STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	02/09/2022

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HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

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F 000	INITIAL COMMENTS Survey Date: 2/9/22 Census: 45 Sample: 18 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain ongoing records of communication between the nursing facility and the NJ Exec Order 26 center. This deficient practice was identified for 1 of 1 resident (Resident #25) reviewed for NJ Exec Order 26 and was evidenced by the following: On 2/3/22 at 10:22 AM, the surveyor interviewed Resident #25 who stated that he/she received NJ Exec Order 26.4b1 every week on Monday, Wednesday, and Friday. The surveyor reviewed the medical record for Resident #25.	F 698	F 698 D CFR 483.25 Dialysis How POC will be accomplished for those residents found to be effected: The Director of Nursing immediately contacted the Dialysis Center Director and coordinated the protocol for inter-facility communication for the management of the resident #25 NJ Exec Order 26.4b1 monitoring and care. A Communication Flow Sheet was immediately revised and place d in resident #25's communication binder and nursing staff were immediately educated	2/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/03/2022

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 698	Continued From page 1 A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 A review of the resident's most recent significant change Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, reflected a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated a NJ Exec Order 26.4b1 . A further review of the MDS Section O. Special Treatments, Procedures, and Programs; reflected that the resident received NJ Exec Order 26 treatments. A review of the resident's individualized care plan initiated on NJ Exec Order 26, included a problem for NJ Exec related to NJ Exec Order 26.4b1 with an approach for NJ Exec Order 26 Mondays, Wednesdays, and Fridays. On 2/8/22 at 10:19 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the facility's procedure for communication with the NJ Exec Order 26 center. The LPN stated that the resident's NJ Exec Order 26 book went to and from the NJ Exec Order 26 center with the resident on NJ Exec Order 26 days. The NJ Exec Order 26 center obtained the pre and post NJ Exec Order 26 vital signs and weights when the resident arrived at the center and prior to leaving the center. This was documented on the "NJ Exec Order 26 Communication Flow Sheet" along with any new orders or recommendations for the resident that was located in the resident's NJ Exec Order 26 communication book. If no communication sheet was completed for that day, the nurse would call	F 698	on the surveyor's observation, the revised form and were instructed on proper response to incomplete or missing documentation from the NJ Exec Order 26 center. How we will identify others other residents found to be effected by the deficient practice: All dialysis patients have the potential to be effected by this deficient practice. The facility had one dialysis patient so no other residents were effected. Measures or systemic changes in effect to prevent re-occurrence: The facility developed a Protocol "Hemodialysis : Monitoring and Care Protocol" to ensure communication and collaboration of care of all Dialysis patients. The Protocol includes the following areas: Communication Flow Sheet Revision. The Flow Sheet follows the resident to and from Dialysis Center. It provides information from the facility to the dialysis center and areas for information from the Dialysis Center to the facility. Provides specific assignment of nursing personnel to receive, review, document and follow-up. Provides specific assignment of nursing personnel to follow-up in the event of lack of return of flow sheet Provides specific assignment of nursing personnel to evaluate the resident access site pre and post treatment. Revised the Hemodialysis Policy to include the new Hemodialysis: Monitoring and Care Protocol, physician orders that	

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F 698	Continued From page 2 the NJ Exec Order 26 center to obtain the resident's vital signs, weights, and any new orders or recommendations and documented it in the Nurse's Notes. At this time, the surveyor with the LPN and Unit Secretary reviewed the Resident #25's NJ Exec Order 26 communication book which revealed that there were only three NJ Exec Order 26 communication flow sheets the month of NJ Exec Order 26.4 (NJ Exec Order, NJ Exec Order, and NJ Exec Order 26). On 2/8/22 at 1:01 PM, the surveyor interviewed the Director of Nursing (DON) regarding the facility's procedure for the NJ Exec Order 26 communication flow sheets upon the resident's return to the facility from NJ Exec Order 26. The DON stated that the flow sheets should be used for communication and placed in his/her NJ Exec Order 26 book. The DON further stated the vital signs and weights should be documented, and the communication sheets should also be checked for new orders from the NJ Exec Order 26 center. The DON confirmed that the resident brought the book each time he/she went to NJ Exec Order 26 and returned to the facility. On 2/9/22 at 10:02 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, confirmed that the resident's NJ Exec Order 26 communication book was not complete for NJ Exec Order 26. The DON could not speak to how many NJ Exec Order 26 flow sheets were missing or how many days the resident went to NJ Exec Order 26 in NJ Exec Order 26. On 2/9/22 at 10:43 AM, the surveyor interviewed the 3-11 shift Registered Nurse/Charge Nurse (RN/CN) who stated that one of the nurses would be responsible for checking the resident's NJ Exec Order 26	F 698	include access type, dialysis schedule, Nephrologist contact information, dialysis facility contact information, transportation arrangements, medication administration or withholding of medication prior to treatment, fluid restrictions. How we will monitor to prevent re-occurrence: An audit tool was developed and all dialysis patients will have weekly dialysis communication book and chart audits conducted by the Director of Nursing or designee for 4 weeks, then monthly audits for two months. Results of audits will be reported to the Quality Assurance and Performance Committee quarterly.	

