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	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Acres Convalescent Center	51 Madison Ave Madison, NJ 07940

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 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 #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 Dementia (loss of memory) and other behavioral disturbances. A review of the Admission MDS (A/MDS), dated [DATE], reflected that the resident had a Brief Interview for Mental Status score of 04 out of 15, indicating that the resident had severe cognitive impairment. Further review of the A/MDS Section N. Medications under Section N0415 High-Risk Drug Classes: 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. Antipsychotic was checked indicating that the resident used an anti-psychotic medication. Further review of the A/MDS under Section N0450 Antipsychotic Medication Review A. Did the resident receive antipsychotic medications since admission or reentry or the prior OBRA assessment, whichever is more recent? indicated 0 (zero) No - antipsychotics were not received. A review of the August 2024 Order Summary Report revealed a physician's order (PO) dated 7/15/24 for Risperdal oral tablet 0.5 mg (Risperidone) Give 1 tablet by mouth at bedtime which was an anti-psychotic drug. A review of the July 2024 Medication Administration Record revealed a PO indicating a start date of 7/15/24 for, Risperdal oral tablet 0.5 mg (Risperidone) give 1 tablet by mouth at bedtime. The medication was signed as administered on July 15, 16, and July 17, 2024. (continued on next page)

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

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	On 08/28/24 at 11:30 AM, the surveyor interviewed the Registered Nurse who worked part-time as a MDS Coordinator (MDS/C). The part-time MDS/C stated that she missed to code the medication to reflect in the A/MDS. The MDS/C 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 antipsychotic 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 Licensed Nursing Home Administrator, Director of Nursing, Infection Preventionist and discussed the above concern. No further information was provided. NJAC 8:39-33.2(c)2, (d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 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 left hand. The resident stated to the surveyor that their right hand was weak. The resident further stated that the facility provided something for their right hand, but they refused 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 left arm most of the time due to the weakness of the right arm. On 08/27/24 at 12:01 PM, the surveyor interviewed the Licensed Practical Nurse #3 (LPN#3) assigned to Resident #30, who stated that the resident refused to wear the right-hand splint. 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 Hemiplegia (one-side paralysis) and Hemiparesis (one-sided muscle weakness) following Cerebral Infarction (disruptive blood flow to the brain) affecting the right dominant side. A review of the Quarterly Minimum Data Set (an assessment tool used to facilitate the management of care) (Q/MDS), dated [DATE], revealed in Section C. Cognitive Patterns that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Further review of Q/MDS revealed Section GG - Functional Limitation in Range of Motion, A. Upper extremity (shoulder, elbow, wrist, hand) 1. Impairment on one side. B. Lower extremity (hip, knee, ankle, foot) 1. 1. Impairment on one side. The surveyor reviewed Resident #30's comprehensive CP which did not reflect the resident's refusal to wear the right-hand splint. 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 had a resting hand splint during the night 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 resting hand splint at night. The surveyor reviewed the electronic record medical record that revealed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the AR, Resident #15 was admitted to the facility with diagnoses that included but were not limited to other Genetic-Related Intellectual Disability. A review of the Q/MDS, dated [DATE], revealed in Section C - Cognitive Patterns the resident had a BIMS score of 99, indicating severe cognition impairment. A review of the August 2024 Order Summary Report revealed a PO dated 8/12/24 to Apply left resting hand splint at night to wear up to 6+ hours as tolerated. Monitor skin daily and remove if pressure points or redness present. Every night shift for contraction prevention. A review of the Progress Notes dated 7/29/24, documented left-hand splint in place per orders. The surveyor reviewed the residents' comprehensive CP which did not reflect the resident's use of resting hand splint at night. A review of the facility's policy and procedure with a review date of 01/2024 titled Care Plans under 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 Licensed Nursing Home Administrator, Director of Nursing, Infection Preventionist and discussed the above concern. No further information was provided. NJAC 8:39-11.2 (e)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 39399 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 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. (continued on next page)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	(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 Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Infection Preventionist (IP), and Administrator in Training for Entrance Conference. On 8/26/24 at 11:30 AM, the surveyor reviewed various documents and facility policies that were provided by the LNHA 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 LNHA, DON, Operations and IP 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 LNHA 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 LNHA 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. NJAC 8:39-5.1 (a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 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 urinary care 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 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 Infection Preventionist/Registered Nurse (IP/RN), who stated that the staff were in serviced regarding hand washing. The IP confirmed that CNA #1 should have performed hand hygiene after removing the gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/24 at 01:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), IP/RN 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. 37175 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 urinary catheter bag (UCB) (a container or collector for the urine as it leaves the body and passes through the catheter tube) with urine present in the tubing hanging on to the rail next to the toilet. The UCB was not in a plastic bag and the end of the catheter tubing was exposed and not capped. A review of the AR reflected Resident #59 was admitted to the facility on [DATE], with diagnoses that included Hypertension (elevated blood pressure), Neuromuscular dysfunction of the Bladder (lack of bladder control) and Benign Prostatic Hyperplasia (enlarged prostate). A review of the Annual Minimum Data Set, an assessment tool dated 7/11/24, reflected a brief interview for mental status (BIMS) score of 13 out of 15, which indicated intact cognition. Further review revealed in Section H. Bladder and Bowel the resident had an indwelling urinary catheter. A review of the August 2024 Physician Orders Summary Report revealed a physician's order dated 1/11/24, to change the urinary drainage bag to a leg bag (pouch that is worn on the leg to collect urine from catheter) while out of bed daily. A review of the individual person-centered care plan CP revealed that the resident was at risk for multidrug resistant organism (MDRO) infections and was placed on an enhanced barrier precautions (an infection control intervention designed to reduce transmission of MDRO in nursing homes) related to the use of indwelling catheter(hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag), dated 4/10/24, reflected a goal which included, the resident would not contract MDRO infection. Some of the CP interventions included but not limited to implement the use of gown and gloves for high contact care activities such as device care for indwelling urinary catheter. 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 indwelling urinary catheter, and she removed the urinary catheter bag, placed a leg bag on the resident and stored the urinary bag in the bathroom. The surveyor showed CNA #1 the urinary bag and she stated that she omitted the plastic bag and the urinary 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 urinary bag should not be hung on the handrail in the bathroom and must be placed in a plastic bag when removed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 12:50 PM, the surveyor interviewed the IP/RN who stated the urinary drainage bag was changed weekly, washed daily and stored in a plastic bag in the bathroom. The IP/RN further stated that the CNA must clean the tip of the catheter with an alcohol pad and then place a blue cap at the end of the catheter to prevent any contamination. On 08/29/24 at 01:07 PM, the survey team met with the LNHA, DON, and IP/RN 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)