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	01/15/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness.On 1/11/26 at 9:28 AM, the surveyor in the presence of the Food Service Director (FSD) observed the following during the kitchen tour:1. In the three-door standing freezer, the surveyor observed an open bag of French Fries, vegetable burgers, all-beef hamburger and shrimp; all missing open and use-by labels. The FSD stated all items that have been opened should have open and use-by dates.2. In the ice cream freezer, the surveyor did not observe a thermometer. The FSD stated they would put a new thermometer in the freezer immediately. 3. In the beverage preparation area, the surveyor observed the juice dispenser with 4 of 7 tubes noted with a sticky build up on the tubing. The FSD stated the tubing would be cleaned immediately.4. In the milk refrigerator, the surveyor did not observe a thermometer. The FSD stated they would put a new thermometer in the milk refrigerator immediately.5. On the food preparation table, the surveyor observed the can opener with a blackish debris. Also, observed the microwave with a yellowish grease-like substance. The FSD stated both items would be cleaned immediately. 6. In the cooking area, the surveyor observed the top of the standing two door oven and a shelf above the 6-range stove top with a sticky substance. The FSD stated all cooking equipment would be cleaned immediately. 7. On the spice rack, the surveyor observed an 80-ounce (oz) container of honey, 16oz paprika, 1-quart egg shade liquid color, 4 pounds (lb.) fine granulated sugar, 16oz ground cinnamon, 1 quart barbeque sauce, and 24 oz strawberry gelatin mix all open without open and use-by labels. The FSD stated all opened and unlabeled items would be disposed of immediately.8. In the dishwashing area, the surveyor observed two dietary aides (DA#1 and DA#2) both with facial hair that was not covered with a beard guard. The FSD had both DA#1 and DA#2 put on beard guards.9. In the dry storage area, the surveyor observed three bags of hamburger buns and one loaf of white bread, all were open without open and use by labels. The FSD disposed of the nonlabelled items.10. On 1/12/26 at 11:18 AM, during the follow up inspection of the kitchen, in the presence of the FSD, the surveyor observed the chef checking food temperatures for the lunch meal. While the chef was checking the temperature of the baked chicken, the plastic portion of food thermometer touched the chicken, contaminating the chicken. The chef stated they did not realize the plastic portion of the thermometer touched the chicken and that the chicken should be discarded due to contamination. On 1/14/26 at 9:47 AM, the Administrator in Training (AIT) provided the surveyor with multiple facility policies. The labelling and dating policy with a reviewed date of 7/2025 revealed under the process section, 1. All food products, upon receiving, must be dated with a receiving date. 2. All food items must be labeled with either a manufacturer label or handwritten label.a. Once a product has been prepared or portioned, a new use by date is established.c. Once prepared or portioned food items will be dated with compliance of 72-hour rule and labeled with use on or by. The sanitation policy with an updated date of 10/2025 revealed under the procedure section, 1. The dietary service director monitors the safety and sanitation of the dietary department on a daily basis. The hair and beard guard policy with a reviewed date of 9/2025, revealed under the procedure section, 2. [NAME] guards should be worn by any employee with facial hair. The record of food (continued on next page)

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.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature policy with an updated date of 9/2025, revealed under the policy explanation, 14. Food temperatures will be verified using a thermometer which is both clean, sanitized and calibrated to ensure accuracy.On 1/14/26 at 12:23 PM, the surveyor met with the Licensed nursing Home Administrator (LNHA), Infection Preventionist (IP), AIT, Regional Registered Nurse (RRN), Director of Operations (DOP) and Director of Nursing (DON) to review concerns found during the survey. The DOO stated the kitchen concerns would be corrected immediately.On 1/15/26 11:21 AM, the surveyor met with the LNHA, DON, DOO, AIT, RRN, and DON for the exit conference; no further pertinent information was provided. NJAC 8:39-17.2(g)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2707766 Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 6 of 6 residents (Resident #1, #13, #16, #41, #68 and #83) observed for incontinence care on 1 of 