PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315209	B. WING		C 06/13/2023
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037	1 00/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENTS	3	F 00	0	
	COMPLAINT#: NJ 1	64849			
	CENSUS: 185				
	SAMPLE SIZE: 77				
F 658 SS=L	COMPLIANCE WITH 42 CFR PART 483, S TERM CARE FACIL COMPLAINT VISIT. Services Provided M CFR(s): 483.21(b)(3) §483.21(b)(3) Comp The services provide as outlined by the comust- (i) Meet professional	rehensive Care Plans and or arranged by the facility, mprehensive care plan, standards of quality. T is not met as evidenced	F 65	1.	7/26/23
	medical record and r documentation, it was failed to A.) administ timely for 18 of 45 remedication. This occunits. Failure to admirisk for EX Order 26 possible death. On 6	n, interview, review of the eview of other facility s determined that the facility er physician ordered sidents who receive urred on 2 floors on 4 of 8 hinister the prescribed residents at \$4b1, hospitalization and //11/2023 at 10:38 AM, urse (LPN) #1 who was		 LPN #3 who refused to take the assignment of 1B for 6/10/23 received couching and counseling with a one-dassuspension. Medication errors were completed the residents with missed administrations and fasting blood sugate. The Medical Director and primary care physicians were notified of the missed medications on 6/10/23 and 6/11/23. 	l for
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUF	 RE	TITLE	(X6) DATE

Electronically Signed

07/10/2023

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)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN			С	
		315209	B. WING _			6/13/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		0/13/2023	
				43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR F	REHABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 658	Continued From p	page 1	F 6	558			
		oor C hall, had not completed		Medication errors were of	completed for		
		ass within the acceptable		the identified residents who r	•		
		eters. LPN #1 had not		outside the time frame			
	·	Order 26 § 4b1		The Medical Director was	as informed of		
		for 2 residents (Resident #9		the late administration of	and other		
	and Resident #10) that were due at 7:30 AM.		medications on 6/10/23 and	<u>6/1</u> 1/23.		
				Medication errors were of	•		
		nit Manager LPN #1 arrived to		the identified residents with I	ate		
		complete the medication pass.		medications.	+: - : -		
		esidents (Resident #4, Resident		 The Medical director wa the missed medications and 			
	EX Order 26 §	nd Resident #8) on due		medical intervention was req			
	at 07:30 AM.	401		than administration of subse	•		
	Gt 07.00 7 twi.			Families were notified of	•		
	On 06/11/2023 at	10:33 am and 11:04 am, LPN		administration and missed m	nedications		
	#3 was administe	ring medications on the 2nd		including EX Order 26 § 4	b 1		
	floor C wing. LPN	#3 confirmed that medications		administrations.			
		late including Resident #1 who		 Individual counseling was 			
		n addition, Resident #49, #50,		LPN #1, LPN #2, LPN #5 for			
		all received their am		the physicians order for fasti			
	parameters on 6/	4b1 past physican ordered 11/23.		glucose and administration of the identified nurses that			
		1:01, LPN #5 (2nd fl) confirmed		administered medications ou			
	EV 0 1 00 0	vet administered physician		parameters of the physician			
		nich was due at 07:30 AM for		received individual counselin	•		
		#5 confirmed she had not yet		The identified nurses The identified nurses The identified nurses The identified nurses in the identified nurse in the ident			
	completed her mo	orning medication pass.		administer scheduled medica received individual counselin			
	Interviews with Re	esidents on 1st floor B unit		received individual couriseiin	ıg.		
		as no nurse on the unit on		Specific interventions for ide	ntified _		
		ney had not received their		residents are as follows:	in i		
		dose or EX Order 26 § 4b1 due at					
		30 AM on 06/10/2023. LPN #3		Resident #1 subsequent	t doses of		
		ke the assignment of 1st floor B		and medication were			
		, which included residents on		Medical director, physician, a			
		, continued to work on		responsible party notified. Vi			
	06/11/2023.			blood sugar obtained. On 6/1			
				resident was evaluated for la			
	This resulted in a	n Immediate Jeopardy (IJ)		missed administration of med	dication; no		

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OLIVILIV	OT OIT MEDIO TILE &	THE DIGITIES CELEVIOLE					7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						، ا	c
		315209	B. WING _				13/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020
					N WHITE HORSE PIKE		
HAMMON'	TON CENTER FOR REH	ABILITATION AND HEALTHCARE			AMMONTON, NJ 08037		
(V4) ID	QUIMMADV QT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 658	Continued From page	<u> </u>	F	658			
	'	dentified on 06/11/2023	' '	030	lasting negative effect noted. Resident		
		nsed staff failed to administer			evaluated with no lasting negative effe		
		ne facility Licensed Nursing			of EX Order 26 § 4b1 noted. HgA1C	J.	
		(LNHA) and Director of			completed with no additional interventi	ons	
	Nursing (DON) were				required. Medication error form		
	,	PM. A removal plan was			completed.		
	received on 06/12/20	23 and was verified by the			·		
	surveyor on 06/13/20	23 at 2:16 PM.			 Resident #2 subsequent doses of 		
					and medication were administer	red.	
	The facility also B.) fa				Medical director, physician, and		
		ed for the residents by the			responsible party notified. Vital signs a	nd	
	physician in accordar				blood sugar obtained. On 6/12/23,		
	standards of practice	•			resident was evaluated for late and/or	_	
	This deficient practice	e was evidenced by the			missed administration of medication; n lasting negative effect noted. Resident		
	following:	, was evidenced by the			evaluated with no lasting negative effe		
	Tollowing.				of EX Order 26 § 4b1 noted. HgA1C	J	
	Reference: New Jers	sey Statutes, Annotated Title			completed with no additional interventi	ons	
	45 Chapter 11, Nursii				required. Medication error form		
		tate of New Jersey states;			completed.		
	"the practice of nursir	ng as a Registered					
	Professional Nurse is	s defined as diagnosing, and			 Resident #3 subsequent doses of 		
		onse to actual or potential			and medication were administer	red.	
		al health problems, through			Medical director, physician, and	_	
		e finding, health teaching,			responsible party notified. Vital signs a	nd	
	health counseling, an				blood sugar obtained. On 6/12/23,		
	1	tive of life and wellbeing, and			resident was evaluated for late and/or	_	
		gimens as prescribed by a legally authorized Physician			missed administration of medication; n lasting negative effect noted. Resident		
	or dentist."	legally authorized Fifysician			evaluated with no lasting negative effe		
	or derition.				of Ex.Order 26.4(b)(1) noted. HgA1C	J.	
	Reference: New Jers	sey Statutes Annotated, Title			completed with no additional interventi	ons	
	45, Chapter 11. Nursi				required. Medication error form		
		tate of New Jersey states:			completed.	ſ	
		ing as a licensed practical			·	ĺ	
	nurse is defined as p				Resident #4 subsequent doses of		
	responsibilities within	the framework of case			and medication were administe	red.	
		e patient and family teaching			Medical director, physician, and	ſ	
	program through hea	lth teaching, health			responsible party notified. Vital signs a	nd	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII			(
		315209	B. WING _			06/	13/2023	
	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	43 H <i>A</i>	REET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE AMMONTON, NJ 08037 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	restorative care, un registered nurse of authorized physicists. On 6/11/23 at 11:0 LPN #1 and Unit May which residents has morning medication. Surveyor #2 with the surveyor #2 w	ovision of supportive and order the direction of a r licensed or otherwise legally an or dentist." 8 am, Surveyor #2 asked both danager LPN on the 1st floor d not yet received their ns. The nurses provided ne names of those residents ceived their morning ude and	Fé	658	blood sugar obtained. On 6/12/23, resident was evaluated for late and/or missed administration of medication; relasting negative effect noted. Resident evaluated with no lasting negative effect of x.Order 26.4(b)(1) noted. HgA1C completed with no additional intervention required. Medication error form completed. • Resident #6 subsequent doses of and medication were administer Medical director, physician, and responsible party notified. Vital signs a blood sugar obtained. On 6/12/23, resident was evaluated for late and/or missed administration of medication; relasting negative effect noted. Resident evaluated with no lasting negative effect of x.Order 26 x 451 noted. HgA1C completed with no additional intervention required. Medication error form completed.	et ons red. nd o		
	1. Resident #1 (2nd floor) was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 a. A review of the current Order Summary Report (OSR) revealed the following physician orders; Ex.Order 26.4(b)(1) UNIT/ML (milliliters) (EX Order 26 § 4b1) (Check before meals.)				Resident #7 subsequent doses of and medication were administer Medical director, physician, and responsible party notified. Vital signs a blood sugar obtained. On 6/12/23 Resident evaluated for late and/or miss administration of medication; no lasting negative effect noted. Resident evaluar with no lasting negative effect of [x.Order 26.4(b)(1)] noted. HgA1C complete with no additional interventions require Medication error form completed. Resident #8 subsequent doses of	nd sed J ted		

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CENTER OF THE MEDICATE CONT	LDIO/ (ID OLI (VIOLO				DIVID INO. U	300 000 1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SUF COMPLET	
					С	
	315209	B. WING _			06/13/	2023
NAME OF PROVIDER OR SUPPLIER HAMMONTON CENTER FOR REHAB	ILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP OF 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037	CODE		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	-	(X5) OMPLETION DATE
Record (MAR) confirmed aforementioned medical scheduled to be administration. Review of the MAR revealed the Review of the "Medication Admin Audit revealed the Review was am (1 hr. 46 min late). During an interview with at 4:50 pm, Resident #1 received his/her X Order Administered late. 2. Resident #2 (2nd floof facility with diagnoses in X Order 26 § 4b1 a. A review of the current following order; EX Order 26 § 4b1 A review of the 6/2023 If aforementioned order at to be administered on 6 Review of the MAAR readministered at 11:21 and a distribution of the material and ministered at 11:21 and a distribution of the ma	Medication Administration of the order for the tion and noted it was stered on 6/11/23 at 7:30 Realed the MAAR) The surveyor on 6/11/23 confirmed that he/she order 26 § 4b1 Resident #1 Ther medications are MAR confirmed the including but not limited to: The order at 10:16 MAR confirmed the including but not limited to: MAR confirmed the including but noted it was scheduled it was sched	F	and medication were Medical director, physician responsible party notified. blood sugar obtained. On the Resident evaluated for late administration of medication negative effect noted. Reswith no lasting negative effect noted. HgA with no additional intervent Medication error form com Resident #8 is no longer at Hammonton Center • Resident #9 subseque and medication were Medical director, physician responsible party notified. blood sugar obtained. Resfor late and/or missed administration on 6/12/23; no noted. Resident evaluated negative effect of HgA1C completed with no interventions required. Medical director, physician responsible party notified. • Resident #10 subseque and medication were Medical director, physician responsible party notified. Blood sugar obtained. On the form completed. • Resident #10 subseque and medication were Medical director, physician responsible party notified. Blood sugar obtained. On the form completed with no lasting negative effect note evaluated with no lasting negative effect note evaluated with no addition required. Medication error	a, and Vital signs are 6/12/23 e and/or miss on; no lasting ident evaluate fect of .1C complete tions required pleted. resident at ent doses of re administered, and Vital signs are ident evaluate inistration of lasting effect with no lasting effect with no lasting additional dication error usent doses of re administered, and Vital signs are 6/12/23, relate and/or nedication; no ed. Resident legative effect gali interventional interventional interventional interventional interventional interventional signs are 6/12/23, relate and/or nedication; no ed. Resident legative effect gali interventional inte	ed ed dd. hd ed. hd ed. hd ed. hd ed hd	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C 06/13/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	I DE	06/13/2023	
				43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR R	EHABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	that morning days medications	ent #2 did not remember getting ng. Resident #2 stated most are given late. of the OSR/MAR and MAAR vealed:	F	completed. Resident #13 subsequer and medication were a Medical director, physician, a responsible party notified. Vit blood sugar obtained. On 6/1 Resident evaluated for late a administration of medication; negative effect noted. Reside with no lasting negative effect with no additional intervention Medication error form completed. Resident #13 is no longer and Hammonton Center. Resident #14 subsequer and medication were and medication were and medication were and medication were and medication was evaluated for lamissed administration of medicating negative effect noted. evaluated with no lasting negative effect noted. evaluated with no lasting negative effect noted. evaluated with no additional required. Medication error for completed. Resident #15 subsequer and medication were and medication were and medication error for completed. Resident #15 subsequer and medication were and medica	administered. and tal signs and 12/23 and/or missed no lasting ent evaluated at of 2 completed in required. The ent doses of administered. The and tal signs and 12/23, the and/or dication; no Resident agative effect and tal signs and 12/23, the and/or dications rm.		

