm pull station is not less than 42 inches and not more than 48 inches above the floor level. No Residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: All fire alarm stations were audited to ensure there were no further pull stations that needed to be moved.	10/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING **01** B. WING _____	**08/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	**51 MADISON AVE** **MADISON, NJ 07940**

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K 342	Continued From page 9 An observation at 1:15 PM, revealed that the manual fire alarm pull station near room 315 was 66-inches above the floor. An observation at 1:16 PM, revealed that the manual fire alarm pull station outside of the third-floor exit stairs was 66-inches above the floor. An observation at 1:20 PM, revealed that the manual fire alarm pull station near room 318 was 68-inches above the floor. An observation on 8/27/2024 at 10:31 AM, revealed that the manual fire alarm pull station near the second-floor exit stairs was 66-inches above the floor. An observation at 10:50 AM, revealed that the manual fire alarm pull station near the first-floor exit door was 66-inches above the floor. In interviews at the time of the observations, the U.S. FOIA (b)(6) confirmed the observations. The U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 08/28/2024. N.J.A.C 8:39-31.2(e) NFPA 72	K 342	All residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Director of Maintenance/Designee will perform monthly x3 and quarterly x3 observations to ensure the fire alarm pull stations are maintained with proper placement. The US FOIA (b)(6) was rein-serviced on the proper placement of fire alarm pull stations. The Director of Maintenance/Designee will report the trends from these observations to the Administrator, with follow up as necessary How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Maintenance will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355		10/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315053	A. BUILDING **01** B. WING _____	**08/30/2024**

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PINE ACRES REHABILITATION AND HEALTHCARE	**51 MADISON AVE** **MADISON, NJ 07940**

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K 355	Continued From page 10 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/27/2024 and 08/28/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that portable fire extinguishers were installed so that the top of the fire extinguisher is not more than 5 feet above the floor in accordance with NFPA 101:2012 Edition, Sections 9.7.5 and NFPA 10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/28/2024 at 10:05 AM, revealed that the portable fire extinguisher near room 206 was installed so that the top of the fire extinguisher was 65-inches above the floor. An observation at 10:45 AM, revealed that the portable fire extinguisher near room 215 was installed so that the top of the fire extinguisher was 65-inches above the floor. In interviews at the time of the observations, the U.S. FOIA (b)(6) confirmed the observations. The U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 08/28/2024. N.J.A.C 8:39-31.2(e) NFPA 10	K 355	How the corrective actions will be accomplished for those residents found to have been affected: The portable fire extinguishers were lowered to ensure they are not more than 5 feet above the floor. No Residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice: All portable fire extinguishers were audited and there were no further portable fire extinguishers that needed to be moved. All residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Director of Maintenance/Designee will perform monthly x3 and then quarterly x3 observations to ensure the portable fire extinguishers are selected, installed, inspected, and maintained. The US FOIA (b)(6) [redacted] rein-serviced on fire extinguishers needing to be selected, installed, inspected, and maintained. The Director of Maintenance/Designee will report the trends from these observations to the Administrator, with follow up as necessary	

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K 355	Continued From page 11	K 355	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Maintenance will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly.	

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
315053 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND HEALTHCARE	51 MADISON AVE MADISON, NJ 07940

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 K0223	10/02/2024	LSC K0233	10/18/2024	LSC K0255	10/02/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	10/18/2024	LSC K0293	10/18/2024	LSC K0342	10/18/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0355	10/18/2024	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	
8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO