STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315425	A. BUILDING _____ B. WING _____	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	**39 EAST MOUNTAIN ROAD HILLSBOROUGH, NJ 08844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: Recertification CENSUS: 119 SAMPLE: 24 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 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	F 656		3/31/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/16/2023

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

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F 656	Continued From page 1 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 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, record review, and facility policy review, the facility failed to ensure a resident's use of EX Order 26 § 4b1 was addressed in the comprehensive care plan for 1 (Resident #277) of 3 residents reviewed for EX Order 26 § 4b1 . Findings included: A review of an "Interdisciplinary Care plans" policy and procedure, last dated as reviewed in 01/2023, revealed, "Policy: This facility believes that each resident is a unique individual with physical, mental, emotional, psychological, social, spiritual and medical needs. An individual who possesses strengths and has a potential for betterment of self, no matter what stage of life	F 656	PLAN OF CORRECTION: F656 SS=D 483.21 (b)(1)(3) Develop/Implement Comprehensive Care Plan CORRECTIVE ACTION(S): • Foothill Acres will ensure that a comprehensive person-centered care plan is implemented for each resident. Care plan for resident #277 was revised to include resident's EX Order 26 § 4b1 . • Nursing staff in-serviced regarding policy and procedures on EX Order 26 § 4b1 and completion of care plan. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE	

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F 656	Continued From page 2 they are in. This facility also believes in ensuring quality of life and providing quality care to all its residents through the use of the interdisciplinary care planning process." The policy objectives included, "2. To provide a guideline for all staff to follow in their delivery of care." The policy procedure noted, in part, "4. The care plan will be individualized and will include problems, goals and approaches that reflect the resident's uniqueness and idiosyncrasies." A review of Resident #277's "Admission Record" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted]. A review of Resident #277's quarterly Minimum Data Set (MDS), dated 11/22/2022, indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had EX Order 26 § 4b1 [redacted]. A review of Resident #277's "Order Summary Report" revealed an order dated 02/08/2023 that directed staff to EX Order 26 § 4b1 [redacted]. A review of Resident #277's comprehensive care plan revealed the plan failed to address the resident's use of EX Order 26 § 4b1 [redacted]. On 02/21/2023 at 10:36 AM, Resident #277 was observed sitting in bed, visiting with a family member. The surveyor noted Resident #277 had [redacted] on by way of a EX Order 26 § 4b1 [redacted].	F 656	AFFECTED BY THE SAME DEFICIENT PRACTICE • All residents with oxygen therapy have the potential to be affected by this deficient practice. MEASURES PUT IN PLACE: • Nursing staff in-serviced regarding policy and procedures on oxygen therapy and completion of care plan. • Process of completion of resident care plan revised to include that the unit manager/designee will review care plan completion initiated by admitting nurse • MDS will review comprehensive care plan includes oxygen therapy when appropriate prior to MDS submission MONITORING OF MEASURES: • DON/Designee will audit residents on oxygen therapy to ensure this is reflected in the resident's care plan weekly x 4 weeks, monthly x 2 then quarterly there after • Audit findings will be reported to QA committee quarterly.	

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F 656	Continued From page 3 During an interview on 02/22/2023 at 3:55 PM, Licensed Practical Nurse (LPN) #3 said if a resident received EX Order 26 § 4b1, it should be on their care plan. During an interview on 02/22/2023 at 4:10 PM, LPN #4 said if a resident EX Order 26 § 4b1, it would be included on their care plan. New Jersey Administrative Code 8:39-11.2(e)(2)	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined that the facility failed to provide services to a resident who was unable to carry out activities of daily living (ADLs) necessary to maintain good grooming and personal hygiene for 1 (Resident #328) of 1 sampled resident reviewed for ADLs. Specifically, Resident #328 had EX Order 26 § 4b1 [redacted] Findings included: Review of a facility policy titled, "Supporting ADLs," issued 04/2016 and last reviewed by the facility in 01/2023, specified, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal	F 677	PLAN OF CORRECTION: F677 SS=D 483.24(a)(2) ADL Care Provided for Dependent Residents CORRECTIVE ACTION(S): • Nursing staff in-serviced regarding assistance with ADLs, maintaining good grooming and personal hygiene, to include shaving residents. • Staff counseled to ensure assistance is provided for residents who are unable to carry out ADLs and providing good grooming and hygiene, to include shaving residents. • Resident #328 received proper grooming and hygiene. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE	3/31/23

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F 677	Continued From page 4 and oral hygiene." The policy further specified, "2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: 1. Hygiene (bathing, dressing, grooming, and oral care)." Furthermore, the policy indicated, "6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice." A review of an "Admission Record" indicated the facility admitted Resident #328 with diagnoses of EX Order 26 § 4b1 [redacted] A review of a "COMS [Communications] - ADL Only Evaluation - V2," dated 02/09/2023, revealed Resident #328 was EX Order 26 § 4b1 [redacted] Review of Resident #328's care plan, initiated on 02/20/2023, revealed the resident had an EX Order 26 § 4b1 [redacted] On 02/21/2023 at 9:57 AM, Resident #328 was observed in bed with a EX Order 26 § 4b1 [redacted] On 02/22/2023 at 11:17 AM, Resident #328 was	F 677	AFFECTED BY THE SAME DEFICIENT PRACTICE • All residents who require assistance with ADLs to maintain good grooming and personal hygiene have the potential to be affected by this deficient practice. MEASURES PUT IN PLACE: • Nursing staff in-service on ADL's policy to ensure assistance is provided for residents who are unable to carry out ADLs and providing good grooming and hygiene to include shaving residents MONITORING OF MEASURES: • DON/Designee will randomly inspect 5 residents for proper grooming and hygiene to include shaving weekly x 4 weeks, monthly x 2 then quarterly thereafter • Audit findings will be reported to QA committee quarterly.	

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F 677		F 677		

Continued From page 5

EX Order 26 § 4b1 [redacted]

During an interview on 02/22/20233 at 11:21 AM, Certified Nurse Aide (CNA) #5 stated Resident #328 required Ex.Order 26.4(b)(1) and needed to be shaved. CNA #5 stated Resident #328 was not shaved because the staff were too busy, but noted Resident #328 would be shaved later.

During an interview on 02/22/2023 at 11:26 AM, Licensed Practical Nurse (LPN) #6 revealed Resident #328 was Ex.Order 26.4(b)(1) for all care. LPN #6 indicated Resident #328 had EX Order 26 § 4b1 [redacted]. LPN #6 stated Resident #328 should be EX Order 26 § 4b1 [redacted]. Per LPN #6, the unit managers were usually responsible for monitoring ADL care provided by CNAs, but if she noticed a resident needed care, she would tell the resident's CNA to perform the care.

During an interview on 02/22/2023 at 11:41 AM, Unit Manager (UM) #7 stated Resident #328 required Ex.Order 26.4(b)(1) and should be shaved as needed, including when staff identified the resident had EX Order 26 § 4b1 [redacted]. UM #7 stated Resident #328 would be shaved that day. Per UM #7, CNAs were required to make rounds to monitor the resident's ADL needs but the CNA staff were busy and did not get a chance to shave Resident #328.

During an interview on 02/23/2023 at 9:01 AM, the Director of Nursing (DON) revealed Resident #328 required Ex.Order 26.4(b)(1) and was not able to self-shave. The DON stated staff should ensure ADLs were completed daily for Resident

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F 677	Continued From page 6 #328 and anticipate the resident's needs. Per the DON, she expected good grooming and personal hygiene for the residents to be completed daily and as needed. The DON stated staff indicated Resident #328 had [redacted] and, when it was first found, the CNA should have notified the nurse. According to the DON, she made daily rounds to monitor care, but the unit manager and CNAs were responsible for ensuring residents received good grooming and personal hygiene. During an interview on 02/23/2023 at 10:51 AM, the Administrator revealed Resident #328 was [redacted] on staff for all care. The Administrator stated the CNAs were responsible for ensuring residents were shaved and groomed daily. The Administrator stated the resident's assigned nurse was responsible for monitoring ADL care. Per the Administrator, he expected residents to receive good grooming and for personal hygiene to be provided daily and as needed.	F 677		
F 695 SS=D	New Jersey Administrative Code 8:39-27.1(a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		3/31/23