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<u> </u>		WILDIO/ (ID CLITTIOLS				10.0000 0001	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING		<u> </u>	6/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658		EX Order 26 § 4b1	F 6	evaluated with no lasting negative effect noted. Figure 26 state and medication of medicating negative effect noted. Figure 26 state and medication error form completed. Resident is no long resident at Hammonton Center. • Resident #16 subsequent and medication were and Medical director, physician, an responsible party notified. Vita blood sugar obtained. On 6/12 resident was evaluated for late missed administration of medical lasting negative effect noted. Find evaluated with no lasting negative effect noted. Find evaluated with no additional in required. Medication error form completed. Resident #16 is no resident of Hammonton Center.	nterventions m ger a er. t doses of dministered. al signs and 2/23, e and/or cation; no Resident ative effect C interventions m o longer a		
	(OSR) revealed the final EX Order 26 § 4k subcutaneously before A review of the MAR revealed the EX Order.	re meals and at bedtime for 6/1/2023-6/30/2023 der 26 § 4b1 date of 6/10/23 timed at		Resident #49 subsequent and medication were as Medical director, physician, an responsible party notified. Vita blood sugar obtained. On 6/12 resident was evaluated for late missed administration of medic lasting negative effect noted. Fevaluated with no lasting negatof of a completed with no additional ir required. Medication error form completed. Resident is no long resident at Hammonton Center and medication were as and medication were as a completed.	dministered. and all signs and 2/23, e and/or cation; no Resident ative effect C interventions in ger a er. at doses of		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(>	(X3) DATE SURVEY COMPLETED	
		315209	B. WING _			C 06/13/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	00/13/2023	
				43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR RI	EHABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From particle documentation that administered as tire documented. A review of the "Me (MAAR) revealed in the 0730am and 1 administered as problem. A further review. EX Order 26 § mouth one time a continue and the co	age 7 It the medication had been ned and prescribed. The at EX Order 26 § 4b1 edication Admin Audit Report" no documentation of the time of 130am as having been rescribed on 6/10/23. of the OSR revealed: by day for supplement 4b1 one time a day for XORGE 26 § 4b1 4b1 give one tablet a day for supplement	F6	DEFICIENCY	and ital signs and 12/23, ate and/or dication; no . Resident gative effect A1C I intervention orm and ed. Medical consible party d sugar ent was essed ; no lasting ent evaluate ct of C completed ons required. eted. ett doses of administered and ital signs and 12/23,	d.	
	by mouth two times EX Order 26 § mouth three times EX Order 26 § EX Order 26 §	4b1 give 1 capsule by a day for XOrder 26 § 4b1 4b1 by mouth one		missed administration of me lasting negative effect noted evaluated with no lasting ner of SCOTOGET 26 § 451 noted. Hg/completed with additional intrequired. Medication error for	dication; no . Resident gative effect A1C terventions		
	time a day for	4-6 ounces of water		completed.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С	
		315209	B. WING_		06/	13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
наммом	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE		
TIAMMION	TON GENTERT OR REID	ADELIATION AND HEALTHOAKE		HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	EX Order 26 § 4b1 subcutaneously before EX Order 26 § 4b1 one time a day for EX Order 26 § 4b every EX Order 26 § 4b EX Order 26 § 4b	notify MD (medical doctor) re meals and at bedtime give one tablet by mouth order 25 § 461 y 12 hours for EX Order 26 § 461 other and a day for the MAR revealed	F 6	,	red. nd o d ed f I rty 3,	
	indicated no documer had been administered to the manual was administered at 18:10 was do	um ntation that the medication ed as prescribed on 6/10/23. that on 6/10/23 the		Resident #18 subsequent doses o medication were administered. Medical director, physician, and responsible par notified. Vital signs obtained. On 7/6/23 resident was evaluated for late and/or missed administration of medication; no lasting negative effect noted. Medication error form completed. Resident #19 subsequent doses of medication were administered. Medical director, physician, and responsible par notified. Vital signs obtained. On 7/6/23 resident was evaluated for late and/or missed administration of medication; not medication	I rty 3, o o on f I rty 3,	

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315209 R WING 06/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE HAMMONTON, NJ 08037 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 658 Continued From page 9 F 658 documented as administered at 18:11 (6:11pm). lasting negative effect noted. Medication error form completed. During an interview with the surveyor on 6/11/2023 at 4:45 PM, Resident #3 said when Resident #20 subsequent doses of asked if he/she received their EX Order 26 § medication were administered. Medical on 6/10/2023, Resident #3 director, physician, and responsible party responded "I did not get my EX Order 26 § 4b1 or notified. Vital signs obtained. On 7/6/23, until the second shift came on duty resident evaluated for late and/or missed yesterday. We got no meds yesterday." administration of medication; no lasting negative effect noted. Medication error 4. Resident #4 was admitted with diagnoses form completed. including but not limited to: Resident #21 subsequent doses of A review of the current OSR revealed the medication were administered. Medical following physician orders: director, physician, and responsible party notified. Vital signs obtained. On 7/6/23, X Order 26 § 4b1 resident was evaluated for late and/or missed administration of medication; no lasting negative effect noted. Medication error form completed. Resident #22 subsequent doses of medication were administered. Medical A review of the MAR dated 6/1/2023-6/30/2023 revealed the order for EX Order 26 § 4b director, physician, and responsible party notified. Vital signs obtained. On 7/6/23, . On 6/11/23 at and According to resident was evaluated for late and/or was documentation of the "Chart Codes" 5=Hold/See Nurses Notes. missed administration of medication; no lasting negative effect noted. Medication A review of the PN did not include documentation error form completed. Resident #22 is no to indicate why the medication was not longer a resident at Hammonton Center. administered. Resident #23 subsequent doses of A review of the MAAR revealed the 0730am medication were administered. Medical ordered was administered at 12:14pm director, MD, and responsible party and the notified. Vital signs obtained. On 7/6/23, resident was evaluated for late and/or missed administration of medication; no lasting negative effect noted. Medication

error form completed.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		315209	B. WING _			C 06/1 :	3/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		<u></u>	
HAMMON	TON CENTER FOR RE	HABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE	
F 658	A review of the MAI revealed the order of the MAI review of the MAI revealed the order of the MAI review of the PN to indicate why the	admitted with diagnoses nited to: EX Order 26 § 451 Tent OSR revealed the orders: EX Order 26 § 451 Ab1 R dated 6/1/2023-6/30/2023 for EX Order 26 § 451 did not include documentation medication was not fithe resident refusal.	F 6	Resident #24 subseque medication were administere director, physician, and resp notified. Vital signs obtained resident was evaluated for la missed administration of me lasting negative effect noted error form completed. Residlonger a resident at Hammon. Resident #25 subseque medication were administered director, physician, and resp notified. Vital signs obtained resident was evaluated for la missed administration of me lasting negative effect noted error form completed. Resident #26 subseque medication were administered director, physician, and resp notified. Vital signs obtained resident was evaluated for la missed administration of me lasting negative effect noted error form completed. Resident #27 subseque medication were administered director, physician and respondified. Vital signs obtained resident was evaluated for la missed administration of me lasting negative effect noted error form completed. Resident #27 subseque medication were administered director, physician and respondified. Vital signs obtained resident was evaluated for la missed administration of me lasting negative effect noted error form completed.	ed. Medical ponsible par l. On 7/6/23 ate and/or edication; no l. Medication ent #24 is no not consible par l. On 7/6/23 ate and/or edication; no l. Medication; no l. Medicat	ty, one or. ty, on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	I	06/13/2023	
INAME OF T	NOVIDEN ON OUT FIEN			43 N WHITE HORSE PIKE	•		
HAMMON	TON CENTER FOR F	REHABILITATION AND HEALTHCARE					
	I			HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	Continued From p	page 11	F 65	58			
	(1:28 PM).	^{3 § 451} was documented at 13:28		medication were administered director, physician, and respor notified. Vital signs obtained. O	nsible party On 7/6/23,		
		as admitted to the facility with ng but not limited to: Excorder 26 5 4 bit.		resident was evaluated for late missed administration of medic lasting negative effect noted. N	cation; no		
	A review of the confollowing physicia	urrent OSR revealed the n orders:		error form completed. • Resident #30 subsequent			
	EX Order 26 §			medication were administered director, physician, and respon notified. Vital signs obtained. Cresident was evaluated for late missed administration of medic lasting negative effect noted.	Medical nsible party On 7/6/23, and/or cation; no		
		AR dated 6/1/2023-6/30/2023 r for EX Order 26 § 4b1		Resident #31 subsequent medication were administered director, physician, and respornotified. Vital signs obtained. Cresident was evaluated for late missed administration of medic lasting negative effect noted. Merror form completed.	Medical nsible party On 7/6/23, and/or cation; no		
	Nurses Notes. The Ex.Order 26.4(b)(1) was am by the Unit Ma (UM/LPN#1). The	Chart Codes" 5=Hold/See e MAR also indicated that the vas signed as administered at 9 anger/Licensed Practical Nurse EX Order 26 § 4b1		 Resident #32 subsequent medication were administered. director, physician, and respor notified. Vital signs obtained. Of resident evaluated for late and administration of medication; in negative effect noted. Medicat form completed. 	Medical nsible party On 7/6/23, /or missed to lasting		
		he audits also		Resident #33 subsequent medication were administered.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		315209	B. WING _			C 06/13/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE	1 00/13/2023	
				43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 080			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			
F 658	Continued From page	e 12	F6	58			
	reflected that the 9:00 AM dose, that was signed as administered, was documented as having been given at 11:34 AM. 7. Resident #8 was admitted to the facility with			director, physician, and responsible party notified. Vital signs obtained. On 7/6/23, resident evaluated for late and/or missed administration of medication; no lasting		3, ed	
	diagnoses including b			form completed.	oted. Medication error		
	A review of the MAR dated 6/1/2023-6/30/2023 revealed the order for Ex.Order 26.4(b)(1). There was no documentation on 6/11/23 at 0730am or 1130am to indicate the was taken and the medication administered as prescribed. A review of the PN did not indicate why the had not been administered as prescribed. A review of the "Medication Admin Audit Report" revealed there was no documentation that the medication had been administered as timed and prescribed. 8. Resident #9 was admitted to the facility with diagnoses including but not limited to: Excorder 26 \$ 451			medication were a director, physicial notified. Vital sign evaluated for late administration of	medication on 7/6/23 effect noted. Medication	l rty no	
				medication were a director, physician notified. Vital sign evaluated for late administration of	medication on 7/6/23 effect noted. Medication	I rty no	
				medication were a director, physiciar notified. Vital sign evaluated for late administration of lasting negative error form comple	medication on 7/6/23 effect noted. Medication eted. Resident #36 is	no on no	
	A review of the current following orders: EX Order 26 § 4b			Resident #37 medication were a director, physician	at Hammonton Center 7 subsequent doses of administered. Medica n, and responsible pa ns obtained. Resident	f I rty	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING_			06/1) 13/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, C	CITY, STATE, ZIP CODE	1 00/	13/2023	
				43 N WHITE HORSE	PIKE			
HAMMON	TON CENTER FOR REH	IABILITATION AND HEALTHCARE		HAMMONTON, NJ	08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	F 658 Continued From page 13		F6	58				
		dated 6/1/2023-6/30/2023		administration	late and/or missed n of medication on 7/6/23; ive effect noted. Medication mpleted.			
	. There was not to indicate the medic 0730am or 1130am a 0730am was docume to the "Chart Codes"	the OSR revealed:		medication we director, , phy notified. Vital evaluated for administratior lasting negative error form cor Resident medication we director, phys notified. Vital evaluated for administration	t #39 subsequent doses of the administered. Medical sician, and responsible pasigns obtained. Resident late and/or missed in of medication on 7/6/23; we effect noted. Medication	il arty ; no on of il irty ; no		
				medication we director, phys notified. Vital evaluated for administratior lasting negative rror form cor longer a resid Resident medication we director, phys notified. Vital evaluated for	t #40 subsequent doses of ere administered. Medical sician, and responsible particular, and responsible particular	il irty ; no on no er. of il		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 315209 R WING 06/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE HAMMONTON, NJ 08037 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 658 Continued From page 14 F 658 lasting negative effect noted. Medication error form completed. Resident #42 subsequent doses of medication were administered. Medical director, physician, and responsible party notified. Vital signs obtained. Resident evaluated for late and/or missed administration of medication on 7/6/23; no lasting negative effect noted. Medication error form completed. Resident #43 subsequent doses of b. A further review of the MAR revealed that on medication were administered. Medical 6/11/2023 the **EX Order 26 § 4b1** director, physician, and responsible party notified. Vital signs obtained. Resident evaluated for late and/or missed administration of medication on 7/6/23: no lasting negative effect noted. Medication A review of the PN did not indicate why the error form completed. Resident #43 is no had not been administered as prescribed. longer a resident at Hammonton Center. The MAAR further showed the Resident #44 subsequent doses of medication were administered. Medical were documented as administered at 11:02am. The director, physician, and responsible party notified. Vital signs obtained. Resident and were documented as administered at 10:59am. The evaluated for late and/or missed was documented as administered at 11:00am. administration of medication on 7/6/23; no lasting negative effect noted. Medication 9. Resident #10 was admitted to the facility with error form completed. Resident #44 is no diagnoses including but not limited to: longer a resident at Hammonton Center. Resident #45 subsequent doses of A review of the current OSR revealed the medication were administered. Medical following physician orders: director, physician, and responsible party notified. Vital signs obtained. Resident

a. EX Order 26 § 4b1

evaluated for late and/or missed

administration of medication on 7/6/23: no lasting negative effect noted. Medication

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			С	
		315209	B. WING _			06/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR RI	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 658	revealed that there 6/3/23 at 0730am, EX Order 26 § sliding scale were 6/11/23 at EX Ord documentation of a Codes" 5=Hold/Se A review of the MA the 0730am the EX administered at EX	4b1 MAR dated 6/1/2023-6/30/2023 was no documentation on 0800am and 1200pm the 4b1 administered as ordered. On er 26 § 4b1 was a "5". According to the "Chart	F 6	· · ·	Medical ble party sident 7/6/23; no dication 4/6 is no Center. Descriptions of Medical ble party sident 7/6/23; no dication Descriptions of Medical ble party sident 7/6/23; no dication Descriptions of Medical ble party sident 7/6/23; no dication 4/8 is no Center. Descriptions of Medical ble party sident		
	he/she did not rece before breakfast. F their room at 10:30	0 PM, Resident #10 said eive their morning except #10 said he/she left of the part of the		director, physician, and responsi notified. Vital signs obtained. On resident was evaluated for late a missed administration of medical lasting negative effect noted. Me error form completed.	7/6/23, nd/or tion; no		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING_			C 06/13/2023	
NAME OF P	ROVIDER OR SUPPLIER	1.1211	 	STREET ADDRESS, CITY, STATE, ZIP CODE	 E	1 00/	13/2023
				43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 658	A review of the PN di	d not include documentation d not been administered. the OSR revealed:	Fé	Resident #53 subsequent medication were administered director, physician, and responsition of medication were administered director, physician, and responsive effect noted. It error form completed. Resident #54 subsequent medication were administered director, physician, and responsition of medication were administered director, physician, and responsive effect noted. It error form completed. Resident #55 subsequent medication were administered director, physician, and responsive effect noted. It error form completed. Resident #55 subsequent medication were administered director, physician, and responsitified. Vital signs obtained. Or resident was evaluated for late missed administration of medicating negative effect noted. It error form completed. Resident #56 subsequent medication were administered director, physician, and responsitified. Vital signs obtained. Or resident was evaluated for late missed administration of medication were administered director, physician, and responsitified. Vital signs obtained. Or resident was evaluated for late missed administration of medicating negative effect noted. It error form completed.	d. Medical nsible part on 7/6/23 e and/or ication; no Medication of the doses of th	I rty 3, o on of I rty 3, o on f I rty 3, o on f I rty 3, o on	
				Resident #57 subsequent medication were administered			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315209	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	313203		STREET ADDRESS, CITY, STATE, ZIP CODE	0	6/13/2023	
NAIVIE OF PI	ROVIDER OR SUPPLIER			, , ,			
HAMMON'	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE			
				HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 658	F 658 Continued From page 17		F 65	director, physician, and responsibl	e party		
	EX Order 26 § 4b	01		notified. Vital signs obtained. On 7 resident was evaluated for late and missed administration of medicatic lasting negative effect noted. Medierror form completed.	7/6/23, d/or on; no		
				Resident #58 subsequent dos medication were administered. Me director, physician, and responsibl notified. Vital signs obtained. On 7 resident was evaluated for late and missed administration of medication lasting negative effect noted. Medication form completed.	edical e party 76/23, d/or on; no		
				Resident #59 subsequent dos medication were administered. Me director, physician, and responsibl notified. Vital signs obtained. On 7 resident was evaluated for late and missed administration of medication lasting negative effect noted. Medication form completed.	edical e party 76/23, d/or on; no		
				Resident #60 subsequent dos medication were administered. Me director, physician, and responsibl notified. Vital signs obtained. On 7 resident was evaluated for late and missed administration of medication lasting negative effect noted. Medication form completed.	edical e party 7/6/23, d/or on; no		
				Resident #61 subsequent dos medication were administered. Me director, physician, and responsible	edical		

