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 12/21/2023

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
F 000	INITIAL COMMENTS COMPLAINT # NJ00167104, NJ00169822 CENSUS: 200 SAMPLE SIZE: 6 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		1/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/31/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 1 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842		

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	315423	A. BUILDING ______ B. WING ______	C 12/21/2023

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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F 842	Continued From page 2 This REQUIREMENT is not met as evidenced by: C #: NJ00167104 Based on interviews, medical record review, and review of other pertinent facility documents on 12/21/23, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" (DSR) the Activities of Daily Living (ADL) status and care provided to the resident according to facility policy and protocol for 1 of 3 residents (Resident #3) reviewed for documentation. This deficient practice was evidenced by the following: According to the facility "Admission Record (AR)," Resident #3 was admitted with diagnoses that included but were not limited to EX Order 26.4B1 The Minimum Data Set (MDS), an assessment tool, dated NJ Exec. Order 26.4, revealed a Brief Interview of Mental Status (BIMS) of EX O which indicated the resident's cognition was EX Order 26.4B1 and the resident needed assistance with Activities of Daily Living (ADL) including toileting. Review of Resident #3's DSR (ADL Record) and the progress notes (PN) for the month of EX Order 26.4B1 and EX Order 26.4B1, lack any documentation to indicate that the care for toileting was provided and/or the resident EX Order 26.4B1 on the following dates and shifts. 7:00 am-3:00 pm shift on 8/6/23, 8/12/23, 8/17/23, 8/27/23, 9/3/23 3:00 pm-11:00 pm shift on 8/5/23 to 8/9/23, 8/12/23, 8/15/23 to 8/16/23, 8/18/23, 8/22/23 to	F 842	Resident identified as #3 is no longer a resident of the facility but was not affected by this deficient practice and was toileted as needed. This deficient practice had the potential to affect all residents lacking documentation of Activities of Daily Living (ADL) at the facility. All Certified Nursing Assistance (CNA) received re-education on the Documentation Policy which addresses documentation on Activities of Daily Living (ADL) status and care provided to the residents in accordance with state and federal laws and regulations. A review of ADL documentation for current residents requiring assistance was conducted to identify potential gaps in care documentation. Through the reviewal process, no residents were identified as being affected by this practice. CNAs are responsible for documenting the ADL care they provided to the residents into the Point of Care (POC). As such, CNAs must document in the kiosk subsequent to providing care to a resident. The facility will ensure no other residents will be affected by this practice as it will monitor all future documentation of ADLs. The Director of Nursing (DON) Unit Managers (UM) and/or designee will monitor all Point of Care documentation to ensure it is completed by end of shift. If it is not completed, the CNA will be requested to return to work to complete the documentation and will receive	

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	315423	A. BUILDING ______ B. WING ______	C 12/21/2023

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HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	2300 HAMILTON AVE HAMILTON, NJ 08619

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F 842	Continued From page 3 8/23/23, 9/1/23, 9/5/23 11:00 pm-7:00 am shift on 8/8/23, 8/12/23, 8/19/23, 8/24/23, 8/26/23 to 8/29/23, 9/1/23 to 9/2/23, 9/4/23 to 9/5/23 During an interview with the surveyor on 12/21/23 at 11:15 a.m., the Certified Nursing Assistant (CNA) stated that after providing care to a resident, she would document in the kiosk at the end of the day. CNA further explained that she is responsible for documenting the ADL care provided into the Point of Care (POC). During an interview with the surveyor on 12/21/23 at 3:36 p.m., the Director of Nursing (DON) stated that CNAs are to document that the care were provided to the residents in the DSR at the end of the shift. DON further stated it is important to document to indicated that the care was provided. A review of the facility's policy titled, "Documentation Policy" under Policy "Documentation is a professional tracking to enhance continuity of care ...The key goals of a sound clinical documentation are to describe information in a way that everyone can understand what is happening to the resident and to enhance continuity of care so that the staff on all shift and among all disciplines will know what must be carried out to monitor outcomes of care ...Who will Document: All members of the interdisciplinary team (licensed nursing staff) ...who provided care and services to the resident ...Where it will be documented: All documentation will be documented in the Electronic Health Record (EHR) which in this facility is Point Click Care (PCC) ...Why it will be documented: To enhance continuity of care so that the staff on all shifts and among all	F 842	education and disciplinary action when applicable. The Documentation Policy was reviewed and reinforced in order to emphasize the importance of proper documentation. In services were provided to all CNAs on how and when to document. UMs were requested to monitor POC documentation moving forward. The DON also designated an employee to check at the end of the shifts to ensure all documentation was completed for that shift. Additionally, the DON will monitor as well to establish that compliance is achieved. The Director of Nursing/Designee will conduct weekly POC reviews of each unit to audit for compliance with proper documentation of ADLs for the next four weeks then monthly x 2 months. Any untoward results will be corrected immediately and the nurse 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 POC audits to the next quarterly Quality Assurance (QA) meeting for follow-up and to determine if additional oversight of this area is required.	