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F 695	Continued From page 7 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff administered Ex.Order 26.4(b)(1) at the rate ordered by the physician for 1 (Resident #277) of 3 residents reviewed for EX Order 26 § 4b1. Findings included: A review of a facility policy titled, "Administration of Oxygen," last reviewed by the facility in 01/2023, revealed, "Purpose: To prevent hypoxia [absence of enough oxygen in the tissues to sustain bodily function]. Nurses and other certified/trained staff. Procedure: 1. Obtain orders from the primary care physician for: a. Oxygen therapy b. Flow rate or concentration in a cannula, mask, re-breather mask, etc. c. Respiratory therapy consultation, if indicated. d. Pulse oximetry reading if desired." A review of Resident #277's "Admission Record" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted] A review of Resident #277's quarterly Minimum Data Set (MDS), dated 11/22/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had EX Order 26 § 4b1 . A review of Resident #277's comprehensive care plan revealed the plan failed to address the resident's use of EX Order 26 § 4b1 or staff expectations surrounding such use. A review of Resident #277's "Order Summary Report" revealed an order dated 02/08/2023 that	F 695	PLAN OF CORRECTION: F695 SS=D 483.25(i) Respiratory/Tracheostomy Care and Suctioning CORRECTIVE ACTION(S): • Ex.Order 26.4(b)(1) for resident #277 was adjusted to the correct rate according to MD orders. • Staff counseled to ensure proper administration of Ex.Order 26.4(b) is delivered per MD orders. • Staff in-service regarding policy on Ex.Order 26.4(b)(1) to ensure Ex.Order 26.4(b) administered per MD orders. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE • All residents on Ex.Order 26.4(b)(1) have the potential to be affected by this deficient practice. MEASURES PUT IN PLACE: • Staff in-service regarding policy on Ex.Order 26.4(b)(1) administered per MD orders. MONITORING OF MEASURES: • DON/Designee will randomly audit 5 residents on Ex.Order 26.4(b)(1) weekly x 4 weeks, monthly x 2 then quarterly thereafter. • Audit findings will be reported to QA committee quarterly.	

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F 695	Continued From page 8 directed staff to administer EX Order 26 § 4b1 [redacted] On 02/21/2023 at 10:36 AM, Resident #277 was observed sitting in bed. Resident #277 was receiving s EX Order 26 § 4b1 [redacted] During an interview on 02/22/2023 at 3:55 PM, Licensed Practical Nurse (LPN) #3 said physician orders should be followed. LPN #3 stated she checked a resident's EX Order 26 § 4b1 setting each time she entered a resident's room. During an interview on 02/23/2023 at 4:10 PM, LPN #4 stated physician orders should always be followed. Per LPN #4, she checked a resident's EX Order 26 § 4b1 each time she entered a resident's room. New Jersey Administrative Code 8:39-11.2(b)	F 695		

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	061803	A. BUILDING: _____ B. WING _____	C 02/23/2023

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S 000	Initial Comments Census: 119 Sample Size: 24 TYPE OF SURVEY: Recertification The facility is not in substantial compliance with all of 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 deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of 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: Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 3 of 14 day shifts for the week of 02/05/2023 - 02/11/2023 and 02/12/2023 - 02/18/2023. This deficient practice had the potential to affect all residents.	S 560	PLAN OF CORRECTION: S560 8:39-5.1(a) Mandatory Access to Care – STATE'S STAFFING RATIOS CORRECTIVE ACTION(S): • Foothill Acres is continuously active in seeking to hire CNAs and train NAs to become CNAs in order to ensure that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls being made by the shift supervisor to	3/31/23

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S 560	Continued From page 1 Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aid to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the week of 02/05/2023 - 02/11/2023, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 2 of 7 day shifts in CNAs as follows: - 02/05/2023 had 15 CNAs for 125 residents on the day shift, required 16 CNAs.	S 560	fill the shift. Facility has documented evidence to reflect facility's Recruitment and Retention Efforts in its attempts to comply with the staffing ratios. No residents have been adversely affected. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE • All residents have the potential to be affected by this situation. MEASURES PUT IN PLACE: • Facility's Recruitment and Retention Strategies and Efforts to comply with the State's Staffing Ratios have been continuously in progress, which include: o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage referrals from current staff and new hired staff o Offering daily and weekend bonuses to attract overtime or PRN staff shifts o Aggressively running ads in various social media platforms o Continuous signing up with new staffing agencies in addition to the ones we already use o Attended job fairs outside of facility o Flexible shifts and schedules o Increased wages to be well above state minimum o Increased agency staff wages o Approved agency overtime o Increased expedience getting staff on board by offering Orientation every week o Working with C.N.A. schools to recruit new grads and to send temp N.A.'s for	