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CENTER	3 FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	7. 0930 - 0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			D MANAGE				С
		315209	B. WING _			06/	13/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
I I A MANAGANI	TON CENTED FOR DEL	LADU ITATION AND LIEALTHOADE		43	N WHITE HORSE PIKE		
HAWWON	ION CENTER FOR REP	ABILITATION AND HEALTHCARE		H	AMMONTON, NJ 08037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 658	Continued From pag	ue 18	F 6	558			
	-	, -			notified. Vital signs obtained. On 7/6/2	3	
	EX Order 26 § 4	h1			resident was evaluated for late and/or	J,	
	EX Older 20 g 4				missed administration of medication; n	0	
					lasting negative effect noted. Medication		
	b. A further review of	f the MAR showed that the			error form completed.	211	
	EX Order 26 § 4						
	0						
					 Resident #62 subsequent doses of 	f	
					medication were administered. Medica	l	
					director, physician, and responsible pa	rty	
					notified. Vital signs obtained. On 7/6/23	3,	
					resident was evaluated for late and/or		
					missed administration of medication; n		
		ne MAAR showed the			lasting negative effect noted. Medication	on	
	EX Order 26 § 4	01			error form completed.		
					Resident #63 subsequent doses of	f	
					medication were administered. Medica		
	The EX Order 26	8 4h1			director, physician, and responsible pa		
	THE EXTENSION ES	3 15 1			notified. Vital signs obtained. On 7/6/2		
					resident was evaluated for late and/or	-,	
					missed administration of medication; n	0	
					lasting negative effect noted. Medication		
					error form completed.		
		were					
		inistered at 12:46pm on			 Resident #64 subsequent doses of 		
	6/11/23.				medication were administered. Medica		
	40 D : 1 : "40				director, physician, and responsible pa	•	
		as admitted to the facility with			notified. Vital signs obtained. On 7/6/23	3,	
	diagnoses including	but not limited to:			resident was evaluated for late and/or	_	
					missed administration of medication; n		
	a A rayiou of the	rrent OSR revealed the			lasting negative effect noted. Medication	ווכ	
	following physician c				error form completed.		
	EX Order 26 § 4				Resident #65 subsequent doses of	f	
	L/ Older 20 8 41	01			medication were administered. Medica		
					director, MD, and responsible party		
					notified. Vital signs obtained. On 7/6/2	3.	
			1	- 1		- ,	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	313203	1 2:	STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	06/13/2023	
NAME OF F	NOVIDER OR SUFFLIER			43 N WHITE HORSE PIKE	JE		
HAMMON	TON CENTER FOR F	REHABILITATION AND HEALTHCARE					
	1			HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE	
F 658	Continued From p	page 19	F 6	58			
	breakfast call MD	the morning for IDDM before if below 70 or above 400.		resident was evaluated for la missed administration of med lasting negative effect noted error form completed.	dication; no		
	A review of the MAR dated 6/1/2023-6/30/2023 revealed the order for EX Order 26 § 4b1			•			
	A review of the M. EX Order 26 §	AAR revealed the 6/10/23 the 4b1		Resident #67 subseque medication were administere director, physician, and resp notified. Vital signs obtained resident was evaluated for la missed administration of med lasting negative effect noted error form completed.	ed. Medical onsible party . On 7/6/23, ate and/or dication; no		
	b. A further review EX Order 26 §	of the OSR revealed: 4b1		Resident #68 subseque medication were administere director, physician, and respondified. Vital signs obtained resident was evaluated for lamissed administration of mediasting negative effect noted error form completed.	ed. Medical onsible party . On 7/6/23, ate and/or dication; no		
				Resident #69 subseque medication were administere director, physician, and respontified. Vital signs obtained resident was evaluated for lamissed administration of mediasting negative effect noted error form completed.	ed. Medical onsible party . On 7/6/23, ate and/or dication; no		
				Resident #71 subseque medication were administere director, physician, and resp	ed. Medical		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
			71. BOILDING		С	
		315209	B. WING		06/13/2023	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HAMMON	TON CENTER FOR RE	EHABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE		
HAMIMON	TOW CENTER FOR RE	INABIENATION AND HEALTHCAKE		HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION	
F 658	Continued From pa		F 65	notified. Vital signs obtained. On 7/ resident was evaluated for late and missed administration of medicatio lasting negative effect noted. Medical	/or n; no	
	indicated a "2" which indicated the Residual A further review of documented as ha 6/11/2023 at 14:16	The MAR documentation ch according to the chart codes dent refused the medication. the EX Order 26 § 4b1 were ving been refused on		Resident #72 subsequent dose medication were administered. Medicector, physician, and responsible notified. Vital signs obtained. On 7/ resident was evaluated for late and missed administration of medicatio lasting negative effect noted. Medicerror form completed. Resident #73 subsequent dose medication were administered. Medicector, physician, and responsible notified. Vital signs obtained. On 7/ resident was evaluated for late and missed administration of medicatio lasting negative effect noted. Medicerror form completed.	dical e party 6/23, /or n; no eation es of dical e party 6/23, /or n; no	
	A review of the MA revealed the order scale X Order 2	R dated 6/1/2023-6/30/2023 for the Ex.Order 26.4(b)(1)		 Resident #74 subsequent dose medication were administered. Medirector, physician, and responsible notified. Vital signs obtained. On 7/resident was evaluated for late and missed administration of medicatio lasting negative effect noted. Medicerror form completed. Resident #75 subsequent dose medication were administered. Medirector, physician, and responsible notified. Vital signs obtained. On 7/resident was evaluated for late and 	dical e party 6/23, /or n; no eation es of dical e party 6/23,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315209	B. WING _			C 06/13/20	22
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	I P CODE	00/13/20	23
				43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR REI	HABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		СОМІ	(X5) PLETION DATE
F 658	Continued From pag	ge 21	F 6	658			
	medication was administered at 0730am or 1130am as ordered.			I	missed administration of medication; no lasting negative effect noted. Medication		
		s prescribed on 6/10/23 at f the OSR revealed:		 Resident #76 subse medication were administ director, physician, and rotified. Vital signs obtain resident was evaluated from the inseed administration of lasting negative effect not error form completed. Resident #77 subse medication were administ director, physician, and rotified. Vital signs obtain resident was evaluated from isseed administration of lasting negative effect not error form completed. 2. 	stered. Medical esponsible par ned. On 7/6/23 or late and/or medication; no ted. Medication quent doses of stered. Medical esponsible par ned. On 7/6/23 or late and/or medication; no medication; no	ty , n	
	did not inclu	ne MAR revealed the ude documentation that the nadministered as ordered.		All dependent records for 1 month were not administered to additional non-compliant completed from 6/6/23 to Al according resident.	e reviewed for a to identify se. Review of 7/5/23. records were administered ent in the order ompliance. 6/6/23 to 7/5/23 residents that ed/ late figns/ symptoms.	to 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315209	B. WING _				C 1 13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHI	DDRESS, CITY, STATE, ZIP CODE TE HORSE PIKE NTON, NJ 08037	1 00/	13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 658	was administered as 0730am or 1130am. revealed the administered at 19:45 EX Order 26 § 45 documentation of have 6/10/23. 12. Resident #15 was diagnoses including be a review of the current the following physicial extended by the following physicial extended the order for documentation to indicate the following the following physicial extended the order for documentation to indicate the following the following physicial extended the order for documentation to indicate the following physicial extended the order for documentation to indicate the following physicial extended the order for documentation to indicate the following physicial extended the order for documentation to indicate the following physicial extended the order for documentation to indicate the following physicial extended the order for documentation to indicate the following physicial extended the following ph	sliding scale prescribed on 6/10/23 at A further review of the MAAR EC and C7:45 PM). The did not include ving been administered on admitted to the facility with out not limited to: X	F	on 6. any i adm 6/12. inclu resid addr on 6. revie med adm nurs assig immeresid adm clinic med 3. Adm adm comply guide adm	was identified. Complete //12/23 and 7/6/23. Medication errors were completed identified medication inistration error. Completed on //23 and 7/6/23. The medical director ordered labs iding Complete //14/23. All medication administrations were exactly the physician. Complete //14/23. All medication administrations were exactly the physician of //23 for ications not administrations were evaluated in with vital signs completed. The great physicians were notified. No ediate concern was identified for a dient. Medication errors were completed identified medication inistration error. Completed on 7/6 No resident identified with a negativation and of calculation in mistration error. The facility policy on medication in inistration and determined to be in pliance with state and federal elines on 7/6/23. The facility policy on medication inistration and liberal medication inistration and liberal medication inistration was reviewed by the	ed If for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315209	B. WING		06/	13/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ПУММОМ	TON CENTED FOR DELL	ADII ITATION AND UEALTHCADE		43 N WHITE HORSE PIKE			
HAIVINON	ION CENTER FOR RED.	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 658	A review of the PN di as to why the medical A review of the MAAF documentation that the were administered as times. 13. Resident #16 was diagnoses including to a. A review of the cur following physician of	d not include documentation tions were not administered. R did not include to the facility with out not limited to: The prescribed at the indicated to the facility with the put not limited to: The prescribed the received the reference to the facility with the put not limited to: The prescribed the reference to the facility with the put not limited to: The prescribed the reference to the facility with the put not limited to:			and with 3. ration reflect a pm . 7:30		
	A review of the MAR dated 6/1/2023-6/30/2023 revealed the order for EX Order 26 § 4b1 There was no documentation that the medication had been administered as prescribed on 6/10/23. A review of the MAAR revealed there was no documentation that the Ex.Order 26.4(b)(1) EX Order 26 § 4b1 b. A further review of the OSR revealed: EX Order 26 § 4b1			Licensed Practical Nurses) on professional standards specifically focusing on insulin administration requirements. The education includes: a. Short acting orders must adhered to as ordered. Short acting is scheduled AC (before mea ensure that the resident's blood glud levels remain stable. b. AC administration means starting minutes prior to the meal and canno administered after the resident consthe meal. c. AC times are scheduled: 7:30 at 11:30 am, 4:30 pm. d. In the event that administration does not occur prior to the meal the physician is to be notified and or will be given based on the resident's status at the time.	be Is) to ose Ig 30 It be umes Im, of eal, ders		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_			C
		315209	B. WING			06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43	REET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Ex.Order 26.4(b)(1) timed at	e MAR revealed that the 7-10a, EX Order 26 § 4b1	F	658	e. Failure to follow orders can result in destabilization of blood glucose levels leading to either hyperglycemia or hypoglycemia, hospitalization, and possible death. • Starting on 6/10/23, the staff educator/ designee educated all license nurses (including licensed practical nurses and registered nurses) on professional standards specifically focusing on medication administration. • The education includes: a. Medications are to be administered one hour prior and one hour after the designated time of administration. b. Residents that refuse medications must have documentation in the medication record noting physician and designated representative notification. c. Medications that are administered must include physician notification. d. Medications that are not administered must include physician and designated representative notification. 4. • The Director of Nursing/ designee perform medication observations of 200 of all nurses to ensure insulin is administered within the prescribed time frame. These audits will occur daily for first week then weekly times four weeks then monthly until compliance is met. 100% of all licensed nurses will be observed at least once, at minimum, to meet completion of this audit. Audits started on 6/12/23. • The Director of Nursing/Designees.	ed d al d late ered will % e the s	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING _			C 13/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	13/2023	
				43 N WHITE HORSE PIKE			
HAMMON'	TON CENTER FOR RE	HABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETION DATE	
F 658	Continued From pa	ge 25	F 6	358			
	A review of the MAA	AR did not include		audit the medical record of 10 Excorder 26.	•		
	documentation that	the aforementioned		dependent excorder 25.4(b)(1) for adherence t	0		
	medications had be	en administered as ordered		administration times. These a	ıudits		
	on 6/10/23 at the in	dicated times.		will be completed weekly for 4 week	s and		
				then monthly until compliance is me			
		as admitted to the facility with		100% of all coorder 26. dependent reside			
	diagnoses including	but not limited to:		will be audited at least once, at mini			
				to meet completion of this audit. Aud	its		
				started on 6/12/23.	adiata		
	a A raviou of the o	urrent OSR/ Medication		 Negative findings will have imm corrective action. 	ediate		
		R)/MAR/MAAR revealed the		The findings of these audits will	he		
	following orders;	it ty/ivii ii vivii v ii t i o vodiod ii io		presented at monthly Quality Assura			
	EX Order 26 § 4	lb1		Performance Improvement meeting	1100		
				starting in July 2023.			
				The Director of Nursing/ design	ee will		
				perform medication observations of	20%		
				of all nurses to ensure medications			
				administered within the prescribed to			
				frame. These audits will occur daily			
		023 MAR confirmed the order		first week then weekly times four we			
		ned medication and noted it		then monthly until compliance is me			
		e administered on 6/11/23 at		100% of all licensed nurses will be	4-		
	7:30 am.			observed at least once, at minimum meet completion of this audit. Audits			
	Review of the MAR	revealed the EXOrder 26 § 461		started on 7/5/23.			
	Troviow of the final	Tovodiod tilo		Negative findings will have imm	ediate		
				corrective action.			
				The Director of Nursing/ design	ee will		
				audit all medication administration to			
	However, review of	the facility "EX Order 26 § 4b1		late and/or missed administration of			
				medication. These audits will be			
				completed daily for 30 days; weekly			
				weeks and then monthly until substa			
		of the OSR/MRR/MAR and		compliance is met for a minimum of	six		
		#49's 6/11/2023 am		months.			
	medications revealed			Negative findings will have imm			
	EX Order 26 § 4	+D1		 corrective action. Audits started on 7 The results of these audits will l 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED	
		315209	B. WING	R WING		C	
NAME OF D	ROVIDER OR SUPPLIER	010200	1	STREET ADDRESS, CITY, STATE, ZIP CODE		06/13/2023	
NAIVIE OF PI	ROVIDER OR SUPPLIER						
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE			
				HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			
F 658	Continued From page	e 26	F	658			
	was administered at EX Order 26 § 4kg	11:00 (1 hr. late)		presented at monthly Quality As Performance Improvement mee starting in July 2023. Target Completion is 7/26/23			
	15. Resident #50 wadiagnoses including I	es admitted to the facility with but not limited to: Exception of		Responsible Party: Director of	Nursing		
	a. A review of the cur revealed the following EX Order 26 § 46						
	for the aforementions was scheduled on 6/ Review of the facility						
	EX Order 26 § 4k	with meals for					
	for the aforementione was to be administer Review of the facility	3 MAR confirmed the order ed medication and noted it ed on 6/11/23 at 8:00 am. MAAR revealed the 10:42 am (1 hr. 42 min late).					
	b. A further review of MAAR for Resident #	the OSR/MRR/MAR and 50's 6/11/2023 am					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			1, ,	TE SURVEY MPLETED
		315209	B. WING _			C 6/13/2023
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		0/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	administered at 10:51 16. Resident #51 was diagnoses including be a. A review of the currevealed the following EX Order 26 § 40 A review of the 6/202 for the aforementione was scheduled to be 7:30 am. However, revealed the am (2 hr. 13 min late) EX Order 26 § 40 Notifiabove Notified A review of the 6/202 for the aforementione	nistered at 9:00 AM was am (51min. late). admitted to the facility with out not limited to: arent OSR/MRR/MAR/MAAR gorders; 3 MAR confirmed the order d medication and noted it administered on 6/11/23 at eview of the facility MAAR was administered at 10:43 by MD if BS below or 3 MAR confirmed the order d medication and noted it administered on 6/11/23 at eview of the facility MAAR was administered on 6/11/23 at eview of the facility MAAR was administered at 10:43	F6	358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
	315209 B. WING			C 06/13/2023		
	ROVIDER OR SUPPLIER	REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		10/10/2023
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 658	a. A review of the revealed the followadministered; EX Order 26 § b. A further review	was admitted to the facility with ang but not limited to: Current OSR/MRR/MAR/MAAR wing orders/times to be 4b1 y of the OSR/MAR and MAAR is 6/11/2023 am medications	F6	558		
		was admitted to the facility with ncluded but were not limited to;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING _	B. WING		C 06/13/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	00/13/2023	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE			
				HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIA		
F 658	Continued From pag	e 29	F 6	558			
	a. A review of the cur revealed the following administered; Ex.Order 26.4(b)						
		3 MAR confirmed the order ed medication and noted it 23 at 7:30 am.					
	Review of the facility checked 10:18 am (1	MAAR revealed the BS was hr 18 min late) [XX OTHER 20 S 40]					
		the OSR/MAR and MAAR 11/2023 am medications					
	EX Order 26 § 4k	01					
	PART B						
	19. Resident # 17 wa diagnoses including l	ns admitted to facility with out not limited to:					
	A review of the curre following orders:	nt ORS revealed the					
	EX Order 26 § 4k	01					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
	315209		B. WING			С		
NAME OF PROVIDER OR SUPPLIER		315209	B. WING_	STREET ADDRESS, CITY, STATE, ZIP COL		13/2023		
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE		EHABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 658	Continued From p	age 30	F 65	58				
	EX Order 26 §	4b1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING _		06	/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE	
F 658	EX Order 26 § 4b A review of the MAR or revealed the EX Order A review of the MAAF all of the aforemention	dated 6/1/2023-6/30/2023 ler 26 § 4b1 R revealed the revealed that ned medications were g been administered at 3.	F	658			
	6/11/2023 at 10:46 AN	M who said EX Order 26 § 4b1					
	diagnoses including b	out not limited to:					
	A review of the currer following physician or						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245200	B. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	315209	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	06/13/2023	\dashv
		A DU 174710N AND 11541 7110A DE		43 N WHITE HORSE PIKE		
HAMMON	ION CENTER FOR REH	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	N
F 658	Continued From page	22		858		
1 000	EX Order 26 § 4b			000		
	3					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTI		(X3) DATE SURVEY COMPLETED	
			A. BOILD	, a solidario			С
		315209	B. WING			06/	/13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE	•	STREET ADDRE 43 N WHITE HO HAMMONTON			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	A review of the MAAF aforementioned medi as having been admit 06/11/2023.	R revealed all the cations were documented nistered at 12:10pm on a sadmitted to the facility without not limited to:	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315209	B. WING			С	
NAME OF P	ROVIDER OR SUPPLIER	315209	B. WING	STREET	ADDRESS, CITY, STATE, ZIP CODE	06/	13/2023
		ADULTATION AND LIFALTICADE			ITE HORSE PIKE		
HAMMON	ION CENTER FOR REHA	ABILITATION AND HEALTHCARE		НАММС	ONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 34	F	658			
	EX Order 26 § 4b	01					
	A review of the MAR indicated that EX Or	dated 6/1/2023-6/30/2023 rder 26 § 4b1					
	There was no docum medications had bee prescribed on 6/11/23						
	A review of the MAAF documentation that the medications were adulthe indicated times.						
		ss note to indicate why the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			A. BOILDI	A. Bollesino		С	
		315209	B. WING		06	/13/2023	
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
F 658	prescribed.	ns admitted to the facility with but not limited to: TOWN 2019-11 TOWN 2019-11 TOWN 2019-11 TOWN 2019-11 TOWN 2019-11	F	658			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING		06	/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIA		(X5) COMPLETION DATE	
F 658	Continued From page EX Order 26 § 4b EX Order 26 § 4b		F	658			
	revealed for each of the timed for 07:00am, 05 the number "5" docur "Chart Codes" 5=Hold A review of the PN dias to why the medical as prescribed. A review of the MAAF	d not include documentation tions were not administered R revealed the ***Concerns \$ 1.00 to the facility with					
	23. Resident #21 was diagnoses of EX Or						