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F 842	Continued From page 4 disciplines will know what must be carried out ..." NJAC 8:39-35.2(d)(9)	F 842		

New Jersey Department of Health

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	061103	A. BUILDING: ______ B. WING ______	C 12/21/2023

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

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S 000	Initial Comments COMPLAINT # NJ00167104, NJ00169822 CENSUS: 200 SAMPLE SIZE: 6 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 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 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: Based on facility document review on 12/21/2023, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 21 of 21 day shifts. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	No residents were identified to have had a negative impact from the current staffing ratios. This deficient practice had the potential to affect all residents residing at the facility during the time periods that the facility did not reach the proper staffing ratios per the state of New Jersey. The Director of Nursing (DON) and Staffing Coordinator implemented a comprehensive review process of staffing	1/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 01/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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 Aide (CNA) 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 CNAs, 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 CNA and perform CNA duties. The survey team requested staffing for the weeks of 9/3/2023 to 9/9/2023 and 12/3/2023 to 12/16/2023. 1. For the week of Complaint staffing from 09/03/2023 to 09/09/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -09/03/23 had 13 CNAs for 194 residents on the day shift, required at least 24 CNAs. -09/04/23 had 18 CNAs for 192 residents on the day shift, required at least 24 CNAs. -09/05/23 had 21 CNAs for 192 residents on the day shift, required at least 24 CNAs. -09/06/23 had 18 CNAs for 192 residents on the	S 560	schedules to ensure compliance with New Jersey state regulations regarding the required staff-to-resident ratios. A meeting to review staffing for the upcoming week was immediately held and will continue on a weekly basis as feasible. This meeting included and will continue to include the Staffing Coordinator, Director of Human Resources (HR) Director of Nursing (DON) and Administrator as feasible. Open positions for Certified Nursing Assistance (CNA) were posted on multiple websites with sponsorships to increase applicant pool. A new system was created by the facility to address callouts. A shared document notating every call out was created to identify staff callouts and provide education and discipline when necessary. The facility has also increased nursing rates (such as CNA rates) to further encourage applicants to apply for positions at the facility. A CNA school was contacted to notify them of open positions that can be filled by their students. The CNA school agreed to notify their students. Additionally, the facility administrator went to the school to provide applications to the students and to set up interviews. A very positive outcome was received and a relationship with this school will continue so as to fill any vacant CNA positions. An immediate audit was conducted of staffing ratios for the future month to identify any further instances of non-compliance with staffing ratios and to ensure appropriate ratios are met. The facility will continually work to obtain staffing ratios that align with the New	

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	061103	A. BUILDING: ___ B. WING ___	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 day shift, required at least 24 CNAs. -09/07/23 had 19 CNAs for 192 residents on the day shift, required at least 24 CNAs. -09/08/23 had 19 CNAs for 201 residents on the day shift, required at least 25 CNAs. -09/09/23 had 19 CNAs for 201 residents on the day shift, required at least 25 CNAs. 2.For the 2 weeks of Complaint staffing from 12/03/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/03/23 had 14 CNAs for 195 residents on the day shift, required at least 24 CNAs. -12/04/23 had 18 CNAs for 195 residents on the day shift, required at least 24 CNAs. -12/05/23 had 22 CNAs for 195 residents on the day shift, required at least 24 CNAs. -12/06/23 had 19 CNAs for 195 residents on the day shift, required at least 24 CNAs. -12/07/23 had 18 CNAs for 197 residents on the day shift, required at least 25 CNAs. -12/08/23 had 19 CNAs for 197 residents on the day shift, required at least 25 CNAs. -12/09/23 had 20 CNAs for 196 residents on the day shift, required at least 24 CNAs. -12/10/23 had 18 CNAs for 196 residents on the day shift, required at least 24 CNAs. -12/11/23 had 17 CNAs for 196 residents on the day shift, required at least 24 CNAs. -12/12/23 had 19 CNAs for 196 residents on the day shift, required at least 24 CNAs. -12/13/23 had 20 CNAs for 199 residents on the day shift, required at least 25 CNAs. -12/14/23 had 20 CNAs for 197 residents on the day shift, required at least 25 CNAs. -12/15/23 had 21 CNAs for 197 residents on the day shift, required at least 25 CNAs.	S 560	Jersey mandated staffing ratios. The facility's staffing policy was reviewed for accuracy to align with the state regulation. Additional training was provided to the Staffing Coordinator, Director of HR, DON and Administrator on effective staffing strategies. Additionally, the facility reached out to their advertising platforms for further ideas on how to ensure best practices for advertising and hiring are achieved. Follow up meetings were set to continue monitoring our performance. The goal of this plan aims to address the deficiency in staffing ratios and establish procedures to prevent recurrence, and to ensure ongoing compliance with New Jersey state regulations. The Director of Human Resources/Designee will conduct weekly audits of (CNA) staffing reports to ensure the facility maintains the mandatory minimum direct care staff-to-resident ratios. The Director of Human Resources/Designee will conduct weekly meetings with the Administrator and Director of Nursing as feasible to review daily CNA ratios. The Director of Human Resources will present the findings of the weekly staffing audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	

New Jersey Department of Health

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	061103	A. BUILDING: ______ B. WING ______	C 12/21/2023

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S 560	Continued From page 3 -12/16/23 had 20 CNAs for 197 residents on the day shift, required at least 25 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
315423 (Y1)	(Y2)	2/7/2024 (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 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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 01/31/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
12/21/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061103 Y1	A. Building B. Wing Y2	2/7/2024 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 01/31/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			