STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING _____ B. WING _____	C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	**2300 HAMILTON AVE HAMILTON, NJ 08619**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: 07/11/23 CENSUS: 195 SAMPLE SIZE: 35 + 3 closed records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide a physically impaired resident clear access to the handrails equipped in the hallways. This deficient practice was identified for Resident #27, 1 of 35 residents reviewed and was evidenced by the following:	F 558	Resident #27 was affected by this deficient practice. Additionally, this deficient practice had the potential to affect all residents. All carts and equipment obstructing the handrails in the hallways were removed to ensure clear access for all residents,	8/25/23

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

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F 558	Continued From page 1 During an interview with Resident #27 on 07/06/2023 at 11:29 AM, the resident stated the handrails were blocked daily with carts and he/she did not have clear access to use the handrails along the hallways. The surveyor observed in the hallway directly outside Resident #27's room, there were three carts along both sides of the hallway. A linen cart, a medical cart, and a cart used by the CNAs. At the time of observation, none of the three carts were in use, the linen cart was on the left side against the handrails and the other two carts were placed against the handrails on the right side. The surveyor interviewed Certified Nurse Aide (CNA) who observed the three carts on both sides of the hallway. The CNA added their cart was being used but confirmed the other two carts were located on opposite sides of the hallway against the handrails. The CNA further confirmed that the handrails should be clear for the residents use. The surveyor interviewed the Unit Manager (UM) on that same date, who observed the same and confirmed that the handrails should be clear at all times. The surveyor toured the remaining hallways with the Director of Nursing (DON) and observed there were carts and equipment located on each side of the hallways in each unit on each floor. The DON confirmed the handrails should be clear at all times to allow the residents access.	F 558	including Resident #27. An interview was conducted with Resident #27 to discuss specific needs and preferences regarding accessibility and mobility. Resident was reassured that this practice was corrected and will continue to be so moving forward. Staff training and in-services were immediately provided to all CNA□s (Certified Nursing Assistants), nurses, and relevant staff regarding the importance of keeping hallways clear at all times, especially the areas around handrails. All staff were further educated to reinforce the understanding that clear access to handrails is essential for residents with mobility impairments, including those who require the use of wheelchairs. All out of use carts and equipment will be placed in non-patient areas unless in use. When in use, everything will be on one side of the hallway to provide physically impaired residents clear access to the handrails equipped in the hallways. The Director of Nursing/Designee will conduct weekly auditing of the hallways to ensure that handrails remain unobstructed at all times and all carts and equipment not in use are stored away and all in-use carts and equipment are on one side of the hallway. The Director of Nursing/Designee will conduct these weekly audits for the next four weeks then	

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F 558	Continued From page 2 The surveyor reviewed the annual Minimum Data Set (MDS) an assessment tool dated EX Order 26.4B1 which revealed Resident #27 was EX Order 26.4B1 [redacted] with a Brief Interview for Mental Status (BIMS) of [redacted] The MDS further indicated that Resident #27 locomotion on and off the unit required supervision, the resident required use of a wheelchair, and further revealed EX Order 26.4B1 on EX Order 26.4B1 in both the EX Order 26.4B1 [redacted]. On 07/11/2023 at 12:13 PM, the Administrator stated that they had given the staff in-services to keep unused equipment out of the hallways to ensure easy access to handrails. NJAC 8:39- 4.1 (a) 11 and 12.	F 558	monthly x 2 months. Any untoward results will be corrected immediately and the staff will receive re-education by the staff educator on the deficient area with return demonstration of the corrected practice to determine competency. The Director of Nursing/Designee will report the findings of the weekly and monthly auditing to the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to EX Order 26.4B1 a Resident with a significant EX Order 26.4B1 in EX Order 26.4B1. This deficient practice was identified in Resident #86, 1 of 1 resident reviewed for NJ Exec. Ord [redacted] and was evidenced by the following: On 06/27/23 at 09:35 AM, the surveyor observed the resident in the bed awake. The resident was a EX Order 26.4B1 resident and the surveyor observed a syringe/container in a closed plastic container with a date of EX Order 26.4B1. The resident	F 658	I. Corrective action(s) accomplished for resident(s) affected: Resident #86 was EX Order 26.4B1 on EX Order 26.4B1 and it was determined that the resident□s weight was EX Order 26.4B1 There was no negative impact from the documented weight error. II. Residents identified having the potential to be affected and correction action taken: All residents who had a significant weight	8/25/23