CENTER	o i o i i inebio; ii ie a i	I					1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		315209	B. WING			06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		43	REET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE NMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page EX Order 26 § 4b A review of the OSR residual continued from page 25 page 25 page 26 pag	1	F	658			
	physician orders:	ovodica and following					
	EX Order 26 § 4b	1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315209	B. WING_			C	
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COI 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		6/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	A review of the MA documentation that administered as properties of the PN documentation to had not been administered as properties of the MA documentation that administered as properties of the MA documentation to the MA documentation that administered as properties of the MA	The MAR did not include at the medication was rescribed on 6/11/23. If for 6/11/23 did not include indicate why the medication inistered as prescribed. AAR did not include at the medications had been rescribed on 6/11/23 at the modern of the facility with order 26 § 4b1	F 6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315209	B. WING			l	0
NAME OF D	ROVIDER OR SUPPLIER	313203	D. Wiito		FREET ADDRESS, CITY, STATE, ZIP CODE	06/	13/2023
NAME OF FI	NOVIDER OR SUFFLIER				S N WHITE HORSE PIKE		
HAMMON'	TON CENTER FOR REHA	ABILITATION AND HEALTHCARE			AMMONTON, NJ 08037		
0/0.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES	ID.	- 1			(V5)
(X4) ID PREFIX TAG					(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 658	Continued From page	20		658			
1 000	mouth one time a day		F'	000			
							
	EX Order 26 § 4b	1					
	A ravious of the MAP	dated 6/1/2023-6/30/2023					
	indicated th EX Orc						
		. There was no					
	documentation that the						
	administered as timed	d and prescribed on 6/11/23.					
	A review of the PN die as to why the medica administered as prese						
	A review of the MAAF documentation that the medications had been prescribed on 6/11/23	ne aforementioned					
	25. Resident # 23 wa	s admitted to the facility with					
	diagnoses including b	out not limited to: X Order 28 § 451					
	A review of the currer following physician or						
	EX Order 26 § 4b	01					
	EX Order 26 § 4b	01					
	EX Order 26 § 4b	1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		315209	B. WING _			C 06/13/2023
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		00/13/2023
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 658	Continued From p EX Order 26 §		F 6	58		
	A review of the MA	AR dated 6/1/2023-6/30/2023				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		(
		315209	B. WING			06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REI	HABILITATION AND HEALTHCARE		4	TREET ADDRESS, CITY, STATE, ZIP CODE 3 N WHITE HORSE PIKE IAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	medications were ad indicated times and A review of the PN of why the medication as prescribed. A review of the MAA documentation that administered on 6/1 26. Resident #24 was diagnoses including	mentation to indicate the dministered on 6/11/23 at the as prescribed. did not include documentation on had not been administered AR did not include the medications were 1/23 as prescribed and timed. as admitted to the facility with but not limited to: EX Order 26 § 451 ent OSR revealed the orders:	F	658	DEFICIENCY)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245200	B. WING	· ·		С	
NAME OF D	ROVIDER OR SUPPLIER	315209	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CC		6/13/2023	
NAME OF FI	NOVIDER OR SUFFLIER			43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR RI	EHABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From pa	age 42	F 6	558			
	EX Order 26 §	4b1					
	A review of the MA revealed tha						
		. There n for each of the above ting they were administered at 0/23.					
	aforementioned mon 6/10/23 at 20:00 indication in the	AR revealed that the edications were administered 6 (8:06 PM). There was no edical record that the physician dminister the medications at					
		vas admitted to the facility with g but not limited to					
	A review of the cur following physician	rent OSR revealed the orders:					
	EX Order 26 §	4b1					
	EX Order 26 §	4b1					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	313209	B. WING	C.	TREET ADDRESS, CITY, STATE, ZIP CODE	06/	13/2023
		ABILITATION AND HEALTHCARE		43	3 N WHITE HORSE PIKE AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page EX Order 26 § 4b		F	658			
	other medications we was no documentation had been administered. A review of the PN die of why the medication administered as present to indicate that the meadministered as present.	ras timed at 0900am. All re timed for 7-10a. There in to indicate the medication at as prescribed on 6/11/23. Id not include documentation in had not been cribed. R revealed no documentation edications had been cribed and timed.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING			l	C 13/2023
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		43	REET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE AMMONTON, NJ 08037	1 00/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 44	F	658			
	A review of the currer following physician or						
	EX Order 26 § 4b	1					
	A review of the MAR revealed the EX Ord						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245200	B. WING			С
		315209	B. WING		06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 658			F	658		
	A review of the MAAF aforementioned medi- administered as preso	cations had not been				
	29. Resident # 27 was diagnoses of EX Ord	s admitted to the facility with der 26 § 4b1				
	A review of the currer following physician or					
	EX Order 26 § 4b	1				
		ere all timed for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315209	B. WING_			C 6/13/2023	
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		0/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	7-10a. A review of the MA aforementioned me as being given at 1 30. Resident # 28 diagnoses includin	AR revealed the edications were documented 1:21am on 06/11/2023. Was admitted to the facility with g but not limited to entered the orders:	F 65	58			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) C	(X3) DATE SURVEY COMPLETED		
		315209	B. WING _			C 06/13/2023		
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037				
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 658	Continued From pa EX Order 26 § A review of the MA	4b1	F 6	58				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN	A. BUILDING		С	
		315209	B. WING _		0	6/13/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
				43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR R	REHABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From p EX Order 26 § 451 A review of the MA EX Order 26 §	AAR revealed the	F 6:	58			
	06/11/2023. 31. Resident #29	were dministered at 11:34am on was admitted to the facility with any but not limited to					
	A review of the cu following physicia	rrent OSR revealed the n orders:					
	EX Order 26 §	4b1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25			c		
		315209	B. WING			06/	13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		43	TREET ADDRESS, CITY, STATE, ZIP CODE 3 N WHITE HORSE PIKE IAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From page	<u>.</u> 49	F	658				
	EX Order 26 § 4b	1						
	A review of the MAR							
	EX Order 26 § 4b							
	A review of the MAAF 06/11/2023 the EX							

