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 05/25/2021

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 C #: NJ: 138806, 140939, 142086 143027, 145106 Census: 162 Sample Size: 7 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 compliant visit.	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	F 842		6/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/04/2021

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 842	Continued From page 1 records, except when release is- (i) To the individual, or their resident 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	F 842		

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F 842	Continued From page 2 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C # NJ: 138806, 140939 Based on interviews and record review, as well as review of pertinent facility documents on 5/24/21 and 5/25/21, it was determined that the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices for 2 of 7 residents (Res #2 and Res #3). reviewed for documentation. This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Res #2 was admitted to the facility on NJAC 8:43E-2.1 ar, and readmitted on NJAC 8:43E-2.1 ar with diagnoses which included but were not limited to: NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . According to the Minimum Data Set (MDS), an assessment tool dated NJAC 8:43E-2.1 and E, Res #2 was NJAC 8:43E-2.1 and Exec Order 26, 4. b and required extensive to total assistance from staff with Activities of Daily Living (ADL). The MDS further showed that Res #2 was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. The Care Plan (CP) for Res #2 initiated on 7/12/13, revised on 7/6/15, showed that Res #2 required extensive assistance with NJAC 8:43E-2.1 ar NJAC 8:43E-2.1 Intervention included but was not limited to: Offer Res #2 NJAC 8:43E-2.1 ar according to his/her preference schedule as follows: 9:00 am to 10:00 am and 3:00 pm to 4:00 pm. The form "Documentation Survey Report V (version) 2 (DSRV2)" dated 7/2020 and 8/2020,	F 842	Resident #2 was discharged from this facility on NJAC 8:43E-2.1 and E. The residents NJAC 8:4 NJAC 8:43E-2.1 and Exe upon discharge. Resident #3 was discharged from the facility on NJAC 8:43E-2.1 and Exec O. The residents NJAC 8:4 NJAC 8:43E-2.1 and Exe upon admission on NJAC 8:43E-2.1 and Exe and was intact at the time of the residents discharge. The Registered Nurse making the error in the Nursing Admission Assessment for Resident #3 no longer works in this facility. The nurse who made the error did provide a written statement as to what had occurred with the admission documentation and was provided a verbal in-service by the Director of Nursing on the importance of accurately documenting nursing assessment findings. Residents requiring extensive assistance for toileting with a scheduled toileting plan had the potential to be affected. No other residents requiring extensive assistance were noted with scheduled toileting plans at the time this 2567 report was received. An audit was conducted on Point of Care (POC) documentation by the Certified Nurse Aides in Point Click Care (PCC) - which is the facility's electronic health record system - in regards to documenting activities of daily living that are performed more than once per shift. It was determined that re-education for staff on documenting multiple entries for activities	

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	315423	A. BUILDING ______ B. WING ______	C 05/25/2021

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F 842

Continued From page 3

for completion of ADLs under "Intervention/Task "NJAC 8:43E-2.1 and Exe at 9:00 am to 10:00 am, and 3:00 pm to 4:00 pm" did not include documentation that NJAC 8:43E-2.1 and was done for the following dates:
On 7/1/20 to 7/3/20, 7/5/20 to 7/11/20, 7/13/20, 7/15/20 to 7/22/20, 7/24/20, 7/26/20 to 7/27/20, 7/29/20 to 7/31/20, 8/4/20, 8/8/20, 8/11/20, 8/13/20, 8/21/20, and 8/23/20 during the 7:00 am to 3:00 pm shift.
On 7/9/20, 7/23/20, 8/2/20, 8/6/20, 8/8/20, and 8/25/20 during the 3:00 pm to 11:00 pm shift.

The surveyor conducted an interview with the Assistant Director of Nursing (ADON) and the Certified Nursing Assistant (CNA) on 5/25/21 at 10:05 am and 10:22 am. They could not explain why the aforementioned task was not documented on the aforementioned dates and time.

2. According to the AR, Res #3 was initially admitted to the facility on NJAC 8:43E-2.1 and E with diagnosis that included but was not limited to: NJAC 8:43E-2.1 and Ex NJAC 8:43E-2.1 ar.

The MDS for Res #3 dated 10/1/20 showed that the Resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. and required extensive assistance from staff with ADL.