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F 658	Continued From page 3 could not be interviewed due to cognitive status. Review of Resident #86 admission record revealed the resident was admitted to the facility in [redacted] Medical diagnoses included, but not limited to EX Order 26.4B1 [redacted] The surveyor reviewed the most recent quarterly Minimum Data Set (MDS) an assessment tool dated [redacted]. Under section K, titled swallowing, and nutritional status, EX Order 26.4B1 was coded as one, meaning the resident had a EX Order 26.4B1 Resident #86 had a Brief Interview of Mental Status (BIMS) of [redacted] meaning the resident [redacted] due to the EX Order 26.4B1 [redacted] On 06/27/23 at 10:45 AM, the surveyor reviewed the resident [redacted] in the Electronic Medical Record (EMR). It revealed that Resident #86 had an EX Order 26.4B1 [redacted]. There was not a repeat [redacted] at the time of the review. EX Order 26.4B1 [redacted] On 06/27/23 at 12:31 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) regarding the most recent [redacted] and the EX Order 26.4B1 that was documented for Resident #86 in the EMR on	F 658	change of +/- five pounds had the potential to be affected by this practice. An audit was conducted by the facility dietitian and determined that no other residents were affected by this practice. III. Measures were put into place to ensure the deficient practice will not recur: The facility Weight Policy and Procedure was reviewed by the interdisciplinary team. No changes to the weight policy were recommended. The Licensed Nurse documenting the erroneous weight was re-educated on the facility policy for weights and when it is necessary to obtain a reweigh. Licensed nursing staff were re-educated on the facility weight policy emphasizing the procedure section of the weight policy to include that a re-weight is required if the resident had a weight change of +/- five pounds. Corrective actions will be monitored to ensure the deficient practice will not recur: The Dietitian/designee will conduct weekly (one time per week) audits for the next four weeks then monthly x 2 months on resident weekly weights to ensure that weight changes of +/- five pounds have re-weighs, and that the Dietitian is kept informed of these weight changes. Any untoward results will be corrected immediately. Staff will receive	

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F 658	Continued From page 4 EX Order 26.4B1. The unit manager told surveyor that a reweight would be done to confirm the weight. The surveyor asked when and the UM/LPN said, "right away". The UM/LPN could not say why the weight was not done on EX Order 26.4B1 the time of the weight change was identified. On 06/27/23 at 12:39 AM, the surveyor reviewed the progress notes from all disciplines and there was no documentation regarding the EX Order 26.4B1 and no notification to the physician had been documented. On 06/28/23 at 11:08 AM, the surveyor interviewed the UM/LPN regarding the resident's re-weight. The UM/LPN told the surveyor that the resident was a weekly weight, and the re-weigh should have been done that day, NJ Exec. Order 26:4.b.1 . The surveyor asked if it was done after the surveyor inquired and the UM/LPN said, "no, the resident gets weighed weekly". The surveyor asked if anyone was notified of the EX Order 26.4B1, and the UM/LPN said, "No, the resident will be reweighed before anyone is notified". On 06/28/23 at 11:35 AM, the UM/LPN approached the surveyor and said, "It was an error, the resident's NJ Exec. Order 26:4.b.1". The UM/LPN told the surveyor, "They should have told me or someone else and got a NJ Exec. Order 26:4.b.1 right away, it was EX Orde pound difference". On 06/28/23 at 12:01 PM, the surveyor reviewed the care plan which showed the following focus: Resident at NJ Exec. Order 26:4.b.1 related to medical diagnoses. Interventions included monitoring NJ Exec. Order 26:4.b.1 weekly as ordered.	F 658	re-education by the Dietitian/designee as applicable. The Dietitian/designee will report the results of the weekly weight audits to the Quality Assessment and Assurance (QAA) Committee for the next quarter. The QAA Committee will determine the need for any additional monitoring of weight at the next quarterly meeting.	