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C 6/13/2023	
	ROVIDER OR SUPPLIER	IABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		6/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	EX Order 26 § 4ll administered at 12:2	were documented as 1pm. s admitted to the facility with but not limited to:	F 6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING			06/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 658	A review of the MAR revealed that EX Order 26 § 4b for 0900am. A review of the MAAF 06/11/2023 the EX C	dated 6/1/2023-6/30/2023 is timed for 1000am. was timed was timed d as administered at s admitted to the facility with but not limited to: at OSR revealed the rders:	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		045000	D. WING			С	
NAME OF B	20//255 05 01/25/155	315209	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE		06/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 658	Continued From page	÷ 52	F	658			
	EX Order 26 § 4b	1					
	A review of the MAR or revealed the EX Orc	dated 6/1/2023-6/30/2023 ler 26 § 4b1					
	A review of the MAAR 06/11/2023 the						
	having been administ	were documented as ered at 11:57am.					
	34. Resident #32 was	admitted to the facility with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING _		06	/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 658	diagnoses including b	out not limited to: EX Order 26 § 461	Fé	558			
	A review of the currer following physician of EX Order 26 § 4k	rders;					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315209	B. WING _			C 06/13/2023	
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		70/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	A review of the MAAF 06/11/2023 the EX Communication were all documents administered at 12:08 respectively.	R revealed that on Order 26 § 4b1 sumented as having been 8pm and 12:07pm s admitted to the facility with out not limited to:	F 6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 ti Boiles			С	
		315209	B. WING		06	6/13/2023	
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE	
F 658	A review of the MAR revealed that the X A review of the MAAF 06/11/2023 the X	dated 6/1/2023-6/30/2023 Order 26 § 4b1 R revealed that on Order 26 § 4b1 a admitted to the facility with out not limited to: out OSR revealed the ders:	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) D	(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C 06/13/2023	
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO. 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		00/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	A review of the Marevealed that X		F 65	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315209	B. WING_			C 06/13/2023	
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COI 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		06/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From p	age 57	F 6	558			
	A review of the cur following physician EX Order 26 § There was no documedication had be a review of the MA that the ax order 25 s ab 6/10/2023 at 0800 38. Resident #36 v diagnoses including	umentation to indicate the en administered as prescribed. ARR revealed no documentation was administered on am. was admitted to the facility with g but not limited to: Trent OSR revealed the norders:					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING			06/1	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE		(X5) COMPLETION DATE
F 658	Continued From page by mouth every 12 hore EX Order 26 § 4b A review of the MAR revealed that EX Order 26 § 4b was time There was no docume medication had been on 6/10/23. A review of the MAAR that the medications had prescribed on 06/10/2	dated 6/1/2023-6/30/2023 der 26 § 4b1 d for 1400 (2:00 PM). entation to indicate the administered as prescribed R reflected no documentation had been administered as 2023. admitted to the facility with but not limited to: at OSR revealed the ders:					

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES			OND NO. 0930-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0.45000	D WING		C	
		315209	B. WING		06/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REH	IABILITATION AND HEALTHCARE	4	TREET ADDRESS, CITY, STATE, ZIP CODE 3 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 658	Continued From pag	e 59	F 658			
	A review of the MAR revealed the EX Or 7-10a.	dated 6/1/2023-6/30/2023 der 26 § 4b1 were timed at				
	There was no docum	nentation to indicate the inistered as prescribed on				
		R did not include he medications had been scribed on 06/10/2023.				
	40. Resident #38 wadiagnoses including EX Order 26 § 4					
	A review of the curre following physician of	ent OSR revealed the orders:				
	EX Order 26 § 4	01				

<u> </u>	O I OIK MEDIOMIKE OF	INLEDIO/ (ID CEITVICE)				CIVID IVE). 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							c
		315209	B. WING			06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		43	REET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ILD BE COMPLETION	
F 658	EX Order 26 § 4b		F	658			
	PM). There was no document prescribed on 6/10/23	entation that the entation that the was administered as 3. s admitted to the facility with out not limited to: at OSR revealed the entation.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I	LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		315209	B. WING			C 6/13/2023
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CC 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		15/2025
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 658	Continued From p EX Order 26 §		F 65			

OLIVIE	OT OIL MEDIO/ IILE &	WEDIO/ ND OEI (VIOLO				011110	7. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		315209	B. WING			06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N \	ET ADDRESS, CITY, STATE, ZIP CODE WHITE HORSE PIKE MONTON, NJ 08037		
	OLIMANA DV. OT	ATEMENT OF DEFICIENCIES		117 (101			0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From page	e 62	F	658			
	EX Order 26 § 4b	01					
	A review of the MAR dated 6/1/2023-6/30/2023 revealed the EX Order 26 § 4b1						
	at 1000am.	were timed					
	A review of the MAAF	ere					
	documented as havin 21:33 (9:33 PM).	ng been administered at					
	A further review of the 06/10/2023 the	e MAAR showed that on Order 26 § 4b1					
	documentation that the administered as pres	did not include ne medications had been cribed on 6/10/23.					
		s admitted to the facility with out not limited to: HTN, 01					
	A review of the currer	nt OSR revealed the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
			7 5012511			С	
		315209	B. WING _			/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	Continued From page following physician or EX Order 26 § 4b	ders:	F	S58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		(c
		315209	B. WING			06/	13/2023
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		43	TREET ADDRESS, CITY, STATE, ZIP CODE 3 N WHITE HORSE PIKE IAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page EX Order 26 § 4b		F	658			
	A review of the MAR or revealed the EX Orc	dated 6/1/2023-6/30/2023 der 26 § 4b1					
	There was no docume medications had been prescribed on 06/10/2						
		R revealed there was no ne medication had been cribed and timed on					
	43. Resident #41 was EX Order 26 § 4b	admitted to the facility with					
	A review of the currer following physician or						
	EX Order 26 § 4b	1					

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OIME	3 NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		315209	B. WING _			C 06/13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 658	Continued From page	e 65	F	658		
	EX Order 26 § 4b	01				
	revealed the EX Ord 0800am. There was r	was timed at no documentation to indicate administered as timed and				
	A review of the MAAFEX Order 26 § 4b					
	when asked if he/she time, that B unit had	vith the surveyor on 1, Resident # 41 responded 2 gets their medications on 3 no nurse yesterday (6/10/23) 4 got no meds (medications)				
	44. Resident #42 was diagnoses including b	s admitted to the facility with out not limited to:				

OLIVIER	O I OIT WEDIO/ ITE & I	VIEDICAID SERVICES			OIVID IN	<u> </u>
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUND PLAN OF CORRECTION IDENTIFICATION		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315209	B. WING		l	C 5/ 13/2023
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	:	
HAMMON	TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
						T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	at 0900am. A review of the MARFEX Order 26 § 4b	dated 6/1/2023-6/30/2023 was timed for were timed R revealed that the were administered on 23. There was no	F 65			
	yesterday, 06/10/2023 unit on the 1st floor at 7-3 shift. We got then 45. Resident #43 was diagnoses including b	AM, Resident #42 said that 3 there was no nurse on B and we got no meds on the n on 3-11 shift.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l l	PLE CONSTRUCTION G	(X3) DATE COMI	(X3) DATE SURVEY COMPLETED		
		315209		B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	010200		STREET ADDRESS, CITY, STATE, ZIP CODE		/13/2023	
				43 N WHITE HORSE PIKE			
HAMMON'	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	, , ,		F 6	58			
	EX Order 26 § 4h	o1					

STATEMENT OF DEFICIENCIES (XI) PROVIDER SUPPLIER A BUILDING A BUILDING CONSTRUCTION A BUILDING COMPLETED C	CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IV	<u> </u>	
MANE OF PROVIDER OR SUPPLIER HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE SUMMARY STATEMENT OF DEPCENCIES DEPCENCIES PREFIX REGULATORY OR LSC DENTEYING INFORMATION) REPORT TAG REGULATORY OR LSC DENTEYING INFORMATION) REGULATORY OR LSC DENTEYING INFORMATION REGULATORY OR LSC DENTEYING INFORM				` '			COMPLETED		
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE X VA D REEFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) REGULATORY OR LSC IDENTIFYING INFORMATION) REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REFIX TAG CROSS-REFERENCED THE APPROPRIATE CROSS-REFERENCED THE APPROPRIATE			315209	B. WING _					
CAJID SUMMARY STATEMENT OF DEFICIENCY PREFIX (RACH DEFICIENCY WILK THE RECORD) BY TILL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (RACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC I			ABILITATION AND HEALTHCARE		43 N V	VHITE HORSE PIKE			
A review of the MAR dated 6/1/2023-6/30/2023 revealed the XOrder 26 \$ 4b1 There was no documentation to indicate the medications were administered as timed and prescribed on 6/10/23. A review of the MARR revealed that there was no documentation that the aforementioned medication were administered on 06/10/2023 as timed and prescribed. 46. Resident #44 was admitted to the facility with diagnoses including but not limited to:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION	
EX Order 26 § 4b1	F 658	A review of the MAR revealed the X Ord There was no docummedications were adriprescribed on 6/10/23 A review of the MAAF documentation that the medication were admitted and prescribed 46. Resident #44 was diagnoses including to A review of the currer following physician or	dated 6/1/2023-6/30/2023 er 26 § 4b1 entation to indicate the ministered as timed and 3. R revealed that there was no be aforementioned dinistered on 06/10/2023 as a dinistered on 06/10/2023 as a dinistered to the facility with bout not limited to: and OSR revealed the orders:	F	958				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE	06	6/13/2023	
HAMMON	ION CENTER FOR REHA	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULE TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE	
F 658			F	658			
	EX Order 26 § 4b						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		TE SURVEY MPLETED
		315209	B. WING _			C 06/13/2023
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CC 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		10/13/2023
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 658	There was no door medications were prescribed on 6/10/23 at 18:4 documented as ac (5:17 PM). The re documentation to administered on 0 prescribed. 47. Resident #45 diagnoses including	was timed at 1000am. The sumentation to indicate the administered as timed and 0/2023. AAR showed that the were administered were administered was dministered on 6/10/23 at 17:17 maining medications had no indicate having been 6/10/2023 as timed and Was admitted to the facility with may but not limited to: The sum of the sum	F6	58		