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F 698	Continued From page 3 communication flow sheets upon their return to the facility for weights, vital signs, and any new orders. The RN/CN stated that the importance of the communication sheets was to inform the facility about the resident's diet; how the resident responded to NJ Exec Order 26; and any new orders that were recommended. The RN/CN stated that he used to check the communication flow sheets, but because the facility was short staffed, he had not been able to in "quite a while." On 2/9/22 at 10:43 AM, the surveyor reviewed with the DON, Resident#25's NJ Exec Order 26.4b1 Treatment Report which indicated that the resident received NJ Exec. Order 26 NJ Exec Order 26 treatments in the month of NJ Exec Order 26.4 A review of the facility's "Dialysis Resident Care" policy dated revised 6/29/19, which included: The facility's staff will communicate via phone or in the communication book any current issue, depending upon the urgency. This communication will help to offer the resident continuum of care and positive outcomes in their wellness... The facility charge nurse/designee will review the communication log pre and post the resident's hemodialysis (HD) treatment. If any logged communication is received from the dialysis center upon the resident's return, the nurse is requested to initial the entry, follow the recommendations or comment if any, and document in the nursing notes, if indicated. NJAC 8:39 - 27.1(a)	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		2/11/22

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F 755	Continued From page 4 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure backup medications were available for use for a NJ Exec. Order 26:4.b.1 resident. This deficient practice was identified for 1 of 2 Residents (Resident #36) reviewed for NJ Exec. Order 26:4.b.1	F 755	F 755 D CFR 483.45 (a) (b) (1) – (3) Pharmacy Services How the POC will be accomplished for those residents found to be effected:	

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F 755	Continued From page 5 admission and was evidenced by the following: On 2/3/22 at 11:04 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN) inspected the High side medication cart. Located in the top drawer of the medication cart, was a zip top bag with NJ Exec Order 26.4b1 inside. On the label outside of the bag, was Resident #25's printed name that had been scratched out in pen and Resident #36's name had been handwritten in. There was no name on the NJ Exec Order 26.4b1 located inside the bag. On 2/3/22 at 11:28 AM, the surveyor interviewed the LPN who stated that when NJ Exec Order 26.4b1 came in from the pharmacy labeled with the resident's name or as facility backup, they were stored in the medication room refrigerator until they were opened. Then when we needed them, we took them out of the refrigerator and dated them. When the surveyor asked why the bag had Resident #25's name crossed out and Resident # 36's name handwritten on instead, the LPN responded that probably Resident #36 needed NJ Exec Order and the facility did not have the resident's NJ Exec Order or a facility backup supply of the NJ Exec Order, so a nurse used Resident #25's unused backup NJ Exec O from the refrigerator. She stated that Resident #25's NJ Exec Order 26.4b1 had been discontinued so the nurse probably took their NJ Exec Order 26.4b1 and used it as backup for Resident #36. The LPN further stated since Resident #36's NJ Exec was never opened, it was okay to use that one for Resident #25, but it would never be okay to use another person's opened NJ Exec Order 26.4b1 on anyone else because it was contaminated. On 2/3/22 at 11:49 AM, the surveyor re-interviewed the LPN who stated that when a	F 755	Those resident found to be effected had a review of physician orders, improperly labeled NJ Exec Order 26.4b1 were discarded and the NJ Exec Order 26.4b1 were replaced by the pharmacy and properly labeled with the resident names. How we will identify others other residents found to be effected by the deficient practice: All residents are at risk when the facility fails to ensure back-up medications are available for use for a newly admitted residents. Measures or systemic changes in effect to prevent re-occurrence: The 3-11 charge nurse was assigned to weekly (Monday) responsibility for re-ordering of required non-controlled back-up medications. A new facility Protocol for the use of back-up insulin pens was written and staff were educated on the new protocol. Staff were also educated regarding the regulations for Pharmacy Services 483.45(a) (b) (1)-(3) and Pharmacy Policies and Procedures related to dispensing and receiving medications including back-up insulin and labeling requirements. How we will monitor to prevent re-occurrence: An audit of all newly admitted resident's ordered medications will be conducted to ensure timely receipt of medications upon admission for 3 months. The weekly ordering of back up	

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F 755	Continued From page 6 new resident was admitted to the facility, the pharmacy orders were put in the computer and were automatically sent to the pharmacy. She further stated the facility had backup medications to be used right away, if needed, and NJ Exec Order was one of those medications because we cannot delay medications for a NJ Exec Order 26.4. The LPN stated the pharmacist reviewed the backup stock medications. The surveyor reviewed the medical record for Resident #36. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1. A review of the admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated a NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 Physician Orders (PO) reflected a PO dated NJ Exec Order 26, for NJ Exec Order 26 three times a day for NJ Exec Order 26.4b1 A review of the corresponding NJ Exec Order 26.4b1 electronic Medication Administration Record (eMAR) reflected that the resident received their first dose of NJ Exec Order 26.4b1 on NJ Exec Order 26 at 4:30 PM. The surveyor reviewed the medical record for Resident #25.	F 755	medications will be audited weekly for 4 weeks and then monthly for 2 months to ensure medications ordered and received An audit of all insulin pens, in use, will be conducted weekly to ensure proper labeling and dating. Result of all audits will be reported to the Quality Assurance and Performance Improvement Committee quarterly. Date Deficiency Corrected: February 11, 2022	

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F 755	Continued From page 7	F 755		

A review of the Face Sheet reflected that the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 eMAR, reflected a PO dated NJ Exec Order 26 with an end date of NJ Exec Order 26, for NJ Exec Order 26.4b1

On 2/3/22 at 12:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated that it was brought to her attention in the past few days that some nurses were not receiving medications that were refilled from the Provider Pharmacy. The DON stated that she was just beginning to investigate the concern, and that she was unsure if medications were not being received because the nurse was faxing the PO instead of electronically sending the PO to the Provider Pharmacy. When questioned, the DON responded that if the nurse did not have a resident's medication, then the nurse should call the resident's physician to see if the resident could have an alternative medication or to hold that medication dose until it was received. The DON stated that the nurse should not "borrow" the medication from another resident.

At this time, the surveyor showed the DON Resident #36's NJ Exec Order 26.4b1 and packaging with Resident #25's name crossed out. The DON confirmed that the nurse should not have taken Resident #25's backup NJ Exec Order 26.4b1 to use for Resident #36 and would look into it.

On 2/3/22 at 1:29 PM, the surveyor interviewed the facility's Provider Pharmacy Representative (PPR) who stated that the facility had both

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F 755	Continued From page 8	F 755		

resident specific medications as well as a backup medication supply that was not resident specific. If the facility had a backup supply of a certain medication, the facility could administer the backup supply medication to their resident. The PPR stated that the pharmacy delivered medications to the facility in the afternoon and in the evening. The facility could also receive a STAT order (immediate) that would arrive from the pharmacy to the facility within two hours. The PPR stated that NJ Exec Order 26.4b1 should be in the facility's backup supply.

On 2/3/22 at 1:43 PM, the surveyor interviewed the Provider Pharmacist (PP) who stated that when the nurse used a facility backup medication, the nurse would either send an electronic order or fax a slip to the pharmacy to replace the medication. The PP stated that Monday through Friday, the pharmacy delivered medications two times a week, and on the weekends, they delivered one time. The facility could also do a STAT order in an emergency which that medication would arrive to the facility within two hours.

At this time, the surveyor requested all pharmacy deliveries for Resident #36's NJ Exec Order 26.4b1

On 2/3/22 at 3:33 PM, the surveyor interviewed the facility's Consultant Pharmacist (CP) who stated that a nurse should not "borrow" medication from one resident to another because it was a safety concern. The CP stated that if the medication was not available at the time of administration, the nurse should call the pharmacy to see when the medication would arrive at the facility and then call the resident's physician to let them know the medication was

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F 755	Continued From page 9	F 755		

not currently available to determine what the physician recommended to do.

A review of the Provider Pharmacy's Delivery Manifest dated NJ Exec Order 26, reflected that Resident #36's NJ Exec Order 26.4b1 arrived at the facility on NJ Exec Order 26 at 12:27 AM.

On 2/4/22 at 11:26 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), informed the survey team that she spoke with the Registered Nurse (RN) who stated that she "borrowed" Resident #25's unused backup NJ Exec Order 26.4b1 on NJ Exec Order 26 for Resident #36 because the resident was admitted to the facility that day and was due for their 4:30 PM NJ Exec Order 2 The DON acknowledged that even in an emergency, a nurse should never "borrow" medication from another resident.

On 2/4/22 at 12:38 PM, the surveyor observed the resident in their room in bed sitting up and finishing their lunch meal. The resident stated he/she was a NJ Exec Order 26 and had to recently been prescribed NJ Exec Order before meals and at bedtime because their NJ Exec Order 26.4b1 When the surveyor inquired if the resident had missed any doses of NJ Exec Order 2, the resident responded that they had never missed a dose of NJ Exec Order and had not been told there was any problem obtaining their medications from the pharmacy.

A review of the facility provided "Medication Administration Guidelines" dated revised October 2017, included medications will be administered in a safe and accurate manner.

A review of the facility provided

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F 755	Continued From page 10 "Dispensing/Receiving Medications Back Up Insulin" policy dated revised 4/8/16, included...the pharmacy will provide an emergency supply of insulin pen(s)/vial(s) in a zip lock bag labeled "Emergency Refrigerator Insulin" to be on specific nursing units and kept in medication refrigerator until needed...once the pen or vial has been assigned to a specific resident, the nurse will complete an Emergency Refrigerator Insulin Form which pharmacy has affixed to the outside of the refrigerator and will fax to the pharmacy...Emergency Refrigerator Insulin...insulin lispro 3 mL pen. A review of the facility provided "Dispensing/Receiving Medications" policy dated effective November 2010, included policy: the pharmacy will provide the facility with a supply of medications to be used in an emergency situation or until the pharmacy delivery is received...the nurse will document any medication removed or replaced in the backup box by filling out the Backup Log Form located in the backup box log book...the nurse will complete and fax the Backup Box Medication Replacement Form and fax to the pharmacy to receive the replacement medications...the backup box contents will be inventoried monthly for expirations, par levels, and integrity of packaging by the pharmacist consultant, facility, and/or pharmacy representative. NJAC 8:39-29.2(d); 29.4(a)	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		2/11/22

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F 761	Continued From page 11 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) properly label and date NJ Exec Order 26.4b1 once opened and removed from the refrigerator, b.) remove discontinued medication from active inventory, and c.) ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 form) were completed with sufficient detail to enable accurate reconciliation. This deficient practice was identified on 2 of 2 medication carts observed and for 3 of 3 provided DEA forms. The evidence was as follows:	F 761	F761 D CFR 483.45 (g) (h) (1) (2) Label/Store Drugs and Biologicals How POC will be accomplished for those residents found to be effected: The improperly labeled NJ Exec Order 26.4b1 for resident 22, resident 36 resident #39 and the discontinued NJ Exec Order 26.4b1 for resident 25 were discarded and new NJ Exec Order 26.4b1 we obtained on NJ Exec Order . NJ Exec Order 26.4b1 were properly labeled with names and dates. The Director of Nursing was educated on the proper procedure by the Pharmacy	

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	315347	A. BUILDING ______ B. WING ______	02/09/2022

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F 761	Continued From page 12 1. On 2/3/22 at 11:04 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #1) inspected the High side cart and found six zip top bags each containing one opened and undated NJ Exec Order 26.4b1 Further inspection of the bags revealed the following: Resident #22's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were labeled with the resident's name but not the date the NJ Exec was opened. Resident #36's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 had no name on the NJ Exec Order 26.4 and no date indicating the date the NJ Exec O had been opened. Resident # 39's NJ Exec Order 26.4b1 and NJ Exec Order were labeled with the resident's name but not the date the NJ Exec was opened. On 2/3/22 at 11:28 AM, the surveyor interviewed LPN #1 who stated when the NJ Exec Order 26.4b1 were received from the pharmacy, they were stored in the medication room medication refrigerator until it was needed. When the NJ Exec Order 26.4b1 was needed, it was then removed from the refrigerator, and the nurse dated both the NJ Exec and the bag with the date opened in case the NJ Exec and bag were separated. On 2/3/21 at 12:41 PM, the Director of Nursing (DON) stated when NJ Exec Order 26.4b1 were in use, they should be stored in the medication cart in a zip top bag. The NJ Exec should have both the resident's name and the date it was opened on it. The surveyor reviewed the above residents' medical records.	F 761	Consultant and immediately corrected the deficient practice of proper completion of DEA 222. How we will identify others other residents found to be effected by the deficient practice: All residents receiving insulin have the potential to be negatively affected by improper labeling and dating of insulin pens once removed from the refrigerator and when insulin pens are not removed from active inventory. All residents are at risk of the results of diversion when the accurate ordering and receiving of narcotic medications is not recorded in sufficient detail on the required DEA 222 form which enables accurate reconciliation. Measures or systemic changes in effect to prevent re-occurrence: The Director of Nursing created a binder system for organizing and filing the DEA 222 forms which includes instructions on the completion of the forms in detail and the reconciling with delivered manifests. The Audit of the DEA 222 forms was permanently added to the monthly audit completed by the Pharmacy Consultant. How we will monitor to prevent re-occurrence: The Pharmacy Consultant will audit the completion of the DEA 222 Form monthly and the results of the audit will be included in the quarterly report to the Quality Assurance and Pharmacy Committee.	

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F 761	Continued From page 13	F 761		

A review of Resident #36's current physician's orders revealed orders for NJ Exec Order 26.4b1 at bedtime initiated on NJ Exec Order 26. Further review revealed an order for NJ Exec Order 26.4b1 three times a day initiated on NJ Exec Order 26.

Date each deficiency corrected: February 11, 2022

A review of Resident #22's current physician's orders revealed orders for NJ Exec Order 26.4b1 once daily initiated on NJ Exec Order 26. Further review revealed an order for NJ Exec Order 26.4b1 at bedtime initiated on NJ Exec Order 26.

A review of Resident #39's current physician's orders revealed orders for NJ Exec Order 26.4b1 twice a day initiated on NJ Exec Order 26. Further review revealed an order for NJ Exec Order 26.4b1 before meals and at bedtime initiated NJ Exec Order 26.

On 2/3/22 at 3:31 PM, the surveyor interviewed the facility's Consultant Pharmacist (CP) who stated, one of her roles at the facility is to review mediation carts. She stated that she checked for expiration dates on mediations and ensured mediations that required dating were dated.

A review of manufacturers recommendations revealed insulin glargine and insulin lispro's expiration upon opening or removing from refrigerator was 28 days and Liraglutide (Victoza) pens should be discarded after 30 days.

2. On 2/3/22 at 2:39 PM, the surveyor in the presence of another surveyor and along with LPN #2, reviewed the NJ Exec Order 26.4b1 located on the Low side medication cart. Inspection revealed an opened NJ Exec Order 26.4b1 for Resident #25. Upon further interview, LPN #2 confirmed the NJ Exec Order had been discontinued on NJ Exec Order 26.

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F 761	Continued From page 14	F 761		

The surveyor reviewed the medical record for Resident #25.

A review of the Admission Record indicated the resident was admitted to the facility in [NJ Exec Order 26.4b1] and had diagnoses which included [NJ Exec Order 26.4b1]

A review of the electronic Medication Administration Record (eMAR) revealed a physician's order for [NJ Exec Order 26.4b1] three times a day initiated on [NJ Exec Order 26] and discontinued [NJ Exec Order 26]

On 2/3/22 at 3:31 PM, the surveyor interviewed the facility's Consultant Pharmacist (CP) who stated that one of her roles at the facility was to review mediation carts. The CP stated that discontinued medications should be removed from the cart and active inventory.

On 2/9/22 at 10:02 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, acknowledged that discontinued medications should not be stored in active inventory.

3. On 2/8/22 at 10:24 AM, the surveyor reviewed the facility's DEA 222 forms which revealed that the facility did not complete the number of packages received or the date the medication was received as instructed to on the reverse of the DEA 222 form. The inaccuracies were as follows:

Order Form:

#192082118, No number received, No date received.

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F 761	Continued From page 15 #192082118, No number received, No date received. #191517467, No number received, No date received. On 2/8/22 at 12:49 PM, the surveyor interviewed the DON who stated one of the responsibilities of the DON was to complete the DEA 222 forms. The DON stated she had verified with the provider pharmacy that the facility only ordered narcotics three times. The DON stated she was unaware she had not completed the form as required. Upon review, the DON acknowledged that she had not completed the portion of the form that indicated when she had received narcotic mediations and that she should have filled in the quantity received as well as the date the medication was received. A review of the instructions for submission of the DEA 222 form (August 2011) located on the reverse of the form revealed "2... (When items are received, the date of receipt and the number of items received must be recorded in the spaces provided on the triplicate copy.)" A review of the undated facility provided policy from the provider pharmacy titled "Medication Administration guidelines, Insulin Pens, Policy 76.3 a", included: ... 2. Insulin pens and multidose vials are labeled with patient name and medication name as follows: If only one pen is being dispensed: A small auxiliary label is placed on the body of the pen indicating resident's name, mediation name, and prescription label. The pen is placed in a zip top bag and the prescription label listing full patient and medication information is placed on the bag... 5. Storage of Insulin ... Once opened, insulin pens may be stored in med	F 761		

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F 761	Continued From page 16 carts and must be labeled with 'date opened' and using manufacturer recommendation for number of days for room temp storage, "discard date." A review of the facility provided policy from the provider pharmacy titled "Disposition of Medications, Medication Storage, Policy 7.1" with an effective date of November 2010, included: 8. Medication and treatment carts must only store medications that are currently ordered by the physician. The nurse must remove any medication that has been discontinued. Facility provided policies did not include the completion of the DEA 222 form once the medication was received by the pharmacy. NJAC 8:39-29.7(c); 29.4(h)	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		5/20/22

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F 880	Continued From page 17 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of pertinent facility records it was determined that the facility failed to implement infection control protocols in a manner that would decrease the possibility of the spread of infection by a.) performing hand hygiene in accordance with the Center for Disease Control and Prevention and facility policy and b.) maintaining a resident's NJ Exec Order 26.4b1 off the floor. This was observed with 1 of 3 residents (Resident# 12) reviewed for NJ Exec Order 26.4b1 and evidenced by the following:

1. On 2/8/22 at 10:41 AM, the surveyor observed the Certified Nurse Aide (CNA) preparing to provide care for Resident #12. The CNA performed hand hygiene, lathering with soap outside the flow of running water for three seconds prior to rinsing with water.

At this time, the surveyor interviewed the CNA regarding the facility's policy for hand hygiene. The CNA responded that you wet your hands with water, then lathered your hands with soap applying friction outside the flow of water for ten seconds, then rinsed your hands off with water. The CNA then proceeded to don (put on) gloves and gather bathing supplies for the resident's bed bath.

F 880

F880 D
CFR480.80 (a) (1) (2) (4) (e)(f)
Infection prevention Control

How POC will be accomplished for those residents found to be effected:
The NJ Exec Order 26.4b1 for resident #12 was removed from the floor. The LPN was first advised of the NJ Exec Order 26 on the floor on NJ Exec Order 26.4b1 and upon that communication, the LPN went to the resident room and the NJ Exec Order 26.4b1 was replaced with a NJ Exec Order 26.4b.
Resident #12 was observed for signs of NJ Exec Order 26.4 related to the observation of the deficient practice of the NJ Exec Order 26.4b1 the floor and the lack of proper hand hygiene.
The Certified Nurse Aide was immediately educated on proper hand hygiene by the Infection Preventionist on 2/8/22

How we will identify others other residents found to be effected by the deficient practice:
All residents are at risk when the facility fails to implement infection control protocols in a manner that would decrease the possibility of the spread of

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On 2/8/22 at 10:50 AM, the surveyor observed the CNA doff (remove) her gloves and perform hand hygiene. The CNA applied soap to her hands, then without rubbing hands together to apply friction, immediately rinsed the soap under running water, and dried her hands.

At this time, the surveyor re-interviewed the CNA regarding the hand hygiene policy and the ten seconds she stated that you lathered your hands with soap applying friction outside the flow of running water. The CNA responded, "supposed to be ten seconds," and "that's what you're supposed to do."

On 2/8/22 at 1:08 PM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, confirmed that the CNA performed hand hygiene inappropriately. The DON stated that when performing hand hygiene with soap and water, you lathered your hands with soap applying friction outside the flow of running water for twenty seconds prior to rinsing

Review of the facility's "Hand Hygiene" policy dated 11/13/2020 included:
Hand hygiene technique when using soap and water:
a. Wet hands with water. Avoid using hot water to prevent drying of skin.
b. Apply to hands the amount of soap recommended by the manufacturer.
c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers.
d. Rinse hands with water ...

F 880

infection.

Measures or systemic changes in effect to prevent re-occurrence:
The Policy for Foley Catheter Care was revised and instructions for infection control practice for catheter maintenance and/or bag placement were added to the policy. Staff have been inserviced on the Policy additions.
The Infection Preventionist will conduct a bi-annual handwashing education of all healthcare staff which will include a demonstration of handwashing technique by staff.

Staff education was conducted for Topline Staff including the Infection Preventionist as follows;

Module 1-Infection Prevention and Control Program
Module 5 Outbreaks
Module 11B-Environmental Cleaning and Disinfection
Module 4-Infection Surveillance
Module 7-Hand Hygiene
Module 6A-Principles of Standard Precautions
Module 6B-Principles of Transmission Based Precautions
Module 11A-Reprocessing Reusable Resident Care Equipment

Frontline Staff Education was conducted as follows;

Keep Covid-19 Out
Sparkling Surfaces

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F 880	Continued From page 20 2. On 2/3/22 at 10:56 AM, during initial tour of the facility, the surveyor observed Resident #12 resting in bed with the NJ Exec Order 26.4b1 without a NJ Exec Order 26.4b1 lying directly on the floor under the bed. The surveyor reviewed the medical record for Resident #12. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 A review of the February Physician's Orders (PO) reflected a PO dated NJ Exec Order 26.4 for NJ Exec Order 26.4b1 care every shift; ensure NJ Exec Order 26.4b1 in use in bed and in wheelchair. On 2/8/22 at 10:28 AM, the surveyor observed the resident in with the NJ Exec Order 26.4b1 without a NJ Exec Order 26.4b1 lying directly on the floor under the bed. On 2/8/22 at 10:28 AM, the surveyor interviewed the CNA regarding NJ Exec Order 26 care who stated that she usually emptied the NJ Exec Order 26.4b1 and reported any concerns observed to the nurses. At this time, the CNA accompanied the surveyor into	F 880	Clean Hands Module 11B-Environmental Cleaning and Disinfection Module 6A- Principles of Standard Precautions Module 6B-Principles of Transmission Based Precautions. A Root Cause Analysis was conducted. The results of the analysis determine the root cause of deficient practices to be related to staffing levels which were effected by medical leave of licensed staff as well as a nationwide shortage of nurse aides requiring that the facility use agency and temporary staffing to fill gaps with staff who were not trained sufficiently and consistently under our direction regarding proper practices. How we will monitor to prevent re-occurrence: Six handwashing audits will be conducted weekly by the Infection Preventionist or designee for both nursing and ancillary staff assigned to the skilled nursing facility for 4 weeks and then monthly for 2 months. All residents with indwelling catheters will be audited weekly for 4 weeks and then monthly for two months for proper placement of the drainage bag and presence of privacy bag. Results of the audits will be reported to the quality Assurance and Performance Improvement Committee Quarterly. Date each deficiency corrected: May 20, 2022	

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Resident #12's room and observed the NJ Exec Order 26.4b1 lying on the floor. The CNA confirmed that the NJ Exec Order 26.4b1 should not be on the floor because it was an infection control issue.

On 2/8/22 at 11:04 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #12 had a history of NJ Exec O and confirmed that the NJ Exec Order 26.4b1 should always be kept off the floor. The LPN stated that if the NJ Exec Order 26.4b1 was found on the floor, it should be emptied, and replaced with a new one for infection control purposes. The LPN stated the resident would "absolutely" be at risk for infection if the NJ Exec Order 26.4b1 was lying on the floor.

On 2/8/22 at 11:15 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated that the NJ Exec Order 26.4b1 must be kept off the floor for infection control.

On 2/9/22 at 10:02 AM, the DON in the presence of the LNHA and survey team, acknowledged that the NJ Exec Order 26.4b1 should not be on the floor.

Review of the facility's current undated "Policy for Foley Catheter Care" did not include infection control practice for catheter maintenance and/or bag placement.

NJAC 8:39-19.4

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S 000	Initial Comments THE FACILITY WAS 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 interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 7 out of 42 shifts reviewed. Findings include: 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	S 560	S560 8:39-5.1 (a) Mandatory Access to Care How POC will be accomplished for those residents found to be effected: Continue to place on-line classified advertising for open certified Nurse Aide Positions. Continue to offer recruitment and referral bonuses. Continue to utilize all available agencies. Continue to offer competitive wages and benefits. Continue to provide scheduling flexibility. Continue	3/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656000	A. BUILDING: ____ B. WING ____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

(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 1 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 CNA 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. During entrance conference on 2/3/22 at 11:18 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing and the Infection Preventionist/Registered Nurse, informed the surveyor that the facility was experiencing staffing shortages. The facility used contracted Agency staff, but that did not cover the shortages. The LNHA stated that the facility has reached out to both the Local and State Health Departments for assistance but has not received any additional staff. As per the "Nurse Staffing Report" completed by the facility for the weeks of 1/16/22 to 1/22/22 and 1/23/22 to 1/29/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift and 1 direct care staff to 14 residents for the overnight shift as	S 560	to offer tuition reimbursement and sponsor Nurse Aide candidates for Certification. Continue to curtail admissions. How we will identify others other residents found to be effected by the deficient practice: All resident have the potential to be effected by the inability for the facility to maintain required minimum direct care staff as mandated by the State of New Jersey. Measures or systemic changes in effect to prevent re-occurrence: Presentation developed to present to the CEO and Board of Director additional program ideas that will support improved staff recruitment. How we will monitor to prevent re-occurrence: Human Resource will provide metrics related to recruitment and retention monthly which includes the number of applicants responding to each referral source to monitor for highest success. Human resource will monitor staff turnover and reasons for departure. Human Resources will monitor certified aide pay rates in the area to maintain competitive wages and benefits. Results of will be presented the Quality Assurance and Performance Improvement Committee Chair monthly and reported to the Committee quarterly.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656000	A. BUILDING: ______ B. WING ______	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

(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 documented below: 1/16/22 had 3 CNAs for 39 residents on the day shift, required 5 CNAs. 1/17/22 had 4 CNAs for 39 residents on the day shift, required 5 CNAs. 1/18/22 had 4 CNAs for 39 residents on the day shift, required 5 CNAs. 1/19/22 had 4 CNAs for 39 residents on the day shift, required 5 CNAs. 1/22/22 had 4 CNAs for 40 residents on the day shift, required 5 CNAs. 1/23/22 had 4 CNAs for 40 residents on the day shift, required 5 CNAs. 1/24/22 had 4 CNAs for 40 residents on the day shift, required 5 CNAs. 1/25/22 had 3 CNAs for 40 residents on the day shift, required 5 CNAs. 1/27/22 had 5 CNAs for 43 residents on the day shift, required 6 CNAs. 1/27/22 had 3 total staff for 43 residents on the overnight shift, required 4 total staff. 1/28/22 had 5 CNAs for 43 residents on the day shift, required 6 CNAs. 1/28/22 had 3 total staff for 43 residents on the overnight shift, required 4 total staff. 1/29/22 had 2 CNAs for 43 residents on the day shift, required 6 CNAs. 1/29/22 had 3 total staff for 43 residents on the overnight shift, required 4 total staff. NJAC 8:39-5.1(a)	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)
315347	A. Building B. Wing	5/27/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

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 F0698 Reg. # 483.25(l) LSC	Correction Completed 02/11/2022	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 02/11/2022	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 02/11/2022
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 05/20/2022	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
2/9/2022	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
656000	A. Building B. Wing	5/27/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

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 03/31/2022	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	
2/9/2022	☐ 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
	315347	A. BUILDING 01 B. WING ______	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

(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		
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 2/08/2022 and Hamilton Place at the Pines 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. Hamilton Place at the Pines is a two (2) story, Type I Fire Resistant building that was built in January 1995. The facility is divided into 4 smoke zones.	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation on 2/08/2022, it was determined that the facility failed to provide a battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with	K 291	K 291 D CFR: NFPA 101 Emergency Lighting How POC will be accomplished for those residents found to be effected:	2/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/03/2022

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
	315347	A. BUILDING **01** B. WING ___	**02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 08759**

(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 291	Continued From page 1 NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 1 emergency generators and evidenced by the following: During the building tour starting at 10:35 AM, with the facility's Administrator (Admin) and Maintenance Director (MD), an inspection of the electrical room where the Nursing Home generator transfer switch was located was performed. The surveyor observed no evidence of a battery backup emergency light. The surveyor asked the MD if there was a battery backup emergency light for the transfer switch. The MD replied, "No." This finding was verified by the facility's Admin and MD at the time of inspection. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 2/8/22 at 2:10 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	The emergency lighting with battery back up was installed above the emergency generator transfer switch independent of the building electrical system and emergency generator on 2/15/22. How we will identify others other residents found to be effected by the deficient practice: All residents are at risk when the facility does not provide battery back up emergency lighting above the emergency generator transfer switch, independent of the building electrical system and emergency generator. Measures or systemic changes in effect to prevent re-occurrence: The emergency lighting with battery back up was installed above the emergency generator transfer switch independent of the building electrical system and emergency generator on 2/15/22. How we will monitor to prevent re-occurrence: The operation of the battery back up lighting will be monitored on monthly facility inspections by the Maintenance Director. Results of monitoring will be reported to the Quality Assurance and Performance Improvement Committee quarterly. Date each deficiency corrected: 2/15/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING **01** B. WING ___	**02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 08759**

(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 521	Continued From page 2	K 521		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview conducted on 2/8/22, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 2 of 6 observed resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During a tour of the building starting at 9:09 AM, in the presence of the facility's Administrator (Admin) and Maintenance Director (MD), an inspection inside of six resident bathrooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 2 of 6 resident bathrooms in the following locations: 1. At 10:19 AM, inside Resident room #2238 bathroom, the exhaust system did not function	K 521	K521 E CFR:NFPA 101 HVAC How POC will be accomplished for those residents found to be effected: The ventilation system motor was ordered on February 10, 2022 and installed the contractor on 2/28/22. Residents were provided an option to utilize alternate toilet facilities temporarily or offered a room change. How we will identify others other residents found to be effected by the deficient practice: All residents have the potential to be effected when the facility fails to ensure that the facility□s ventilation systems are properly maintained. Measures or systemic changes in effect to prevent re-occurrence: Maintenance staff will increase the	2/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING **01** B. WING	**02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 08759**

(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 521

Continued From page 3

properly when tested. At this time, the surveyor informed the Admin and MD that the exhaust system did not function properly.

2. At 10:22 AM, inside Resident room #2234 bathroom, the exhaust system did not function properly when tested.

All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation.

The MD confirmed the finding at the time of the observation.

The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 2/08/2022 at 2:10 PM.

NFPA 90A.
NJAC 8:39- 31.2 (e).

K 521

monitoring of the ventilation system to twice monthly, this change was added to the preventive maintenance schedule.

How we will monitor to prevent re-occurrence:

The exhaust system will be monitored twice monthly by the maintenance department director or designee and the results of the monitoring will be reported to the Quality Assurance and Performance Improvement Committee quarterly.

Date each deficiency corrected: 2/28/22

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
315347 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	5/27/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0291	Correction Completed 02/15/2022	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 02/28/2022	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
2/9/2022

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