3 units (First floor nursing unit). This deficient practice was evidenced by the following: 1. On 1/11/26 at10:39 AM, the surveyor was touring the 1st floor unit and smelled a strong odor of urine throughout the unit. On 1/11/26 at 11:15 AM, the surveyor interviewed Resident #1, who was sitting in their wheelchair next to their bed. The surveyor observed an adult brief laying on the top of the Resident #1's bed that was statured with urine. Resident #1 stated the brief had been there for 45 minutes and they had removed the adult brief themselves because a Certified Nursing Assistant (CNA) had not checked on them. A review of Resident #1's admission Record (AR) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; pneumonia (an infection that inflames the air sacs in one or both lungs), generalized muscle weakness (weakness in multiple muscle groups) and type 2 diabetes mellitus (a metabolic disorder that occurs when the body becomes resistant to insulin or when the pancreas fails to provide enough insulin). A review of Resident #1's Quarterly Minimum Data Set (MDS), an assessment tool dated 12/9/25 reflected Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #1 was cognitively intact. The MDS further revealed that the resident required staff assistance for personal hygiene, and he/she was frequently incontinent of bowel and bladder. A review of Resident #1's two Care Plans (CP): 1. Included a focus area that the resident had the potential for skin breakdown related to decreased mobility and episodes of bowel and bladder (B&B) incontinence with interventions that included but were not limited to; provide incontinence care throughout the shift. 2. Included a focus area that the resident has bladder incontinence related to activity intolerance with interventions that included but were not limited to; incontinent: check throughout shift for incontinence. Wash, rinse and dry eith perineum. Change clothing after incontinence episodes. 2. On 1/13/2026 at 7:25 AM, during an interview with the surveyor, the Licensed Practical Nurse/ Unit Manager (LPN/UM) identified residents as being incontinent and dependent on staff for care. On 1/13/26 at 7:30 AM, the surveyor conducted an incontinence tour on the 1st floor East Nursing Unit and observed the following: a. On 1/13/26 at 7:30 AM, the surveyor accompanied by the LPN/UM observed Resident #13 in bed. The LPN/UM exposed Resident #13's incontinence brief and the surveyor observed that the incontinence brief was saturated with urine. The LPN/UM confirmed that the brief was saturated. A review of Resident #13's admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; dementia (a general term for loss of memory, language, problem-solving and other thinking abilities) anxiety (a feeling of uneasiness and worry subjectively seen as menacing) and hypertension (high blood pressure). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #13's Quarterly Minimum Data Set (MDS), an assessment tool dated 10/19/25 reflected Resident #13 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated Resident #13 had a severe cognitive impairment. The MDS further revealed that the resident required staff assistance for personal hygiene, and he/she was always incontinent of bowel and bladder. A review of Resident #13's Care Plan (CP) included a focus area that the resident had the potential for impaired skin integrity related to bladder incontinence with interventions that included but were not limited to; provide incontinence care throughout the shift. b. On 1/13/26 at 7:40 AM, the surveyor accompanied by the LPN/UM observed Resident #16 in bed with a strong urine odor in the room. The LPN/UM exposed the resident's incontinence brief and the surveyor observed that the brief was wet and the under pad was saturated with urine. The LPN/UM confirmed the strong malodorous odor and the wet and saturated under pad. The surveyor reviewed the medical record for Resident #16 A review of the Resident #16's admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; epilepsy (a brain disorder causing seizures due to abnormal electrical activity), aphasia (a language disorder that impairs a persons ability to speak) and diabetes mellitus (a chronic condition where the body's blood sugar (glucose) levels become too high). A review of Resident 16's Quarterly MDS dated [DATE] reflected the resident's cognitive skills for daily decision making were severely impaired. A further review of the MDS reflected Resident #16 was dependent on staff for personal hygiene and was always incontinent of bowel and bladder. A review of the resident's CP included a focus area that the resident had a potential for skin breakdown related to impaired mobility