OLIVILIV	OT OIL WEDIO, WE W	· · · · · · · · · · · · · · · · · · ·				OIVID ITC	7. 0000 000 1
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/ IDENTIFICAT		I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(C
		315209	B. WING			06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		43	TREET ADDRESS, CITY, STATE, ZIP CODE B N WHITE HORSE PIKE AMMONTON, NJ 08037		
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	A review of the MAR revealed that the Ex. were timed at There was no docum were prescribed on 6/10/23 A review of the MAAF EX Order 26 § 4b did no the medication was a prescribed on 6/10/20 showed that the EX (documented as havin 19:05 (7:05 PM).	dated 6/1/2023-6/30/2023 Order 26.4(b)(1) O900. The were timed at 7-10a. entation that the administered as timed and 3. R reflected that the tinclude documentation that dministered as timed and 023. The MAAR further order 26 § 4b1 were g been administered at	F	658	DEFICIENCY)		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
			, a Bolebino			С	
		315209	B. WING _		06	/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 658	Continued From page A review of the currer following physician or EX Order 26 § 4b	nt OSR revealed the ders:	F	558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			7 5012511			С	
		315209	B. WING _		06	/13/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
LIAMMON	TON CENTED FOR D	ELIADII ITATION AND HEALTHCADE		43 N WHITE HORSE PIKE			
HAMMON	ION CENTER FOR R	EHABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From p	age 73	F 6	58			
	A review of the MA	AAR revealed there was no					
		show that the medications had					
	been administered prescribed.	on 06/10/2023 as timed and					
		was admitted to the facility with ng but not limited to: [25 Order 20 § 401]					
	diagnoses includin	ig but not illnited to.					
	A review of the cur following pohysica	rrent OSR revealed the n orders:					
	EX Order 26 §	4b1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
NAME OF D	ROVIDER OR SUPPLIER	315209	B. WING		FREET ADDRESS, CITY, STATE, ZIP CODE	06/	13/2023	
		IABILITATION AND HEALTHCARE		43	REET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE AMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658		nentation to indicate the en administered as timed and	F	658				
	documentation to inc EX Order 26 § 4 50. Resident # 48 wadiagnoses including	as admitted to the facility with but not limited to: ont OSR revealed the orders:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING _	-		6/13/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
ПУММОМ	TON CENTED FOR D	EHABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE			
HAWINON	ION CENTER FOR R	ENABILITATION AND REALITICARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From p	age 75	F 6	58			
	A ravious of the M/	NP dated 6/1/2022 6/20/2022					
		AR dated 6/1/2023-6/30/2023					
	showed the EX C	ndel 20 9 40 l					
	A review of the M/	AAR revealed that on					
		was administered at					
	18:05 (6:05 PM).	The MAAR also indicated the					
		Iministered on 6/11/2023 at					
	02:46 (2:46 AM).						
	51. Resident # 2 w	vas admitted to the facility with					
	diagnoses includir	ng but not limited to EX Order 26 § 4b1					
		rrent OSR/MRR/MAR/MAAR ving orders/times to be /11/2023;					
	EX Order 26 §	4b1					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315209	B. WING _			C 06/13/2023
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		00/13/2023
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		(X5) COMPLETION DATE
F 658	52. Resident #53 diagnoses including A review of the currevealed the followadministered; EX Order 26 §	was admitted to the facility with ag but not limited to accordance to the facility with a sum of the f	F6	58		
		was admitted to the facility with ng but not limited to:				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE	(X3) DATE SURVEY COMPLETED	
315209 B. WING 06/13	3/2023	
NAME OF PROVIDER OR SUPPLIER HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037	5/2023	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A review of the current OSR/MRR/MAR/MAAR revealed the following orders/times to be administered; EX Order 26 § 4b1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25.			С		
		315209	B. WING			06/	13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REI	HABILITATION AND HEALTHCARE		43	REET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE AMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658		·	F	658				
	55. Resident #56 w diagnoses including	as admitted to the facility with						
	EX Order 26 § 4 A review of the curre	b1 ent OSR/MRR/MAR/MAAR ng orders/times to be						

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CENTER	<u>S FOR MEDICARE & I</u>	MEDICAID SERVICES				OMB NC). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING			1	C 13/2023
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				43	3 N WHITE HORSE PIKE		
HAMMON	TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		H	AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page EX Order 26 § 4b		F	658			
	diagnoses including b						
	A review of the current revealed the following administered;	nt OSR/MRR/MAR/MAAR g orders/times to be					

OLITICI	O I OIT MEDIO/ IITE A	MEDIO/ ND OLITVIOLO				CIVID IVE	7. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(
		315209	B. WING				13/2023
NAME OF P	ROVIDER OR SUPPLIER		I	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	10.2020
наммон	TON CENTED FOR DEL	HABILITATION AND HEALTHCARE		43	N WHITE HORSE PIKE		
TIAMMON	TON CENTER TOR REI	IABILITATION AND TILALITICANE		HA	AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 050							
F 658	, ,		F	658			
	EX Order 26 § 4	01					
	57. Resident #58 wa	as admitted to the facility with					
	diagnoses including	but not limited to: EX Order 26 § 4b1					
	A review of the curre	ent OSR/MRR/MAR/MAAR					
	revealed the followin	ng orders/times to be					
	administered;						
	EX Order 26 § 4	b1					
	20 g 4						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	(X3) DATE SURVEY COMPLETED	
		245200				С	
NAME OF D	ROVIDER OR SUPPLIER	315209	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CO		06/13/2023	
NAME OF P	ROVIDER OR SUPPLIER			43 N WHITE HORSE PIKE	DE		
HAMMON'	TON CENTER FOR R	EHABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE	(X5) COMPLETION DATE	
				DEFICIENCY	·)		
F 658	Continued From p at 8:00 am was give 58. Resident #59 v diagnoses including A review of the cur	age 81 ven at 9:11am (11 min. late). was admitted to the facility with ng but not limited to: Trent OSR/MRR/MAR/MAAR ving orders/times to be	F 6	DEFICIENCY			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						С	
		315209	B. WING		00	6/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 658	given at 11:59am (59 59. Resident #60 wa diagnoses including	d at 7:00 am-10:00 am was min. late). s admitted to the facility with but not limited to: account of the facility with account of the facility with but not limited to: account of the facility with account of the facility with but not limited to: account of the facility with account of the facility with account of the facility with the fac	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NO		С	
		315209	B. WING		00	6/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR R	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037	DE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	60. Resident #61 diagnoses including	was admitted to the facility with g but not limited to: rent OSR/MRR/MAR/MAAR ving orders/times to be	F	658			
		was admitted to the facility with g but not limited to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245200	B. WING			С	
NAME OF D		315209	B. WING		TREET ADDRESS OUTV STATE 7/D CODE	06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		43	FREET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	EX Order 26 § 4b	nt OSR/MRR/MAR/MAAR	F	658			
	administered;	·					
	EX Order 26 § 4b						
	62. Resident #63 was with diagnoses includ EX Order 26 § 4b1						
	A review of the currer revealed the following administered;	nt OSR/MRR/MAR/MAAR g orders/times to be					
	EX Order 26 § 4b	51					

OLIVIEI	OT OIL WEBTON THE CO	WEDICAID SERVICES			O IVI D TY	<u>0. 0930-0391</u>
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		1 ' '	PLE CONSTRUCTION G		E SURVEY PLETED
		315209	B. WING _		06	C 5/ 13/2023
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 658	Continued From page	e 85	F 6	58		
	63. Resident #64 was diagnoses including b	s admitted to the facility with				
	A review of the currer revealed the following administered; EX Order 26 § 4b					
	diagnoses including b	nt OSR/MRR/MAR/MAAR				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING			06/	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		43	TREET ADDRESS, CITY, STATE, ZIP CODE B N WHITE HORSE PIKE AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page EX Order 26 § 4b		F	658			
	with diagnoses includ EX Order 26 § 4b A review of the currer revealed the following	t OSR/MRR/MAR/MAAR					
	administered; EX Order 26 § 4b						
	diagnoses including b	nt OSR/MRR/MAR/MAAR					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		315209	B. WING		06	6/13/2023	
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE	
F 658	Continued From page EX Order 26 § 4t		F	658			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
					1	С	
		315209	B. WING	<u> </u>	06	/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REHA	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 658	Continued From page	e 88	F	658			
	67. Resident #69 wa diagnoses including b	s admitted to the facility with out not limited to: X Order 20 § 461					
	A review of the currer revealed the following administered;	nt OSR/MRR/MAR/MAAR g orders/times to be					
	EX Order 26 § 4b	1					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
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		315209	B. WING			06/13/2023	
	ROVIDER OR SUPPLIER TON CENTER FOR REH	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 658	for EX Order 26 § 4b1 s am was given at 12:0 68. Resident #71 wa diagnoses including b A review of the currer revealed the following administered; EX Order 26 § 4b 69. Resident #72 was diagnoses including b	scheduled at 7:00 am-10:00 8 pm (1 hr. 8 min. late). s admitted to the facility with out not limited to according to the second	F	658			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	1.0200		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	6/13/2023	
				43 N WHITE HORSE PIKE			
HAMMON	TON CENTER FOR REF	IABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE	
F 658	Continued From pag 70. Resident # 73 wa diagnoses including A review of the curre revealed the followin administered; EX Order 26 § 4 71. Resident #74 wa diagnoses including	as admitted to the facility with but not limited to: ant OSR/MRR/MAR/MAAR g orders/times to be as admitted to the facility with but not limited to: ant OSR/MRR/MAR/MAAR g orders/times to be	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
NAME OF D	ROVIDER OR SUPPLIER	315209	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	06/	13/2023
		ABILITATION AND HEALTHCARE		43	NEET ADDRESS, CITT, STATE, ZIF CODE N WHITE HORSE PIKE AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	A review of the currer revealed the following administered; EX Order 26 § 4b 73. Resident # 76 wa diagnoses including be administered; EX Order 26 § 4b administered; EX Order 26 § 4b administered 8:00 am am (49 min late).	e). s admitted to the facility with out not limited to: at OSR/MRR/MAR/MAAR g orders/times to be s admitted to the facility with out not limited to: at OSR/MRR/MAR/MAAR g orders/times to be scheduled to be a scheduled to be a was administered at 9:49 s admitted to the facility with	F	658			
	diagnoses including b	out not limited to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C 6/13/2023	
	ROVIDER OR SUPPLIER	REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		0/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From p A review of the cu revealed the follow administered; EX Order 26 §	rrent EX Order 26 § 4b1 wing orders/times to be	F 68	58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDI	<u> </u>		(C
		315209	B. WING			1	13/2023
	ROVIDER OR SUPPLIER TON CENTER FOR REF	HABILITATION AND HEALTHCARE	•	43	REET ADDRESS, CITY, STATE, ZIP CODE N WHITE HORSE PIKE AMMONTON, NJ 08037	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From pag EX Order 26 § 4	b1	F	658			
	Nurse (LPN#1) said to administer and was between 1st floor C During an interview 06/11/2023 at 10:30 only given 1st floor A	AM, Licensed Practical she still had 20 medications as going back and forth and D hall.					
	1st floor C/D units sa medications to 15 Remoderations to 15 Remoderations and 1 needed date at 01:15 PM, the all the residents recessions scheduled but they sa	AM, the Unit Manger LPN for aid she still had to administer esidents to include 5 on d a XOrder 20 S 401 . On the same e Unit manager LPN said not eived their 07:30am as should have received them.					
	asked why medication hours 7:00 am- 10:0	with Surveyor #1 on om and 3:00 pm, the surveyor ons were scheduled for the 0 am. LPN #5 stated the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315209	B. WING _			C 6/13/2023	
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037	•	0/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	staffing concerns. were able to be ad and one hour after confirmed that Res within the sp. within the sp. During an interview 06/11/2023 at 04:1 has used a liberal ryears to allow nurs residents. This wer 2022. The DON we for with commeal time. If medic day 8:00 AM and 48:00AM, 11:30 AM confirmed the Ex. Ogiven as ordered. The DON also said (06/10/2023) that the medications on B H was assigned to The DON confirme assignment of 1st for the DON	for at least a year due to LPN #3 stated medications ministered one hour before the specified times. LPN #3 ident #2 did not get his/her becified time. with the Surveyor #2 on 2 PM, the DON said the facility medication time for past 1-1.5 es more time to spend with the nt into effect April or May of ent on to say that if the order is erage, we do it right before ations are ordered for twice a :30 PM, three times a day is and 4:30 PM. The DON order 26.4(b)(1) should be I she found out last night the Residents did not get their dall 1st floor on 7-3 shift. LPN to administer the medications. Id that LPN #3 refused the	F 6	58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		315209	B. WING		C 06/13/2023
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037	1 00/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 658	(1) hour of their pres specified (for examp orders)15. If a dru given at a time other individual administer document as such in copy or electronic) signed dose." Review of facility Pol "MEDICATION ADM included but was not be administered accoschedules1. Medicaccording to the follogan (every eight hour of p.m., q4h (every four hour 12 p.m. / 4p.m. / 8 p. qid (four times daily) p.m., tid (three times daily) p.m., tid (three times daily) meals) 7:30 a.m. /11 pc (after meals) 9 a.i a.m., Every morning Insulin (daily)7:30 am a.m. / 2. Routine medicatio may be changed by Assurance Committed 3. A physician's order supersedes any rout 4. Residents may reschedules. Such times specification in the supersedes and times and times and times and times and times and times are supersedes any rout 4. Residents may reschedules. Such times and times are supersedes.	the administered within one cribed time, unless otherwise le, before and after meal g is withheld, refused, or than the scheduled time, the ing the medication shall designated format (hard pace provided for that drug licy dated 9/19, titled INISTRATION TIMES" limited to; "Medications shall ording to established cations are administered owing routine schedule:. rs) 6 a.m. / 2 p.m. / 10 p.m., 12 a.m. / 6 a.m. / 12 p.m. / 6 a.m. / 12 p.m. / 6 a.m. / 10 a.m. / 2 p.m. / 6 a.m. / 2 p.m. / 6 a.m. / 2 p.m. / 6 a.m. / 10 a.m. / 2 p.m. / 6 a.m. / 10 a.m. / 2 p.m. / 6 a.m. / 4:30 p.m., m. / 1 p.m. / 7 p.m., Daily 9 6 a.m., n. a.m. / 8 am, Insulin (twice 4:30 p.m. n. administration schedules the Quality Assessment and see r for specific times	F 65		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		315209	B. WING _			C 06/13/2023	
	ROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		10/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 658	5. Prior to meals/ times meals arrive prepared to eat. T	nsulin will be dependent on the and when the resident is he window for medication y fluctuate depending on the arrive to the unit.	F 6				