The form "ADMISSION OBSERVATION-V6 (AOV6)" dated 9/24/20, documented by Registered Nurse (RN #1) showed that Res #3 had NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. in the following areas:
NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.
NJAC E

F 842

of daily living during the same shift was required.

Residents admitted on NJAC 8:43E-2.1 and Exe had the potential to be affected and were reviewed for nursing assessment documentation. It was determined that Resident #3 was admitted the same date as Resident #A. It was determined that skin assessments for Resident #3 and Residents #A were done by the same RN. The information for Resident #A was inadvertently copied on the assessment of Resident #3. The skin for Resident #3 was intact upon admission. Resident #A did have NJAC 8:43E-2.1 ar NJAC 8:43E-2.1 a sites with appropriate documentation upon admission with treatment orders in place. It was determined that no other residents were affected by this practice.

In-services will be conducted to re-educate licensed and certified nursing staff on Point of Care documentation for activities of daily living in Point Click Care. Education will include that documentation in POC should be done per encounter, not just once per shift, for tasks that could require multiple entries in a shift.

The Director of Nursing or Designee will conduct weekly audits on ADL documentation in POC on 8 charts each week for residents that require assistance with ADL care for the next 4 weeks, then monthly for the next 3 months to ensure that staff are documenting ADLs per encounter. Discrepancies will be reviewed with the staff assigned to the tasks and

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F 842	Continued From page 4 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. The aforementioned documentation did not reflect on the Resident's careplan, physician's order sheet, treatment records or anywhere in Res #3's medical record to indicate that the facility staff addressed the aforementioned NJAC 8:43E-2.1 and Exec Order 26 The surveyor conducted an interview with the Director of Nursing (DON) on 5/24/21 at 1:06 pm. The DON stated that he could not explain why there were no treatments and careplan for the aforementioned NJAC 8:43E-2.1 an. The DON could not locate additional documentation to reflect that the facility addressed the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and Exec Order 2 involving Res #3. The surveyor conducted a post survey telephone interview with RN #1 on 5/26/21 at 12:01 pm. The RN stated that he had two residents who were admitted on NJAC 8:43E-2.1 (Res #3 and Unsampled Res #A). He explained that he documented on the wrong chart. The documentation on the AOV6 was for Res #A not for Res #3. He further explained that Res #3 did not have NJAC 8:43E-2.1 an on the NJAC 8:43E-2.1 and Exec Order 26, 4. b. He revealed that he made a mistake in documentation and did not correct it. NJAC: 8:39-35.2(c)(d)(6)	F 842	re-education will be provided as needed. A new Clinical Morning Meeting Policy was created on 5/17/2021 and introduced to nursing leadership. An update to this policy was done on 5/25/2021 as a result of this survey and in-services were provided to nursing leadership with the updates. Nursing leadership meets Monday-Friday daily to review a list of clinical items including a review of all new admissions. New admission charts are reviewed to ensure the nursing assessment is complete; physician orders are in place and appropriate based on the resident□s assessment, (e.g., medications and treatments); and that baseline care plans have been initiated and updates are made accordingly. This new systematic approach to admission chart reviews will ensure that nursing admission assessments are reviewed for appropriate documentation and that physician orders are reflective of the resident□s needs. The licensed nursing staff will be educated on the importance of accurate documentation of nursing admission assessments to ensure an accurate clinical picture of the resident is obtained upon admission. The Director of Nursing or Designee will conduct weekly audits on admission skin assessment documentation for the next 4 weeks, then monthly for the next 3 months to ensure that skin assessments are documented in the correct chart.	

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F 842	Continued From page 5	F 842	Discrepancies will be reviewed with the staff completing the assessment and re-education will be provided as needed. The Director of Nursing will report the results of the weekly/monthly ADL documentation audits to the Quality Assessment and Assurance (QAA) Committee for quarter 2 2021 and quarter 3 2021. The QAA Committee will determine the need for any additional monitoring of ADL documentation at the quarter 3 2021 meeting. The Director of Nursing will report the results of the weekly/monthly nursing admission skin assessment documentation audits to the Quality Assessment and Assurance (QAA) Committee for quarter 2 2021 and quarter 3 2021. The QAA Committee will determine the need for any additional monitoring of nursing skin assessment documentation at the quarter 3 2021 meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315423		6/14/2021

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 06/11/2021	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 5/25/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			