and incontinence with interventions that included but were not limited to; provide incontinence care every 2 hours and when needed. c. On 1/13/26 at 7:45 AM, the surveyor accompanied by the LPN/UM observed Resident #68 in bed. The surveyor observed a strong smell of urine in the resident's room. The LPN/UM exposed the resident's incontinence brief and observed a second brief inserted within the first one. The surveyor observed that both briefs and the under pad were all saturated with urine. The LPN/UM confirmed the unpleasant odor and saturated briefs and under pad. A review of Resident #68's admission Record reflected Resident #68 was admitted to the facility with diagnoses that included but were not limited to; seizures, (abnormal electrical activity in the brain) hemiplegia (mild or partial weakness or loss of strength on one side of the body) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body) , hypertension and aphasia. A review of Resident #68's Quarterly MDS dated [DATE] reflected that the resident's cognitive skills for daily decision making were severely impaired and that the resident was dependent on staff for personal hygiene. A further review of the MDS indicated the resident was frequently incontinent of bladder, and always incontinent of bowel. A review of Resident #68's CP included a focus area that the resident was at risk for impaired skin integrity related to incontinence and impaired mobility due to cerebral vascular accident (CVA) with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right-sided weakness and history of pressure-related wounds with interventions that included but were not limited to; provide incontinence care as needed. d. On 1/13/26 at 7:55 AM, the surveyor accompanied by the LPN/UM observed Resident #41 in bed. The LPN/UM exposed the resident's incontinence brief and observed the incontinence brief was saturated with urine. The LPN/UM confirmed the incontinence brief was saturated with urine. A review of Resident #41's admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; dementia, congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should) and hypertension. A review of Resident #41's Annual MDS dated [DATE] reflected the resident had a BIMS score of 3 out of 15 which indicated a severe cognitive impairment. A further review of the MDS reflected that the resident required the assistance of staff for personal care and was always incontinent of bowel and bladder. A review of Resident #41's CP included a focus area that the resident had a potential for skin breakdown related to incontinence with interventions that included but were not limited to; provide incontinence care every two hours and as needed. e. On 1/13/26 at 8:00 AM, the surveyor accompanied by the LPN/UM observed Resident #83 in bed with an oxygen concentrator (a medical device that filters nitrogen from the air to provide a concentrated flow of up to 95% pure oxygen) in place with the oxygen flow rate at 3 LPM. The LPN/UM exposed the resident's incontinence brief and the surveyor observed that the brief was saturated with urine. The LPN/UM confirmed the incontinence brief was saturated with urine. A review of Resident #83's admission Record reflected Resident #83 was admitted to the facility with diagnoses that included but were not limited to; hypertension and Congestive Heart Failure. A review of Resident #83's Quarterly MDS dated [DATE] reflected that the resident had a BIMS score of 7 out of 15 which indicated the resident had a severe cognitive impairment. A further review of the MDS revealed that Resident #83 was dependent on staff for personal hygiene and was always incontinent of bowel and bladder. A review of Resident #83's CP included a Focus area that the resident had the potential for impaired skin integrity related to anticoagulant therapy, bladder incontinence and decreased mobility with interventions that included but were not limited to; keep skin clean and dry and provide incontinence care throughout the shift and as needed. On 1/13/26 at 8:05 AM, the LPN/UM confirmed that the residents were not provided with timely and appropriate incontinence care every 2 hours per the facility policy. On 1/13/26 at 8:10 AM, during an interview with the surveyor, the 7PM-7 AM LPN, stated that the CNA should have provided incontinence care every 2 hours, but that the CNA had too many residents and might not have been able to do that. On 1/13/26 at 8:20 AM, during a phone interview with the surveyor and in the presence of the LPN/UM, the 11-7 CNA, confirmed that she should have provided the residents with incontinence care every 2 hours, but that she was only able to make rounds twice during her shift because she had 