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.2.7.27.11		.52	•	A. BUILDING:			
		060113		B. WING		06/1	3/2023
NAME OF PI	ROVIDER OR SUPPLIER	S	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HAMMON	TON CENTER FOR REHA	ABILITATION AND H		E HORSE PIKE ON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments			S 000			
	C/O # NJ 164849						
S 560	8:39, standards for lic Facilities. The facility Correction, including deficieny and ensure implemented. Failure result in enforcement the provisions of the I Code, Title 8, chapter licensure regulations. 8:39-5.1(a) Mandator (a) The facility shall c	Jersey Administrative concensure of Long Term Carmust submit a Plan of a completion date for each that the plan is to correct deficiencies material action in accordance with New Jersey Administrative 43E, enforcement of y Access to Care	re ch ay n	S 560			7/12/23
	Federal, State, and lo regulations.						
	This REQUIREMENT by: C/O # NJ 164849	is not met as evidenced	I		No residents were noted to have be affected by this deficient practice.	een	
	facility documentation facility failed to mainta direct care staff to res the state of New Jers 7-day shifts for weeks deficient in CNAs to to	otal staff on 1 of 7 evening total staff for residents of	by of g		 All residents have the potential to be affected by this deficient practice. The facility policy on staffing was reviewed by the Administrator on July 2023 and determined to follow federal state guidelines. The facilities schedules to the New Je minimum staffing requirements and state or reach these goals daily. The following new systematic changes have been 	5, and rsey rives	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

07/10/23

(X6) DATE

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBE	:K:	A. BUILDING:		COMPLETED		
						l c		
		060113		B. WING		06/13	3/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
	TON OFNITED FOR DELL	A DULITATION AND LL	43 N WHITE	E HORSE PIKI	E			
HAMMON	TON CENTER FOR REHA	ABILITATION AND H	HAMMONT	ON, NJ 08037	7			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FUL		PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATIO	JN)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE	
					,			
S 560	Continued From page	e 1		S 560				
					implemented: Starting June 26, 2023,	а		
	Reference: New Jers	ey Department of Health	1		corporate task force was developed to			
		ed 01/28/2021, "Complia			attract and retain staff. In addition, the			
		ersey Statutes Annotated			task force has weekly sessions to rev	 		
	`	um staffing requirements	,		current staffing levels and discuss nee			
	nursing homes," indic	• .			on future projections. Additional staff			
	Governor signed into				been hired, staffing agencies and			
	codified at N.J.S.A. 3	0:13-18 (the Act), which			recruiters were contracted to aid in the	е		
	established minimum	staffing requirements in	1		efforts to provide additional staff. The			
	nursing homes. The f	following ratio(s) were			facility has initiated sign on bonuses to	0		
	effective on 02/01/20	21:			secure additional staff and bonuses for			
					staff referrals. Additional ads were cre			
		Aide (CNA) to every eigh	nt		on recruiting websites and recruiting f	-		
	residents for the day				and signs placed in the community ar	nd		
	One direct care staff				facility to attract nursing staff, new			
			10			9		
						d = =		
	_	a CNA and Shall penorni			1			
						viiig		
		member to every 14			· · · · · · · · · · · · · · · · · · ·			
		•	h		· ·	-		
						a.c		
		_						
	•				incontinent care to dependent resider	its.		
	As per the "Nursing S	Staffing Report" complete	ed		Nursing supervisors were educated to			
	by the facility for the	weeks of 06/04/2023, the	е		notify administration and the Director	of		
	staffing to residents'	ratios that did not meet t	he		Nursing if there was not enough staff	to		
	· ·	t of 1 CNA to 8 residents	s for		render activities of daily living.			
	the day shift as docur	mented below:						
					4.			
		•						
		_			1	ing		
		s on 3 of 7 overnight shi	IIS			ito		
	as ioliows:				, ,	 		
	-U6/U4/33 Pod 14	1 CNAs for 176 residents	s on			1		
			J 011			,		
	residents for the ever fewer than half of all sections continued in the ever fewer than half of all sections and each direct signed in to work as a nurse aide duties: and One direct care staff residents for the night direct care staff mem CNA and perform	ning shift, provided that restaff members shall be ct staff member shall be at CNA and shall perform member to every 14 at shift, provided that each ber shall sign in to work IA duties. Staffing Report" complete weeks of 06/04/2023, the ratios that did not meet that of 1 CNA to 8 residents mented below: ient in CNA staffing for any shifts, deficient in CNA vening shifts, and deficients on 3 of 7 overnight shifts.	h as a ed e he s for As to ent in		contracts with traveling agencies were initiated. The staffing coordinator was educated ensuring that adequate staffing levels reached to provide activities of daily list of dependent residents. The staff educator in-serviced nursing staff on ensuring that residents needs met including activities of daily living rendered to dependent residents and incontinent care to dependent resider Nursing supervisors were educated to notify administration and the Director Nursing if there was not enough staff	d on are ving g are ats. of to ing its		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		060113		B. WING		C 06/13	3/2023
NAME OF P	ROVIDER OR SUPPLIER	000113	STREET ADD	RESS, CITY, STA	TE ZIP CODE	1 00/13	5/2023
		ADU ITATION AND U		E HORSE PIKE			
HAMMON	TON CENTER FOR REHA	ABILITATION AND H	HAMMONT	ON, NJ 08037	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S 560	Continued From page	2		S 560			
S 560	-06/04/23 had 11 on the overnight shift, -06/05/23 had 15 the day shift, required -06/06/23 had 20 the day shift, required -06/08/23 had 17 the day shift, required -06/08/23 had 11 on the overnight shift, -06/09/23 had 17 the day shift, required -06/09/23 had 17 the day shift, required -06/09/23 had 10 the evening shift, required -06/09/23 had 12 on the overnight shift, -06/10/23 had 11 the day shift, required During an interview w 06/11/2023 at 09:13 A Assistant said I was a weekend off.	total staff for 176 residerequired 13 total staff. CNAs for 176 residents 22 CNAs. total staff for 176 residents 22 CNAs. total staff for 176 residents 23 CNAs. CNAs for 183 residents 23 CNAs. CNAs to 24 total staff ouired 12 CNAs. total staff for 183 residents 23 CNAs. total staff for 183 residents 23 CNAs. ith the surveyor on M, The Certified Nursir alled in today, this is my ith the surveyor on M, Licensed Practical N sidents on A hall on the	s on s on s on s on ents s on ents s on ents y	S 560	until compliance is met. The results of these audits will be presented at monthly QAPI starting in 2023. The Administrator is responsible for the execution and monitoring of this plan correction.	he	

POST-CERTIFICATION REVISIT REPORT

			P031	-CERTII	ICATION	A VEAISH VE	-FUNI			
PROVIDER IDENTIFIC				TRUCTION					DATE OF REVISIT	
315209	7111011111	OWDER	Y ₁ B. Wing					Y2	8/1/202	3 _{Y3}
NAME OF	FACILITY	,	I			STREET ADDRESS, CIT	Y. STATE. ZIP			
			FOR REHABILITATION A	ND HEALTHC	ARE	43 N WHITE HORSE PIK		0022		
						HAMMONTON, NJ 08037	7			
program, corrected	to show and the number	those of date su and the	by a qualified State surveyon deficiencies previously repo uch corrective action was a de identification prefix code p	rted on the CN ccomplished.	MS-2567, Staten Each deficiency	nent of Deficiencies and should be fully identifie	Plan of Corr d using eithe	ection, that have r the regulation o	LSC	
ITEN	1		DATE	ITEM		DATE	ITEM			DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix	F0658 483.21(b	\(3\(i)	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #)(O)(I)	Completed	Reg. #		Completed	Reg. #			Completed
LSC			07/26/2023	LSC _			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
ID I ICIIX				-			ID I ICIIX			Ooricollori
Reg.#			Completed	Reg. #		Completed	Reg.#			Completed
LSC				LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
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LSC			<u> </u>	LSC			LSC			·
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ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
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LSC	-		·	LSC		·	LSC			·
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ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. # Completed		Reg. #		Completed Reg. #		Com		Completed		
LSC		LSC		·	LSC			·		
				_						
REVIEWED STATE AG			REVIEWED BY (INITIALS)	DATE	SIGNATUR	RE OF SURVEYOR			DATE	
REVIEWED) BY		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/13/2023					RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN				S 🗆 NO	

New Jersey Department of Health

AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	R-C
		060113	B. WING		08/	01/2023
NAME OF PROV	IDER OR SUPPLIER	STRE	EET ADDRESS, CITY, ST	ATE, ZIP CODE		
HAMMONTO	N CENTER FOR REHA	BILITATION AND H	WHITE HORSE PIK MONTON, NJ 0803			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{S 000} In	itial Comments		{S 000}			
The state of the s	ne facility was not in andards in the New of 39, standards for lice acilities. The facility re orrection, including a eficieny and ensure to a plemented. Failure of sult in enforcement of the New York	compliance with the Jersey Administrative code, ensure of Long Term Care must submit a Plan of a completion date for each that the plan is to correct deficiencies may action in accordance with lew Jersey Administrative 43E, enforcement of				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATE FORM: REVISIT REPORT

	OTATE FORM. RE	NOT REPORT		
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
060113 _{Y1}	B. Wing	Y2	8/1/2023	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMONTON CENTER FOR RE	43 N WHITE HORSE PIKE			
		HAMMONTON, NJ 08037		

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

roport form).					
ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/12/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 6/13/2023	COMPLETED ON		R ANY UNCORRECTED DEFICIENCIE CTED DEFICIENCIES (CMS-2567) SEI		YES NO
			Page 1 of 1	EVENT ID:	3K4K12

(11/06)