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F 658	Continued From page 5 On 07/11/23 at 11:20 AM, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) met with the survey team. The LNHA said the staff were re-educated on the facility weights policy. The surveyor asked the DON if a weight gain such as [redacted] pounds could mean the resident had a new medical condition and the DON shook her head yes. On 07/12/23 at 09:00 AM, the surveyor reviewed the policy titled, "Weight policy and procedures". The policy had a revision dated of October 11, 2021. Number one, under the procedure section of the policy stated that a re-weigh is required if the resident had a weight change of +/- five pounds.	F 658		
F 812 SS=D	NJAC 8:39-27.1 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		8/25/23

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F 812	Continued From page 6 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner in order to prevent food borne illness. This deficient practice was evidenced by the following: On 06/26/2023 at 9:58 AM, the surveyor accompanied by the Food service Director (FSD) observed the following in the kitchen: The surveyor observed a number of unlabeled and undated items located throughout the kitchen in the refrigerators and freezers which included seven bags of shredded cheese, two roasts, one crate of milk, two bags of frozen French fries, two bags of frozen tater tots, and one bag of frozen broccoli. There were also two metal containers over the shelf located in the food prep area with unlabeled and undated items which included six baggies filled with potato chips, 10 packs of crackers, and one bagel. The surveyor observed four personal disposable cups of beverages located in the food prep areas. The first item observed was an uncovered cup of ice water which was left next to an unwrapped block of cheese. The FSD confirmed at the time of observation, that the items should not be left in the food prep area at any time	F 812	This deficient practice had the potential to affect all residents. I. Corrective action(s) accomplished for resident(s) affected: The items identified in the refrigerators and freezers that were unlabeled and undated were discarded. The items in the two metal containers that were unlabeled and undated were discarded. The personal disposable cups of beverages located in the food prep areas were discarded. A sanitizer bucket was made available in the food prep area. II. Residents identified having the potential to be affected and correction action taken: Residents residing in the facility had the potential to be affected by this practice. No residents were identified as having any negative effects from this practice. III. Measures were put in place to ensure the deficient practice will not recur: The policy for Labeling and Dating of Perishable Food Products was reviewed by the Regional Food Service Director and Food Service Director and determined no updates were required.	

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F 812	Continued From page 7 uncovered. The surveyor also observed two cups of covered coffee and one covered cup with an outside vendor's logo located on the food prep counters, along with two bottles of soda located on the bottom shelf of a cart which had food on the top shelf. The FSD observed the items at the time of the survey and confirmed that all the beverages belonged to staff. The surveyor further observed there was no sanitizer bucket available in the food prep area until after surveyor's inquiry. The policy "Eating, Drinking, Chewing Gum in Food Service Areas" dated for 2023 revealed the following under the Purpose heading, Small droplets of saliva can contain pathogens. In the process of eating, drinking, and chewing gum, saliva can be transferred to hands or directly to food being handled. Procedure: Dietary staff will not consume food or drink in work areas involving exposure or potential exposure to blood or other potentially infectious or toxic materials, or where the potential for contamination of work surfaces exist. The policy "Labeling and Dating of perishable food products" outdated 2017 with a revised date of 2022, revealed any opened perishable and/or nonperishable food items shall be labeled and dated to ensure food safety. 3. All persishable and left over food items shall be marked with a "Use by Date". NJAC 8:39-17.2(g)	F 812	The policy for Eating, Drinking, Chewing Gum in Food Service Areas was reviewed by the Regional Food Service Director and Food Service Director and determined no updates were required. A date gun was purchased to simplify the process for labeling items as they are received. All individual packages, not just the receiving container, are labeled individually. The Regional Food Service Director re-educated the Food Service Director on labeling and dating food items and maintaining a sanitizer bucket available in the food prep area. The Food Service Director re-educated the Dietary staff regarding labeling, dating items with the date gun, use of the sanitizer bucket, and use of personal disposable cups for beverages in the food prep area. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Food Service Director will conduct weekly (one time per week) audits for the next four weeks then monthly x 2 months on labeling and dating food items in the kitchen, use of the sanitizer bucket and use of appropriate beverage containers for staff. The Food Service Director/designee will report the results of the weekly labeling	

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F 812	Continued From page 8	F 812	and dating audits, use of sanitizer buckets, and use of appropriate beverage containers for staff audits to the Quality Assessment and Assurance (QAA) Committee for the next quarter. The QAA Committee will determine the need for any additional monitoring of theseServat the next quarterly meeting.	