21 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents on her assignment and it was just not possible to provide incontinence care every 2 hours with 21 residents. On 1/13/26 at 8:55 AM, during an interview with the surveyor, the staffing coordinator (employed for 3 years), stated that they were unsure of the state-mandated CNA-to-resident ratios but would check upstairs as they had all the ratios listed on their computer. On 1/13/26 at 2:20 PM, during an interview with the surveyor in the presence of the Director of Operations, the staffing coordinator confirmed that they were not aware of the state-mandated staffing ratios. The staffing coordinator further stated that they thought the nurses could be working and counted as CNAs even if they were the only nurse on the unit. The Director of Operations acknowledged that the night shift had a CNA-to-patient ratio of 1:21 and that it should have had 1:14 ratio. The Director of Operations confirmed that the 1st floor was not staffed in accordance with state regulations. On 1/14/26 at 12:25 PM, the survey team met with the LNHA, DON, AIT, Director of Operations, Infection Preventionist Nurse, and Regional Nurse, to discuss the above observations and concerns. A review of the facility's Incontinence Care policy, dated as reviewed 9/2025, reflected .It is the policy of this facility to promote resident comfort by keeping residents clean and dry to prevent skin breakdown . On 1/15/26 at 10:30 AM, the survey team met with the administrative staff. The DON confirmed that incontinence care should be provided by the CNAs every 2 hours and as needed. No further information was provided. NJAC 8:39-27.1 (a), 27.2 (h)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, it was determined that the facility failed to provide a homelike environment in resident rooms. The deficient practice was observed in 1 of 3 units during the initial tour. The deficient practice was evidenced by the following:On 01/13 /2026 at 10:00 AM, the surveyor toured the 1st floor nursing unit and observed the following:1. In room [ROOM NUMBER], the heater cover in the bathroom was broken. The surveyor also observed that the wall behind the door bed had chipped paint, exposing the wallboard, and the wall by the window bed had chipped paint across the entire wall, exposing the wallboard.2. In the shower room, there were broken floor tiles and a broken toilet seat. The shower mat was heavily soiled, and the floor beneath it was covered in a thick brown substance. On 1/14/26 at 10:55 AM, during an interview with the surveyor, the Director of Housekeeping (DHK) stated that the housekeeping staff were responsible for cleaning and mopping the shower rooms daily. The surveyor showed the DHK the soiled shower mat and floor beneath it. The DHK confirmed that the floor had not been cleaned recently, and this did not provide the residents with a clean, homelike environment. On 1/14/26 at 11:02 AM, during an interview with the surveyor, the Housekeeper assigned to the 1st floor nursing unit stated that he was responsible for cleaning the shower room daily. He confirmed that he had not cleaned it today, nor had he cleaned it when he worked on the 1st-floor nursing unit on Monday. The HK stated, I just didn't get to it. On 1/14/26 at 11:10 AM, the surveyor showed the Director of Maintenance (DOM) the broken tiles in the shower room, the broken toilet seat, the broken heater cover in room [ROOM NUMBER], and the chipped paint in room [ROOM NUMBER]. The DOM stated that he was not aware of the above areas in disrepair and confirmed that they should have been repaired, as this does not provide residents with a homelike environment. On 1/15/26 at 10:30 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Administrator in training, Director of Operations, Infection Prevention Nurse and regional nurse to discuss the above observations and concerns. A review of the facility's policy, Clean/Homelike Environment dated as reviewed 9/2025, reflected that residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their personal belongings to the extent possible. NJAC 8:39-4.1(a)11. 31.4 (a), (b), (c), (f)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and review of facility policies it was determined that the facility failed to provide safety measures, nursing orders and follow interventions for a resident who has a history of falls. This deficient practice was identified for 3 of 3 residents (Resident #3, #5, and #66) reviewed for falls.The deficient practice was evidenced by the following: 1. On 1/11/26 at 10:55 AM, the surveyor observed Resident #3 in their room sitting in a medical reclining chair with a call bell in hand. Resident #3 was unable to participate in an interview related cognition. On 1/11/26 at 11:30 AM, the surveyor reviewed the hybrid medical record (combination of the electronic medical record (e-MAR) and the physical medical chart). The admission Record (AR) revealed that the resident had been admitted to the facility with diagnosis that included but were not limited to; hemiplegia and hemiparesis (one-sided paralysis), aphasia (disorder that results from damage usually from a stroke or traumatic brain injury to areas of the brain that are responsible for language), and muscle weakness (weakness in multiple muscle groups). A review of the annual Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/19/25, revealed that the resident had a BIMS score of 99, which indicated Resident #3 was unable to complete the interview. A review of the order summary report revealed a nursing order dated 7/16/24, Floor mat at bedside. Check for placement every shift for fall precautions. A review of Resident #3's care plan (CP) included a focus area that the resident has a potential for falls related to muscle weakness, use of mechanical lift for transfers, secondary to recent hospitalization; with interventions that included but not limited to; mattress on floor next to bed and place bed in the lowest position. On 1/13/26 at 9:24 AM, in the presence of the Regional Registered Nurse (RRN), the surveyor observed Resident #3 in bed without a floor mat present as well as the bed in a high position. The RRN acknowledged that Resident #3 did not have a floor mat at bedside despite a nursing order and the resident's bed was not in the lowest position per care plan interventions. On 1/13/26 at 12:26 PM, the RRN provided the surveyor with a facility policy titled, Care Plans - Comprehensive with a reviewed date of 6/2025. The policy interpretation and implementation revealed, 3. Each resident's comprehensive care plan to: a. incorporates identified problem areas .e. identify the professional services that are responsible for each element of care. 2. On 1/11/26 at 10:24 AM, the surveyor observed Resident #5 lying in bed with their eyes closed on an air mattress. The resident's fall mat was in a folded position leaning up against the nightstand. There was not a floor mat on the floor while the resident was in bed. A review of the AR revealed the resident had diagnoses which included but were not limited to; metabolic encephalopathy, (when the brain has trouble working because of a chemical, or metabolic, problem in the body), muscle weakness, and severe protein-calorie malnutrition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's most recent quarterly MDS, included a BIMS score of 4 out of 15, which indicated the resident's cognition was severely impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 12/9/25,.that the resident presents with decreased strength, transfers, balance and ambulation.has potential for falls related to deconditioning, recent hospitalization, and noncompliance with safety, dated 9/4/25.falls noted on the care plan for 8/26/25 and 9/6/25.interventions included: floor mat in place next to bed, dated 8/31/25 and to monitor on all rounds, dated 8/31/25. A review of the Order Summary Report (OSR) did not include an order for floor mats. 3. On 1/11/26 at 10:36 AM, the surveyor observed Resident #66 lying in bed with their eyes closed on an air mattress. The resident's fall mat was in a folded position between the end of the bed and was leaning against the nightstand. There was not a floor mat on the floor while the resident was in bed. A review of the AR revealed the resident had diagnoses which included but were not limited to; unspecified dementia (symptoms affecting memory, thinking and social abilities). A review of the resident's most recent quarterly MDS, included the BIMS score of 7 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS section J1800, indicated the resident had 3 falls. A review of the resident's individual comprehensive care plan (ICCP) included a focus area. had a history of falls, dated 9/4/23. Intervention included but not limited to floor mat in place next to bed, dated 9/17/25 and to monitor on all rounds, dated 9/22/25. A review of the OSR physician orders (PO): did not include an order for floor mats. On 1/14/26 11:37 AM, the surveyor interviewed the Licensed Practical Nurs/ Unit Manager (LPN/UM). She stated floor mats are used for safety. She further stated that when the residents are in bed floor mats should be in place. On 1/14/26 11:54 AM, the surveyor interviewed the Director of Nursing (DON) who stated, when we identify a patient, the facility puts the floor mats in the room to prevent injury, and the resident will be care planned for it. A review of the Fall Mat- Fall intervention policy, dated 10/2025, revealed.to implement the use floor mats as nonrestrictive, precautionary measure for residents identified as high risk from repeated falls. N.J.A.C. 8:39-27.1 (a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer Oxygen Therapy according to the physician's order for 1 of 3 Residents (Resident # 83), reviewed for respiratory therapy. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 1/13/26 at 8:00 AM, the surveyor, accompanied by the LPN/UM observed Resident #83 in bed with Oxygen (O2) delivered via a nasal cannula (NC) tubing (a light weight tube with two prongs that deliver supplemental oxygen from the oxygen concentrator directly into the nostrils) attached to the O2 Concentrator (a medical device that filters nitrogen from the air to provide a concentrated flow of up to 95% pure oxygen) in place with the O2 flow rate set at 3 liters per minute (lpm. The LPN/UM confirmed that the gauge was set at 3 lpm, but stated that she was not sure if that was what the physician had ordered.A review of Resident #83's admission Record reflected that Resident #83 was admitted to the facility with diagnoses that included but were not limited to; hypertension (high blood pressure) and Congestive Heart Failure (a serious condition in which the heart doesn't pump blood as efficiently as it should). A review of Resident #83's Quarterly Minimum Data Set (MDS) dated [DATE] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident had a severe cognitive impairment. A further review of the MDS revealed that Resident #83 had not received intermittent or continuous oxygen therapy. A review of the current Order Summary Report had a current physician's order (PO) with a start date of 1/11/26, which included Oxygen at 2 lpm as needed for SPO2 (oxygen saturation, representing the percentage of oxygen-carrying hemoglobin in the blood) less than 92 every 6 hours as needed for shortness of breath. A review of the 7 PM-7 AM nurse's note dated 1/13/26 at 7:42 AM, reflected that the resident slept through in no distress.Spo2 97% on O2 at 3 lpm. A review of Resident #83's CP included a Focus area that the resident had Congestive Heart Failure with interventions that included but were not limited to; Oxygen therapy as ordered by MD. On 1/13/26 at 8:30 AM during an interview with the surveyor, 7 PM-7 AM, LPN confirmed that she had not checked the PO to ensure that the O2 was administered according to the physician's orders and confirmed that the PO was to administer the O2 at 2 lpm, not 3 lpm. The LPN stated that she should have checked the PO. On 1/15/26 at 10:30 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Administrator in training, Director of Operations, Regional Nurse, and Infection Control Nurse to discuss the above observations and concerns. The DON confirmed that nurses should follow the physician's orders for administering O2. A review of the facility's Oxygen Administration policy dated 10/2025 reflected It is the policy and procedure of this facility to provide oxygen to residents in compliance with their physician's order. On 1/15/26 at 11:25 AM, no further information was provided. NJAC 8:39-27.1 (a)

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	315053	A. Building B. Wing	01/15/2026

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2707766 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to ensure that sufficient and competent staff were available to provide appropriate incontinence care to dependent residents for 5 of 6 residents (Resident #13, #16, #41, #68 and #83) on 1 of 3 units (1st -floor Nursing Unit). This deficient practice was evidenced by the following: Refer to F6771.On 1/13/2026 at 7:25 AM, during an interview with the surveyor, the Licensed Practical Nurse/ Unit Manager (LPN/UM) identified residents as being incontinent and dependent on staff for care. On 1/13/26 at 7:30 AM, the surveyor conducted an incontinence tour on the 1st floor East Nursing Unit and observed the following: a. On 1/13/26 at 7:30 AM, the surveyor accompanied by the LPN/UM observed Resident #13 in bed. The LPN/UM exposed Resident #13's incontinence brief and the surveyor observed that the incontinence brief was saturated with urine. The LPN/UM confirmed that the brief was saturated. A review of Resident #13's admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; dementia (a general term for loss of memory, language, problem-solving and other thinking abilities) anxiety (a feeling of uneasiness and worry subjectively seen as menacing) and hypertension (high blood pressure). A review of Resident #13's Quarterly Minimum Data Set (MDS), an assessment tool