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S 560	Continued From page 2 - 02/11/2023 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. 2. A review of the "Nurse Staffing Report," completed by the facility for the week of 02/12/2023 - 02/18/2023, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 1 of 7 day shifts in CNAs as follows: - 02/18/2023 had 15 CNAs for 125 residents on the day shift, required 16 CNAs. During an interview on 02/23/2023 at 2:15 PM, the Administrator stated the facility tried to follow the staffing ratio guidelines and used agency staff. The Administrator indicated her expectation was to have the facility fully staffed per the New Jersey state guidelines.	S 560	certification o Allow C.N.A. training classes in facility o Offer Tuition reimbursement in full for all new grads o Facility currently offering housing MONITORING OF MEASURES: • Staffing Coordinator or designee will provide weekly reports to the Director of Nursing and Administrator regarding all efforts made to try to comply with the State's Staffing Ratios. • Reports will be submitted to the QAPI Committee monthly X 3 months. • Director of Nursing will submit monthly reports to document status of all recruitment efforts. Director of Nursing will report monthly to the QAPI Committee X 3 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315425	A. Building B. Wing	4/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	39 EAST MOUNTAIN ROAD HILLSBOROUGH, NJ 08844

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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 03/31/2023	ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 03/31/2023	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 03/31/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/23/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061803 Y1	A. Building B. Wing Y2	4/17/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	39 EAST MOUNTAIN ROAD HILLSBOROUGH, NJ 08844

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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 03/31/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON
2/23/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315425	A. BUILDING **03** B. WING _____	C **02/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	**39 EAST MOUNTAIN ROAD** **HILLSBOROUGH, NJ 08844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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		
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 02/23/2023 and Foothill Acres Rehabilitation & Nursing Center 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. Foothill Acres Rehabilitation & Nursing Center is a two-story Type II Protected building that was built in 2010. The facility is divided into 13 smoke zones.	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K 761		4/17/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/16/2023

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315425	A. BUILDING **03** B. WING _____	C **02/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	**39 EAST MOUNTAIN ROAD** **HILLSBOROUGH, NJ 08844**

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K 761	Continued From page 1 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on interviews and facility document review, it was determined the facility failed to inspect all fire-rated doors required by National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protective. This deficient practice had the potential to affect 119 residents. The facility identified 70 fire rated doors in the facility. Findings included: A review of life safety code documentation revealed no annual inspection of all fire rated doors for the prior 12 months. During an interview on 02/23/2023 at 1:17 PM, the Maintenance Director stated he had never been asked for an annual fire rated door inspection for all fire-rated doors. The Maintenance Director indicated he was not aware of the code requirements to annually inspect the fire rated doors and had been employed by the facility as the Maintenance Director for three years. The Maintenance Director acknowledged the findings and stated he expected all life safety code requirements to be followed. In an interview on 02/23/2023 at 1:51 PM, the Administrator stated he was not aware of the requirements to annually inspect all fire rated doors. The Administrator indicated the	K 761	Recertification Survey: February 23, 2023 Plan of Correction: K761 NFPA 101 Life Safety Code Standard 2012 Edition NFPA 80 SS=F Date of Completion: April 17, 2023 Corrective Action(s): There was no harm to the residents due to the deficient practice. All the fire doors will be inspected. Identifying Other Residents: All residents had the potential to be affected by the deficient practice. Measures Put Into Place: The Maintenance Dept received quotes from vendors certified to inspect fire doors. We selected the vendor that was able to accommodate our mandatory completion date. Root cause analysis revealed Maintenance Dept was unaware of the NFPA Life Safety Code requiring annual inspection of all fire doors. In-servicing of Maintenance personnel were held reeducating staff of the requirement. Monitoring Measures: The Maintenance Director or designee will audit fire doors monthly to ensure the fire	

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	315425	A. BUILDING **03** B. WING _____	C **02/23/2023**

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K 761	Continued From page 2 Maintenance Director was responsible for all life safety code requirements and expected all life safety code requirements to be followed. During a follow-up interview on 02/23/2023 at 1:53 PM, the Administrator stated the facility did not have a policy regarding inspecting all fire-rated doors. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	doors meet NFPA 101 Life Safety Code Standard 2012 Edition NFPA 80, with results of the audit to be brought to the QA Committee quarterly to ensure desired outcomes are met and sustained.	

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

POST-CERTIFICATION REVISIT REPORT

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315425	A. Building 03 - FOOTHILL ACRES B. Wing	4/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	39 EAST MOUNTAIN ROAD HILLSBOROUGH, NJ 08844

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ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 04/17/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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