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: NJ00156348, NJ00158226 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey for 1.) the weeks of 07/10/ 22 through 07/23/22, 2.) the weeks of 09/11/22 through 09/24/22, and 3.) for the weeks of 06/11/23 through 06/25/23. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	No residents were identified to have had any negative effect from the current staffing ratios. The deficient practice has the potential to affect all residents residing at the facility. The Staffing Policy and Procedure was reviewed to ensure alignment with the New Jersey Department of Health staffing requirements. No additional updates were required at this time. Education was provided to the Staffing Coordinator on the Staffing Policy and Procedure as well as the impact of	8/25/23

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

Electronically Signed | 08/03/23

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S 560	Continued From page 1 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 (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. As per the "Nurse Staffing Report" completed by the facility for the for the 2 weeks of Complaint staffing from 07/10/2022 to 07/23/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -07/10/22 had 12 CNAs for 162 residents on the day shift, required 20 CNAs. -07/11/22 had 15 CNAs for 162 residents on the day shift, required 20 CNAs. -07/12/22 had 15 CNAs for 162 residents on the day shift, required 20 CNAs. -07/13/22 had 19 CNAs for 162 residents on the day shift, required 20 CNAs. -07/14/22 had 17 CNAs for 162 residents on the day shift, required 20 CNAs. -07/15/22 had 14 CNAs for 165 residents on the day shift, required 21 CNAs.	S 560	appropriate staffing levels on the resident□s care quality. The facility along with administration has been diligently working on increasing staff ratios. The facility implemented targeted recruitment strategies to attract qualified Certified Nurse Aides (CNA□s) and direct care staff to meet staffing requirements. The efforts the facility has made thus far have been as follows: " A market study of the area rates was conducted to ensure rates were above the competitors. " Rates have been increased to encourage more applicants to apply. " A dedicated facility recruiter was hired to advertise and identify potential job candidates and set up interviews. " The facility advertises on various job listing websites that are generally visited by CNA applicants. " Multiple staffing agencies have been contracted to ensure sufficient staff is available to maintain compliance with the mandated ratios. " The facility has connected with a local Certified Nursing Assistant (CNA) training program. Facility staff visit with the new students to offer job opportunities and answer any questions they may have. The facility has also reevaluated the effectiveness of the already existing employee morale committee designed to assist with staff retention to enhance the	

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	061103	A. BUILDING: _____ B. WING _____	C 07/11/2023