dated 10/19/25 reflected Resident #13 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated Resident #13 had a severe cognitive impairment. The MDS further revealed that the resident required staff assistance for personal hygiene, and he/she was always incontinent of bowel and bladder.A review of Resident #13's Care Plan (CP) included a focus area that the resident had the potential for impaired skin integrity related to bladder incontinence with interventions that included but were not limited to; provide incontinence care throughout the shift. A Review of the 11-7:00 AM Certified Nursing Aide (CNA) assignment sheet revealed that the first-floor nursing unit had a census of 21 Residents with 1 assigned aide. The CNA had an assignment of 21 residents on that 11-7AM shift. b. On 1/13/26 at 7:40 AM, the surveyor accompanied by the LPN/UM observed Resident #16 in bed with a strong urine odor in the room. The LPN/UM exposed the resident's incontinence brief and the surveyor observed that the brief was wet and the underpad was saturated with urine. The LPN/UM confirmed the strong malodorous odor and the wet and saturated underpad. The surveyor reviewed the medical record for Resident #16A review of the Resident #16's admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; epilepsy (a brain disorder causing seizures due to abnormal electrical activity), aphasia (a language disorder that impairs a persons ability to speak) and diabetes mellitus (a chronic condition where the body's blood sugar (glucose) levels become too high).A review of Resident 16's Quarterly MDS dated [DATE] reflected the resident's cognitive skills for daily decision making were severely impaired. A further review of the MDS reflected Resident #16 was dependent on staff for personal hygiene and was always incontinent of bowel and bladder.A review of the resident's CP included a focus area that the resident had a potential for skin breakdown related to impaired mobility and incontinence with interventions that included but were not limited to; provide incontinence care every 2 hours and when needed. Review of the CNA assignment sheet revealed that the first-floor nursing unit had a census of 21 Residents with 1 assigned aide. The CNA had an assignment of 21 residents on that 11-7AM shift. c. On 1/13/26 at 7:45 AM, the surveyor accompanied by the LPN/UM observed Resident #68 in bed. The surveyor observed a strong smell of urine in the resident's room. The LPN/UM exposed the resident's incontinence brief and observed a second brief inserted within the first one. The surveyor observed that both briefs and the underpad were all saturated with urine. The LPN/UM confirmed the unpleasant odor and saturated briefs and underpad. A review of Resident #68's admission Record reflected Resident #68 was admitted to the facility with diagnoses that (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included but were not limited to; seizures, (abnormal electrical activity in the brain) hemiplegia (mild or partial weakness or loss of strength on one side of the body) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body) , hypertension and aphasia. A review of Resident #68's Quarterly MDS dated [DATE] reflected that the resident's cognitive skills for daily decision making were severely impaired and that the resident was dependent on staff for personal hygiene. A further review of the MDS indicated the resident was frequently incontinent of bladder, and always incontinent of bowel. A review of Resident #68's CP included a focus area that the resident was at risk for impaired skin integrity related to incontinence and impaired mobility due to cerebral vascular accident (CVA) with right-sided weakness and history of pressure-related wounds with interventions that included but were not limited to; provide incontinence care as needed. Review of the CNA assignment sheet revealed that the first-floor nursing unit had a census of 21 Residents with 1 assigned aide. The CNA had an assignment of 21 residents on that 11-7AM shift. d. On 1/13/26 at 7:55 AM, the surveyor accompanied by the LPN/UM observed Resident #41 in bed. The LPN/UM exposed the resident's incontinence brief and observed the incontinence brief was saturated with urine. The LPN/UM confirmed the incontinence brief was saturated with urine. A review of Resident #41's admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; dementia, congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should) and hypertension.A review of Resident #41's Annual MDS dated [DATE] reflected the resident had a BIMS score of 3 out of 15 which indicated a severe cognitive impairment. A further review of the MDS reflected that the resident