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 02/06/2020

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 #122975, 128623, 131131 CENSUS: 197 SAMPLE SIZE: 5	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		3/16/20

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

Electronically Signed | 03/03/2020

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F 609	Continued From page 1 by: COMPLAINT #131131 Based on interviews, record review and review of pertinent facility documents on 2/5/2020 and 2/6/2020, it was determined that the facility failed to report an injury of unknown source to the New Jersey Department of Health (NJDOH) as well as failure to follow their policy titled "Abuse/Neglect Policy and Procedure" for 1 of 5 sampled Residents (Resident # 1). This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #1 had [redacted]. The MDS also indicated the Resident needed extensive assistance with Activities of Daily Living (ADLs). Review of Resident #1's Care Plan (CP) dated 10/5/2015, included the following: Resident required 2-3 person assist with transfers and repositioning. Interventions included but not limited to: 12/23/19, Assist with 2-3 person for all transfer and 3/18/19. Review of Resident #1's Physician Order Sheet (POS) dated, 11/2019 revealed the following physician orders: Foot cradle to Rock-N-Go chair when OOB dated, 3/18/2019.	F 609	1. The corrective action(s) accomplished for resident(s) found to be affected by this deficient practice . A complete investigation was conducted prior to citation and no abuse was substantiated. Resident currently resides at facility and is at her current level of functioning. Resident #1 injury was reported to DOH and the Office of the Ombudsman on [redacted]. 2.All residents identified having the potential to be affected and corrective action(s) taken. Incident reports from prior 3 months will be reviewed by Nursing Administration for any requirement to report to DOH and/or Office of the Ombudsman and will be reported accordingly. Any report found to meet criteria for reporting will be reported to DOH and the Office of the Ombudsman. 3. Measures that will be put into place to ensure deficient practice will not recur. Administrator and DON were re educated by regional Nurse on guidelines for reporting violations to appropriate officials. Education includes examples of injuries that could indicate physical abuse. 4. Corrective action(s) will be monitored to ensure that deficient practice does not recur. Incident Reports (RMS) will be reviewed daily by IDCT and it will be determined if any injuries of unknown source meet	

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F 609	Continued From page 2 Review of progress note by a Licensed Practical Nurse (LPN) dated 11/28/19 at 1:55 pm, revealed the following: "This writer was call [sik] to the resident's room by the CNA [Certified Nurse's Assistant] between 7:30 am and 8:00 am, with a [redacted] noted on [redacted]. resident was noted with increased facial grimacing. floor mat was present on the lift [sik] side of the Resident's bed. as well as floor mattress was also present at the right side of the resident bed. no blood noted supervisor notified about resident change in condition. supervisor came to the unit and to assess the resident. resident was transported to [hospital].... resident was admitted with [redacted] [redacted] at 4:55 p.m., signed by a Registered Nurse (RN) "floor nurse assigned to resident notified this writer at approx. 8:30 am of a change in condition. Physical assessment done noted [redacted] and transferred via stretcher to [hospital]. F/U [Follow-up] resident was admitted Dx [diagnosis] [redacted] Review of the facility's incident report completed by RN #1 and dated 11/28/2019 8:45am, revealed the following: Resident received by 7-3 nurse noted [redacted]. Per written statements patient was having increased restless behavior [he/she] checked for incontinence and was dry. [redacted] was noted with [redacted] Resident unable to give description.	F 609	reportable criteria. All reportables will be reviewed at the QAPI meeting for the next two quarters.	

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F 609	Continued From page 3	F 609		

The incident report further revealed video was reviewed and possible contributing factors were examined along with verbal and written statements obtained by staff. Due to [redacted] of residents on assignment were unattainable.... Video observations revealed resident exhibit [redacted], they were able to extend at times into the spacing of the side wheels on [redacted] specialty chair and around the modified foot cradle.... After review of the information gathered, it is likely that [redacted] injury occurred while in [redacted] Rock-N-Go chair.

During an interview on 2/5/2020 at 11:52 a.m., the Assistant Director of Nursing (ADON) confirmed an investigation was completed but the incident was not reported to the New Jersey Department of Health (NJDOH).

During an interview on 2/5/2020 at 12:44 p.m., the Director of Nursing (DON) stated, "the Resident [redacted], it's more about the [resident's] behavior. No statement was received [from the Resident] due to [his/her] [redacted]. The [redacted] was not reported." The DON further stated, "we report to rule out abuse and [redacted]

During an interview on 2/6/2019 at 12:40 p.m., the Administrator stated, "based on the policy of the facility the incident should have been reported." The administrator further stated, "I plan on reporting."

During a follow-up interview on 2/6/2020 at 1:08 p.m., the DON stated, "the [redacted] was not observed.... I did not think it needed to be

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F 609	Continued From page 4 reported because there was a lot of facets to it." Review of the facility's policy titled "Abuse/Neglect Policy and Procedure" dated, August (year unknown) revealed the following: "Purpose" To ensure prevention, protection, prompt reporting and interventions in response to alleged, suspected or witnessed abuse, neglect, mistreatment, misappropriation of property, or exploitation of any facility resident. "Definitions" Injuries of Unknown Source: An injury should be classified as an "injury of unknown source" when both of the following criteria is met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. 2. The injury is suspicious because the extent of the injury or the location of the injury... or the number of injuries observed at one point in time or the incidence of injuries over time. "Federal Requirement" (d) The facility shall notify each covered individual of that individual's obligation to: (i) report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any suspicion of a crime against any individual who is a resident of, or is receiving care from , the facility: and (ii) report immediately, but no later than 2 hours after forming the suspicion, if the events that cause suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. N.J.A.C 8:34 9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		3/16/20

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F 610	Continued From page 5 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: COMPLAINT #128623 Based on interviews, record review and review of pertinent facility documents on 2/5/2020 and 2/6/2020, it was determined that the facility staff failed to investigate an [redacted] as well as failure to follow their policy titled "Accident-Incident Report (RMS)" for 1 of 5 sampled Residents (Resident #2). This deficient practice was evidenced by the following: 1. According to the Medical Record (MR), Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to the following: [redacted]. According to the Minimum Data Set (MDS), an	F 610	1. The corrective action(s) accomplished for resident(s) found to be affected by the deficient practice. Resident #2 was discharged AMA (Against Medical Advise) on [redacted]. An Incident report (RMS) was completed and it was determined that the [redacted] was caused by [redacted] brief. 2. All residents identified having the potential to be affected and corrective action(s) taken. Nurses notes for residents that were discharged within the past 3 months were reviewed for any new areas of skin impairment and an RMS completed. 3. Measures that will be put into place to	

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F 610	Continued From page 6 assessment tool, dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated [redacted] and needed extensive assistance with Activities of Daily Living (ADLs). Review of Resident #2's Care Plan (CP) included a focus for risk of skin breakdown, dated 8/7/2019. Interventions included but were not limited to daily skin monitoring during care by Certified Nurse's Aide (CNA), and to notify nurse of areas of concern. Review of Resident #2's Progress Notes (PN)," dated 9/19/2019 at 5:28 pm, revealed the following: ..."staff attempted to shower Resident with [family member] present and [he/she] again displayed combative behaviors-swinging at staff. [family member] stated [he/she] "was going to sign the Resident out [Against Medical Advice] AMA...." "Family bagged up belongings in the room and left [at] 5:31 pm, MD [Medical Doctor] and DON [Director of Nursing] notified." A subsequent progress note dated 9/19/19 at 7:30pm, revealed the resident was given a shower by a nurse and a CNA, an [redacted] was noted to the [redacted]. Review of Licensed Practical Nurse (LPN #1) employee statement received on 2/5/2020 the day of survey, revealed the following: On 9/19/2019, "Prior to leaving the facility [Resident #2] received a shower with the assistance of myself, CNA and [his/her family] as per family request, due to the [residents] frequent refusal of bathing while at home and while [redacted] was a resident in the facility. At the end of the shower	F 610	ensure the deficient practice will not recur. Education was provided to nursing staff on the policy for Incident Reports (RMS), including investigation education. Education included for discharging or AMA (Against Medical Advise) residents also. 4. Corrective action(s) will be monitored to ensure that deficient practice does not recur. All injuries of unknown source will be reviewed by Nursing Administration and all injuries will be investigated and any deficient area rectified. Results will be reviewed at the QAPI meeting by DON for two quarters.	

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F 610	Continued From page 7	F 610		

I did a skin evaluation and noticed a [redacted] were the [resident's] pullups lay on the skin. The area was about the [redacted]. I asked the [resident] how [he/she] got the [redacted] and [he/she] did not know. I then asked [him/her] how long [he/she] had the [redacted] and [he/she] said he did not know...."

During an interview with the surveyor on 2/5/2020 at 12:44 pm, the DON stated "no incident report was completed. The [Resident] left AMA; no staff interviews were obtained. The [redacted] may be related to the brief." The DON further stated, "We could have done staff interviews; it would have been helpful."

During an interview on 2/6/2020 at 10:29 am, the Unit Manager (UM #1) stated, "the [redacted] should have been investigated to prevent further injury. The facility would not investigate the [redacted] since the Resident was going back to the community." The UM further stated, "I did not think it was serious"

During an interview with the surveyor on [redacted] at 1:08 pm, the DON stated, "the Resident's [redacted] came in to take the Resident out AMA. No written statements until [redacted], but a verbal statement was given at the time. A [redacted] would have generated an incident report but, one was not done because [he/she] was taken out AMA." The DON further stated, "The policy was not followed."

Review of the undated facility policy titled "Accident-Incident Report (RMS)" revealed the following.
"Policy" The facility staff will document all

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F 610	Continued From page 8 accidents and incidents, or any unusual occurrences experienced by residents, employee and visitors. "Procedure" (1.) All occurrences of incidents and accidents must be reported to a registered professional nurse immediately following identification of the event to ensure timely assessment of the Resident.... (3.) An Accident/Incident report (RMS) will be completed by the involved staff member to record all actions taken. (4.) Obtain a descriptive statement from the Resident if possible, and from any employee or visitor who may have been involved or witnessed the occurrence.... N.J.A.C 8:39-9.4(f)	F 610		
F 842 SS=B	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	F 842		3/16/20

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F 842	Continued From page 9 (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 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;	F 842		

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F 842	Continued From page 10 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility staff failed to sign the Medication Administration Record (MAR)/Resident "[redacted] Protocol" form, to indicate that mouth care was administered according to physician orders (POs) for 1 of 5 sampled residents (Resident #3). The deficient practice is evidenced by the following: The surveyor reviewed the facility's undated "Medication Administration General" Policy #7.2 on 2/5/2020. According to the policy: "The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific dose administration. Initials on each MAR are cross referenced to a full signature in the space provided." According to the facility Admission Record, Resident #3 was admitted in [redacted] with	F 842	1. The corrective action(s) accomplished for resident(s) accomplished for resident(s) found to be affected by the deficient practice. Resident #3 was discharged from facility on [redacted] without any [redacted]. 2. All resident's identified having the potential to be affected and corrective action(s) taken. Facility transitioned to E MAR live on 1/21/20. An audit was completed for proper signage for [redacted] from go live date. No deficient areas were noted. 3. Measures that will be put into place to ensure the deficient practice will not recur. Nurses were re educated for proper signing compliance for mouth care. Nursing Administration reviews for signature omissions daily with re education and follow up as needed for any infractions. 4. Corrective action(s) will be monitored to ensure that deficient practice does not recur. Nursing Administration will complete monthly audits for 3 months and present results at the QAPI meeting.	

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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 11 diagnoses which included but were not limited to; [redacted]. A Minimum Data Set (MDS), dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted]. A Care Plan, initiated 2/23/2019, included that the resident was [redacted] and was receiving [redacted] to meet nutrition and hydration needs. Interventions included but were not limited to; [redacted] as ordered. Review of Resident #3's 3/2019 Physician Order Sheet (POS) revealed the following PO; [redacted] every shift. Review of the 3/2019 MAR/[redacted] form revealed that for 40 out of 93 opportunities, on the following dates, there was no signatures/initials documented to indicate that mouth care was performed by staff, according to the PO. 3/2/19, 3/10/19, 3/11/19, 3/16/19, 3/17/19, 3/18/19, 3/19/19, 3/25/19, 3/30/19 at 11-7 shift. 3/3/19, 3/7/19, 3/11/19, 3/15/19, 3/21/19, 3/22/19, 3/25/19, 3/28/19, 3/29/19 at 7-3 shift and 3/2/19, 3/5/19, 3/6/19, 3/7/19, 3/8/19, 3/9/19, 3/10/19, 3/11/19, 3/12/19, 3/13/19, 3/14/19, 3/15/19, 3/16/19, 3/17/19, 3/18/19, 3/19/19, 3/20/19, 3/21/19, 3/22/19, 3/23/19, 3/26/19, 3/27/19 at 3-11 shift. During an interview with the surveyor on 2/5/2020 at 11:25 AM, Certified Nursing Assistant (CNA) #2 stated that staff provided [redacted] using [redacted] during AM care and after lunch for the	F 842		

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 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 12 confused residents. The alert residents [redacted] During an interview with the surveyor on 2/6/2020 at 11:42 AM, CNA #3 stated that [redacted] was provided every single morning. The staff used [redacted]. According to the CNA, if the residents were able to do their own [redacted], the staff provided encouragement to complete the task. During an interview with the surveyor on 2/6/2020 at 10:29 AM, Licensed practical Nurse (LPN) #2 indicated that [redacted] was done every shift. She further stated that staff used to sign [redacted] on the TAR. "Now not signed because it is standard of care." During an interview with the surveyor on 2/6/2020 at 11:03 AM, LPN #3 stated that [redacted] was done by CNAs or nurses for non-alert residents. During an interview with the Director of Nursing on 2/5/2020 at 12:55 PM, it was revealed that [redacted] was part of morning care. NJAC 8:39-27.1 (b)	F 842		