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HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -07/16/22 had 14 CNAs for 165 residents on the day shift, required 21 CNAs. -07/17/22 had 10 CNAs for 164 residents on the day shift, required 20 CNAs. -07/18/22 had 13 CNAs for 163 residents on the day shift, required 20 CNAs. -07/19/22 had 16 CNAs for 163 residents on the day shift, required 20 CNAs. -07/20/22 had 15 CNAs for 161 residents on the day shift, required 20 CNAs. -07/21/22 had 15 CNAs for 161 residents on the day shift, required 20 CNAs. -07/22/22 had 14 CNAs for 161 residents on the day shift, required 20 CNAs. -07/23/22 had 11 CNAs for 161 residents on the day shift, required 20 CNAs. 2. For the 2 weeks of Complaint staffing from 09/11/2022 to 09/24/2022, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -09/11/22 had 12 CNAs for 173 residents on the day shift, required 22 CNAs. -09/11/22 had 8 CNAs to 19 total staff on the evening shift, required 9 CNAs. -09/12/22 had 17 CNAs for 173 residents on the day shift, required 22 CNAs. -09/13/22 had 18 CNAs for 173 residents on the day shift, required 22 CNAs. -09/14/22 had 19 CNAs for 173 residents on the day shift, required 22 CNAs. -09/15/22 had 16 CNAs for 173 residents on the day shift, required 22 CNAs. -09/16/22 had 20 CNAs for 173 residents on the day shift, required 22 CNAs.	S 560	overall staff. The committees efforts being made in this area are as follows: " The committee organizes activities, recognition programs, and events to promote a positive work culture, leading to increased employee satisfaction and motivation. " The committee encourages teamwork and collaboration among employees, creating a sense of belonging and camaraderie within the organization. " The committee serves as a channel for employees to voice their ideas and suggestions, creating better communication between management and staff. " The committee helps stimulate innovation by creating spaces for brainstorming, creativity, and sharing ideas. " Through various activities and initiatives, the committee has reinforced the facility□s values as well as others cultures which in turn created a warm work environment. The Director of Human Resources/Designee will conduct weekly audits of Certified Nurse Aide (CNA) staffing reports for the next 3 months to ensure the facility maintains the required minimum direct care staff-to-resident ratios for the day shift. The Director of Human Resources/Designee will report the results of the weekly audits to the Quality Assurance Performance Improvement (QAPI) Committee for the quarter. At that time, the QAPI Committee will determine if any additional follow-up is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 -09/17/22 had 14 CNAs for 173 residents on the day shift, required 22 CNAs. -09/18/22 had 13 CNAs for 173 residents on the day shift, required 22 CNAs. -09/18/22 had 16 total staff for 173 residents on the evening shift, required 17 total staff. -09/19/22 had 15 CNAs for 173 residents on the day shift, required 22 CNAs. -09/20/22 had 19 CNAs for 169 residents on the day shift, required 21 CNAs. -09/21/22 had 16 CNAs for 166 residents on the day shift, required 21 CNAs. -09/22/22 had 17 CNAs for 166 residents on the day shift, required 21 CNAs. -09/23/22 had 18 CNAs for 165 residents on the day shift, required 21 CNAs. -09/24/22 had 16 CNAs for 165 residents on the day shift, required 21 CNAs. 3. For the 2 weeks of staffing prior to survey from 06/11/2023 to 06/24/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -06/11/23 had 15 CNAs for 190 residents on the day shift, required 24 CNAs. -06/12/23 had 21 CNAs for 190 residents on the day shift, required 24 CNAs. -06/13/23 had 16 CNAs for 190 residents on the day shift, required 24 CNAs. -06/14/23 had 20 CNAs for 190 residents on the day shift, required 24 CNAs. -06/15/23 had 19 CNAs for 190 residents on the day shift, required 24 CNAs. -06/16/23 had 17 CNAs for 191 residents on the day shift, required 24 CNAs. -06/17/23 had 17 CNAs for 191 residents on the day shift, required 24 CNAs. -06/18/23 had 12 CNAs for 188 residents on the	S 560	needed. The Director of Human Resources/Designee will conduct weekly meetings with the Administrator and Director of Nursing as feasible to review daily CNA ratios. This will continue for the next 3 months. At that time, the Director of Human Resources/Designee, Administrator and Director of Nursing will determine if any additional follow up is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 day shift, required 23 CNAs. -06/19/23 had 21 CNAs for 188 residents on the day shift, required 23 CNAs. -06/20/23 had 18 CNAs for 188 residents on the day shift, required 23 CNAs. -06/21/23 had 20 CNAs for 188 residents on the day shift, required 23 CNAs. -06/22/23 had 17 CNAs for 192 residents on the day shift, required 24 CNAs. -06/23/23 had 21 CNAs for 192 residents on the day shift, required 24 CNAs. -06/24/23 had 20 CNAs for 192 residents on the day shift, required 24 CNAs. On 07/11/23 at 09:04 AM, the surveyor interviewed the facilities Staffing Coordinator who had been employed by the facility for 10 years. The Staffing Coordinator (SC) was aware of the ratios for all shifts and when asked if the ratios were met, she stated, "We try our best". The SC told the surveyor the facility utilized staffing agencies, recruiting resources, and offered incentives and bonuses. The SC also told the surveyor that for retention they offer several things to boost morale, "like cultural day". On 07/11/23 at 11:08 AM, the surveyor reviewed the policy titled, "Staffing Policy and Procedure". The policy had a review date of 12/7/23. It indicated that it was the policy of the facility to provide adequate staffing to meet needed care and services for our resident population. Under the procedure section of the policy, it indicated that Certified Nursing Assistants will be available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan and with the following rations:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 Once certified nurse aide 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 care staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and one direct care staff member to every fourteen residents for the night shift, provided that each direct care staff member shall be signed in to work as a certified nurse aid and perform certified nurse aid duties.	S 560		