required the assistance of staff for personal care and was always incontinent of bowel and bladder. A review of Resident #41's CP included a focus area that the resident had a potential for skin breakdown related to incontinence with interventions that included but were not limited to; provide incontinence care every two hours and as needed. Review of the CNA assignment sheet revealed that the first-floor nursing unit had a census of 21 Residents with 1 assigned aide. The CNA had an assignment of 21 residents on that 11-7AM shift. e. On 1/13/26 at 8:00 AM, the surveyor accompanied by the LPN/UM observed Resident #83 in bed with an oxygen concentrator (a medical device that filters nitrogen from the air to provide a concentrated flow of up to 95% pure oxygen) in place with the oxygen flow rate at 3 LPM. The LPN/UM exposed the resident's incontinence brief and the surveyor observed that the brief was saturated with urine. The LPN/UM confirmed the incontinence brief was saturated with urine. A review of Resident #83's admission Record reflected Resident #83 was admitted to the facility with diagnoses that included but were not limited to; hypertension and Congestive Heart Failure. A review of Resident #83's Quarterly MDS dated [DATE] reflected that the resident had a BIMS score of 7 out of 15 which indicated the resident had a severe cognitive impairment. A further review of the MDS revealed that Resident #83 was dependent on staff for personal hygiene and was always incontinent of bowel and bladder. A review of Resident #83's CP included a Focus area that the resident had the potential for impaired skin integrity related to anticoagulant therapy, bladder incontinence and decreased mobility with interventions that included but were not limited to; keep skin clean and dry and provide incontinence care throughout the shift and as needed. Review of the CNA assignment sheet revealed that the first-floor nursing unit had a census of 21 Residents with 1 assigned aide. The CNA had an assignment of 21 residents on that 11:00PM-7:00AM shift. A Review of the 11-7:00 AM Certified Nursing Aide (CNA) assignment sheet revealed that the first-floor nursing unit had a census of 21 Residents with 1 assigned aide. The CNA had an assignment of 21 residents on that 11-7AM shift. On 1/13/26 at 8:05 AM, the LPN/UM confirmed that the residents were not provided with timely and appropriate incontinence care every 2 hours per the facility policy. On 1/13/26 at 8:10 AM, during an interview with the surveyor, the 7PM-7 AM LPN, stated that the CNA should have provided incontinence care every 2 hours, but that the CNA had too many residents and might not have been able to do that. On 1/13/26 at 8:20 AM, during a phone interview with the surveyor and in the presence of the LPN/UM, the 11-7 CNA, confirmed that she should have provided (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents with incontinence care every 2 hours, but that she was only able to make rounds twice during her shift because she had 21 residents on her assignment and it was just not possible to provide incontinence care every 2 hours. On 1/13/26 at 8:55 AM, during an interview with the surveyor, the staffing coordinator (employed for 3 years), stated that they were unsure of the state-mandated CNA-to-resident ratios but would check upstairs as they had all the ratios listed on their computer On 1/13/26 at 2:20 PM, during an interview with the surveyor, the Staffing Coordinator confirmed that on 1/12/26- 1/13/26 during 11:00 PM-7:00 AM, shift the census on the first-floor nursing unit was 21. The staffing coordinator stated that there was 1 CNA scheduled to the first-floor unit and that he thought the nurse could be counted as a CNA even though she was the only nurse assigned to the first-floor unit. The staffing coordinator was not aware that the ratio for the 11:00 PM-7:00 AM, shift was 1 CNA to 14 Residents for the night shift.A review of the facility's staffing policy dated as reviewed 10/2025 reflected.It is the policy and procedure of this facility to adequately staff the facility. On 1/15/26 at 10:30 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Administrator in training (AIT), Infection Prevention Nurse (IPN), Regional Nurse (RN) and Director of Operations to discuss the above observations and concerns. The LNHA stated that he was not aware that the staffing on the first-floor nursing unit was not sufficient. He further stated that he felt the nurse on the first-floor should help the CNA provide incontinent care for the residents. The LNHA's lack of awareness failed to ensure adequate staffing levels were maintained to meet the residents' needs. NJAC 8:39-5.1(a), 27.1 (a), 27.2 (h)