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)
315423	A. Building B. Wing	8/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	2300 HAMILTON AVE HAMILTON, NJ 08619

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 F0558 Reg. # 483.10(e)(3) LSC	Correction Completed 08/25/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 08/25/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 08/25/2023
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

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	
7/11/2023	☐ 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
061103 Y1	A. Building B. Wing Y2	8/31/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	2300 HAMILTON AVE HAMILTON, NJ 08619

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/25/2023	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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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 7/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING **01** B. WING _____	**07/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	**2300 HAMILTON AVE** **HAMILTON, NJ 08619**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1990s with no current major renovations or noted additions. It is a three story building Type II (222) protected construction and is fully sprinklered. The 200 KW interior Cummins diesel generator does approximately 60% of the facility.The 3-story building has 11-smoke zones with 2-elevators. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The (interior) generator is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility has 218 certified beds. At the time of the survey, the census was 195. The requirement at 42 CFR Subpart 483.90(a) was NOT MET.	K 000		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		8/25/23

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

Electronically Signed | 08/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING **01** B. WING _____	**07/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	**2300 HAMILTON AVE** **HAMILTON, NJ 08619**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 1 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/29/2023, in the presence of the Maintenance Director (MD), Regional Plant Operations Director (RPOD), and Administrator (ADMIN), it was determined that the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard and was identified by three electronic items located in one (1) of four (4) offices observed and was evidenced by the following: On that same date at 11:12 AM, the surveyor, MD, RPOD, and ADMIN observed in the 1st floor Hamilton nurse main office (across from the dining room), that three (3) refrigerators were	K 920	This deficient practice did not affect any residents, staff or visitors but had the potential to affect all residents, staff and visitors. I. Corrective action(s) accomplished for resident(s) affected: The appliances plugged into the multi-outlet power strip located in the 1st floor nursing office were removed from the power strip and plugged directly into an outlet. The multi-outlet power strip was removed. II. Residents identified having the potential to be affected and correction action taken: Residents residing in the facility had the potential to be affected by this practice. No residents were identified as having any negative effects from this practice. An audit was conducted by Maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING **01** B. WING _____	**07/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	**2300 HAMILTON AVE** **HAMILTON, NJ 08619**

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K 920	Continued From page 2 plugged into one (1) multi-outlet power strip. The multi-outlet power strip was then plugged into a duplex wall outlet. The findings were verified by the MD, RPOD, and ADMIN at the time of the observations, where they stated and confirmed that high draw appliances cannot be plugged into multi-outlet power strips in the facility. The MD, RPOD, and ADMIN were informed of the finding at the Life Safety Code Exit Conference on 06/29/2023. NJAC 8:39-31.2(e)	K 920	personnel for high draw appliances and determined that no other power strips were in use. III. Measures will be put into place to ensure the deficient practice will not recur: Maintenance personnel upon receiving the results of this survey noting the deficient practice, immediately re-educated staff that power strips and extension cords are prohibited beyond temporary installation, as a substitute for adequate wiring, in accordance with the requirements of NFPA guidelines. The Maintenance Department added routine checks of high draw appliances to their routine maintenance checklist to assure power strips and extension cords are not utilized. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: Designated Maintenance staff will conduct weekly (one time per week) audits for the next four weeks then monthly x 2 months on high draw appliances to ensure that no power strips are in use. Any untoward findings will be corrected immediately by Maintenance personnel and reported to the Administrator. The designated Maintenance staff member will report the results of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING **01** B. WING _____	**07/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	**2300 HAMILTON AVE** **HAMILTON, NJ 08619**

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K 920	Continued From page 3	K 920	weekly and monthly high draw appliance audits to the Quality Assessment and Assurance (QAA) Committee for the next quarter. The QAA Committee will determine the need for any additional monitoring of these audits at the next quarterly meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315423 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/31/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	2300 HAMILTON AVE HAMILTON, NJ 08619

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 08/25/2023	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
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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	
7/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO