STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ148720, NJ148438, NJ148225, NJ147973, NJ147766, NJ146520, and NJ145242. Census: 181 Sample Size: 40 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		11/5/21

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

Electronically Signed | 11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ146520 Based on observations, record review, interviews, and facility policy review, it was determined that the facility failed to maintain a dignified environment for two (Resident #1 and Resident #6) of five residents reviewed for dignity. Specifically, the facility failed to treat Resident #1 in a dignified manner by maintaining a safe, comfortable environment for the resident and providing equipment for Resident #1 to use that was not damaged. The facility also failed to provide Resident #6 with assistance with bed pan use. Findings included: 1. A review of Resident #1's Face Sheet revealed Resident #1 was admitted to the facility with diagnoses including [redacted]. A review of the quarterly Minimum Data Set (MDS)	F 550	1.Resident #1's bed was moved to ensure the head of the bed did not block the air conditioner and placed with the head against the wall. Clean sheets, pillow cases and a blanket were placed on the bed. Resident #1's room had the following repairs made: the dirty ceiling tiles were replaced, the broken sheet rock was replaced, the door in the bathroom was repaired, the faucet handles were replaced, the shower head was placed in the proper position, a toilet paper dispenser was installed and toilet paper was provided. A dresser has been provided to store personal items. A call bell cord was provided. Resident #1's wheelchair was repaired. Resident #6 was checked and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 assessment, dated [redacted], indicated the facility was unable to do a Brief Interview of Mental Status (BIMS) assessment and the resident had [redacted]. The resident had [redacted] and other behavioral symptoms directed towards others four to six days during the assessment period. The resident rejected care four to six days and [redacted] one to three days during the assessment period. A review of the comprehensive care plan, dated [redacted], indicated Resident #1 exhibited behavior symptoms such as being [redacted], [redacted] with care, [redacted] to care, sits self on the floor, pulling, breaking, and damaging furniture, electronics and walls related to [redacted] and [redacted] with a goal not to harm self or others through the review date. Interventions included the following: administer [redacted] medications as ordered, determine the cause of the behavior, and assist as needed, distract with activities of interest, document all behaviors, and attempt to identify a pattern to target interventions, have two staff to provide care as needed during [redacted] episodes and when the resident was resistive to care, and initiate [redacted] and [redacted] evaluations as needed. Observations on 10/03/2021 at 6:45 AM, at 11:32 AM, and at 3:14 PM revealed Resident #1 was sleeping in a [redacted] in an area around the nurse's station. An observation of the resident's room on 10/03/2021 at 11:33 AM revealed the resident's call bell light in the hallway was on. The resident's	F 550	incontinence care was given. 2. All residents on [redacted] floor have the potential to be affected by this deficient practice. Environment rounds were completed by the administrator, maintenance director, and DON. The rounds specifically focused on the resident's environment in the key areas of: clean linen, condition of ceiling tiles, sheet rock, sink faucets, toilet paper holders and availability, shower head condition, furniture availability, and position of the resident's bed. Identified items were corrected. Administrative rounds were made and identified call bells were answered. Call bell audits were conducted by the administrator on the 11-7 shift and call bells were answered and incontinence care given. 3. The staff educator will conduct education with all staff on residents' rights specifically focusing on providing a dignified environment. The staff educator will conduct education with nursing staff on residents' rights specifically focusing on answering call bells and providing incontinence care in a timely manner. 4.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 bed was up against the wall with the head of the bed against the air conditioner. The bed had a dirty sheet on it, with smudges of dirt and blood, and a pillow with no pillowcase. A ceiling tile in the corner of the room was missing. There were three large holes in the wall behind the door to the room. The door to the bathroom was hanging crooked and would not close completely. The bathroom had no faucet handles on the sink to turn the water on or off, and the shower hose in the bathtub was pulled down and lying in the bottom of the tub. The bathroom did not have a toilet paper dispenser and had no toilet paper. There were no personal items in the resident's room or bathroom. There was no other furniture in the room. There was no call bell cord in the room. An observation on 10/04/2021 at 10:08 AM revealed the resident was sleeping in their bed covered with a sheet. The bed was placed in the center of the room with no other furniture in the room. The air conditioner on the wall with the window was pulled away from the wall, with a diagonal crack in the sheet rock going from the air conditioner to the window. Pieces of sheet rock and white dust were on the floor under the window. The condition of the rest of the room and bathroom remained the same as observations made on 10/03/2021. An observation on 10/05/2021 at 10:30 AM revealed Resident #1 was curled up in the fetal position on the bed, wearing only an adult brief and covered with a sheet. The bed was in the middle of the room. There was a large piece of sheet rock missing on the wall above the air conditioner. Pieces of sheet rock and white dust were on the floor under the window. The condition	F 550	The administrator/ designee will conduct environmental rounds specifically focusing on providing a dignified environment. Immediate corrections will be initiated when identified. The audits will be completed weekly X 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The DON/ designee will conduct 11-7 audits on call bell response time and incontinence care. The audits will be completed weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI The administrator is responsible for execution and monitoring of this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4	F 550		

of the rest of the room and bathroom remained the same as observations made on 10/03/2021.

An observation on 10/06/2021 at 8:00 AM revealed Resident #1 was lying in their bed that was pushed against the wall and was covered with a sheet. At 11:20 AM, Resident #1 was dressed and sitting in their room in a wheelchair that did not have an armrest cover on the left side of the chair. The resident's head was bowed forward, and their eyes were closed. The condition of the rest of the room and bathroom remained the same as observations made on 10/03/2021.

The Social Service Director (SSD) was interviewed on 10/06/2021 at 2:58 PM. The SSD stated she had not been in Resident #1's room recently. After observations were made of the resident's room with the surveyor, the SSD stated she was concerned about the condition of the resident's room and described the room as bleak and in disarray and disrepair. She stated she wanted to see the residents have comfortable, dignified living arrangements and said Resident #1's room did not portray this. She stated she was going to notify the maintenance department to have the arm of the resident's wheelchair fixed and inquire about when repairs to the resident's room were to be done.

The Nursing Home Administrator (NHA) was interviewed on 10/06/2021 at 4:54 PM. He stated he went into Resident #1's room almost every day and was aware of the condition the room was in. He stated the resident destroyed something in the room every day, and they must go in and fix it. He stated Resident #1 was a [redacted] and could get very [redacted] and [redacted] in the walls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

The NHA stated he thought the facility was doing the best job they could under the circumstances. He stated he did not know Resident #1's wheelchair was broken, and he would make sure the wheelchair was fixed or the resident received a new wheelchair.

A review of the facility's policy, titled, "Quality of Life/Dignity," last revised 09/2019, indicated "Each resident shall be cared for in a manner that promotes and enhanced quality of life, dignity, respect, and individuality. Residents shall always be treated with dignity and respect which means the residents will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Staff shall treat [redacted] residents with dignity and sensitivity; for example, addressing the underlying motives or root causes for behavior."

2. A review of Resident #6's Face Sheet revealed the facility admitted the resident with diagnoses of [redacted].

A review of Resident #6's quarterly Minimum Data Set (MDS), dated [redacted], revealed a Brief Interview of Mental Status score of [redacted], indicating the resident was [redacted]. A further review revealed Resident #6 required limited assistance with transfers, dressing, and toilet use. Resident #6 was always [redacted] and [redacted]

A review of Resident #6's care plan, dated 09/27/2017, revealed the resident was at risk for falls due to a [redacted]). Interventions included the following: can make their needs known, staff will assist as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6	F 550		

needed, be sure call light is within reach and encourage resident to use it for assistance as needed.

A further review of Resident #6's care plan dated [redacted] revealed a focus area of requiring assistance with activities of daily living (ADL) related to [redacted]. Interventions included to encourage use of call light for assistance.

A further review of Resident #6's care plan dated [redacted] revealed a focus for side rails for increased independence and mobility for impaired bed mobility. Interventions included the following: to offer resident assistance with position changing and bed mobility often during the shift, and orient resident to call light and safety measures.

During an interview on 10/02/2021 at 12:43 AM, Resident #6 stated staff did not answer call lights timely and the resident did not use the call light on the 11:00 PM to 7:00 AM shift because staff would not answer it.

During an interview on 10/03/2021 at 6:30 AM, Certified Nurse Aide (CNA) #3 revealed she and one other aide were responsible for all the residents on the floor. She further stated she wished she had at least one more aide, if not more, to complete all the care that needed to be done. When asked, the aide would not specifically say what care was not being delivered.

During an interview on 10/03/2021 at 8:30 AM, Resident #6 stated the resident had learned to take care of themselves because staff did not answer the call light on the 11:00 PM to 7:00 AM shift. The resident could use the bed pan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7	F 550		

unassisted and only wanted staff to help clean the resident and the bed pan. The resident stated it was a challenge as a [redacted] to transfer to the wheelchair and go to the bathroom unassisted. Resident #6 further stated it was really aggravating that staff would not answer call lights. The resident could do some things on their own, but the resident was concerned about the residents who are completely dependent on staff.

During an interview on 10/05/2021 at 9:35 AM, the Director of Nursing (DON) stated no residents had brought any concerns to her about not answering call lights or not getting any help during a certain shift. She expected call lights to be answered as soon as a staff member sees it, and residents should be changed timely.

During an interview on 10/05/2021 at 2:31 PM, the Administrator stated each resident should be checked every two hours for incontinent care and some residents did not need to be assisted during a shift if they were not soiled. He further stated it was his responsibility if staff were not able to meet the needs of the residents.

During an interview on 10/06/2021 at 10:07 AM, Resident #6 stated the facility was short staffed on the 11:00 PM to 7:00 AM shift, and call lights were not answered during that time. Resident #6 was worried that if the resident was tired when using the bed pan at 2:00 AM and missed a step and fell, the resident would be lying on the floor until the 7:00 AM shift. Resident #6 further stated it made the resident feel [redacted] knowing staff would not provide help when the resident needed it.

A review of the facility's policy titled, "Quality of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8 Life and Dignity Policy," revised 09/2019, revealed, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity by assisting with always maintaining and enhancing their self-worth and respect."	F 550		
F 580 SS=D	New Jersey Administrative Code: § 8:39-4.1(a) 12 Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ147973 Based on record review, interviews, and facility policy review, it was determined that the facility failed to make proper notification for two (Resident #3 and Resident #4) of 22 residents reviewed when a change in their plan of care occurred. Specifically, the facility failed to obtain consents for the use of a [redacted] medication and notify Resident #3's responsible party of medication changes. The facility also failed to notify the physician when Resident #4 routinely refused their ordered [redacted]. Findings included:	F 580	1. Resident #4 is no longer a resident. The physician was notified about Resident #3's refusal of [redacted] There was no identified lasting negative effect for either resident. 2. All residents have the potential to be affected by this deficient practice. An orders report for psychotropic medications and all residents with orders for [redacted] medications had consents completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10 1. A review of the record revealed the facility admitted Resident #3 with diagnoses which included [redacted]. A review of the admission Minimum Data Set (MDS) assessment, dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], which indicated the resident had [redacted]. The resident had behaviors that consisted of [redacted], with an [redacted] that was continuously present. A further review of the MDS revealed the resident required extensive assistance of two people for activities of daily living (ADL), and the resident took an [redacted] medication seven of seven days during the assessment period. A review of the comprehensive care plan, dated [redacted], revealed the resident used [redacted] medications related to [redacted] Interventions included to give medications as ordered by the physician, monitor and document side effects and effectiveness, and do gradual dose reduction (GDR) as indicated. A review of the admission physician orders, dated [redacted], revealed orders for [redacted] l - an [redacted] medication) at [redacted] milligrams (mg). The order indicated to give one tablet by mouth in the morning for [redacted]. There was also an order for [redacted] at [redacted] mg. The order indicated to give one tablet by mouth at bedtime for [redacted] A review of the computerized physician orders (CPO) for [redacted] revealed the following:	F 580	The refused medication report was reviewed for the past 30 days and residents with medication refusals had the physician notified and appropriate alternate therapies were initiated if required. 3. Notification of Changes was reviewed and considered to be in compliance with state and federal guidelines. The staff educator will conduct education with licensed nursing staff on notification of changes specifically focusing on [redacted] medication consents and notification of the physician for medication refusals. 4. The DON/ designee will audit medication administration for initiation or change in [redacted] medications and obtaining corresponding consents X 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The DON/ designee will audit medication refusals for physician notification weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The DON is responsible for execution and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11 - [redacted] mg. Give one tablet by mouth in the morning for [redacted]. This was ordered [redacted]. - [redacted] mg. Give one tablet by mouth at bedtime for [redacted] This was ordered [redacted]. A review of Resident #3's record on [redacted] revealed there were no consents for the use of a [redacted] medication to review the risks and benefits of taking [redacted] A review of a physician progress note, dated [redacted], revealed the resident was yelling out for help and when asked why the resident was yelling, the resident stated they were not yelling. The note indicated the nursing staff reported the resident yelled out all night for their spouse, and the resident had had this behavior since admission. The plan was to increase the resident's [redacted] mg in the morning and [redacted] mg at bedtime for [redacted] and [redacted]. There was no documentation in the physician progress note that the resident's responsible party was notified of the increase in the medication. Resident #3's family member was interviewed on 10/03/2021 at 3:37 PM. They said they were not asked to sign a consent for the [redacted] when the resident was admitted, and no one had reviewed the risks and benefits of the medication with them. The family member stated they were never notified when the [redacted] was increased. During an interview on [redacted] at 1:37 PM, Physician Assistant (PA) #1 stated she was the one who increased Resident #3's [redacted] based	F 580	monitoring of this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12	F 580		

on reports she received from the nursing staff. She stated she would have expected those behaviors to be documented somewhere. She stated when she received a phone call about the resident being [redacted] she gave a verbal order over the phone to a nurse to decrease the dose of [redacted] back down to [redacted] mg in the morning and [redacted] mg at bedtime. She stated she did not remember what nurse she gave the order to, but she stated she did not follow up on it to ensure the order was put into the system. PA #1 stated she did not talk to the resident's family about increasing the medication.

During an interview on 10/06/2021 at 5:25 PM, the Director of Nursing (DON) stated that consents were needed for the use of any trial medications and [redacted] medications. The DON stated if the resident was admitted from the hospital with orders for a [redacted] medication, then consent was not required. Consents also did not need to be updated when the dose of a medication changed. She stated the nurse assigned to the resident would be responsible to obtain a consent when it was needed. She stated the resident's responsible party should be notified anytime there was a change in the resident's medications.

A policy related to consents was requested from the facility, but the facility did not provide a policy.

2. A review of Resident #4's Face Sheet revealed the facility admitted the resident with diagnoses of [redacted].

A review of Resident #4's admission Minimum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13	F 580		

Data Set (MDS), dated [redacted] revealed a Brief Mental Interview Status (BIMS) score of [redacted] which indicated the resident was [redacted]. A further review revealed Resident #4 received a [redacted] seven days a week.

A review of Resident #4's care plan, dated [redacted], revealed a focus of an actual or potential risk for fluid deficit related to [redacted] use for [redacted]. Interventions included to administer medications as ordered, monitor and document signs and symptoms of [redacted], and notify the physician as needed.

A review of Resident #4's medication administration record (MAR), dated [redacted] revealed an order for a [redacted] tablet of [redacted] milligrams (mg). The order indicated to give one tablet by mouth two times a day (BID) for [redacted] A further review revealed Resident #4 refused the [redacted] of the [redacted] opportunities in [redacted].

A review of Resident #4's progress notes revealed the following:
- On [redacted] at 9:43 AM: Resident with [redacted] (when [redacted] builds up in the [redacted]) of [redacted]
- On [redacted] at 12:52 PM: Resident refused medication and the physician was made aware.
- On [redacted] at 2:05 PM: An interdisciplinary team meeting (IDT) was held. It was noted that the resident refused medications at times.

There were no other documented physician notifications in Resident #4's progress notes.

During an interview on 10/03/2021 at 9:06 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14	F 580		

the Assistant Director of Nursing (ADON) revealed Resident #4 refused [redacted] because the resident did not want [redacted] as often. She further stated if a resident refused a medication like [redacted], they notified the physician of each refusal so the physician could advise nursing on what to do. Resident refusal should be documented in the progress notes, and if it was not there then the physician was not notified.

During an interview on 10/05/2021 at 3:52 PM, Registered Nurse (RN) #2 revealed the physician should be notified of medication refusal so they could advise nursing or discharge the medication. She further stated Resident #4 refused the furosemide when she tried to administer it, and she did not notify the physician. RN #2 then stated she did not notify the physician every time a resident refused an ordered medication. She notified the physician only if the resident refused it a few days in a row.

During an interview on 10/05/2021 at 9:35 AM, the Director of Nursing (DON) revealed she expected nursing to notify the physician every time a resident refused a medication, and the refusal should be care planned. It was important to notify the physician so the physician was aware if a resident was not taking a medication and could advise nursing on what to do. She further stated she could not be the only person answering questions on why people were not doing what they were supposed to be doing.

During an interview on 10/05/2021 at 10:13 AM, the Administrator revealed he expected nursing to notify the physician of any behaviors such as medication refusal. If a resident was routinely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 15 refusing a medication, it was important to notify the physician every time it was refused so that the physician was aware. A review of the facility's policy titled, "Behavior Management Policy," revised 05/2020, revealed, " ...to manage behavioral symptoms include notifying the physician of any change in resident status. Also, communicate with the attending physician and receive orders for diagnostic studies, interventions, and medication adjustment." NJ Administrative Code: § 8:39-13.1(d)	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ147973 Based on interviews, record review, and facility policy review, it was determined that the facility failed to develop a comprehensive care plan with interventions for medication refusal for one (Resident #4) of 22 residents reviewed for care planning. This deficient practice had the potential to affect all residents. Findings included: 1. A review of Resident #4's Face Sheet revealed the facility admitted the resident with diagnoses of [redacted].	F 656	1. Resident #4 care plans were updated to ensure a behavior care plan was initiated with specific focus on identified behavior of medication refusal. 2. All residents on [redacted] floor have the potential to be affected by this deficient practice. The refused medication report will be reviewed for the past 30 days and residents with the behavior of medication refusal had their care plans updated with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17 A review of Resident #4's admission Minimum Data Set (MDS), dated [redacted], revealed a Brief Mental Interview Status (BIMS) score of [redacted] which indicated the resident was [redacted] A further review revealed Resident #4 received a [redacted] days a week. Resident #4 had no exhibited behaviors. A review of Resident #4's care plan, dated [redacted], revealed a focus of an actual or potential risk for fluid deficit related to [redacted] use for edema. Interventions included to administer medications as ordered, monitor and document signs and symptoms of [redacted], and notify the physician as needed. A further review revealed no care plan with interventions for when Resident #4 refused their medications. A review of Resident #4's medication administration record (MAR), dated [redacted] revealed an order for a [redacted] tablet of [redacted] milligrams (mg). The order indicated to give one tablet by mouth two times a day (BID) for [redacted]. A further review revealed Resident #4 refused the [redacted] of the [redacted] opportunities in [redacted] During an interview on 10/06/2021 at 10:28 AM, MDS #1 stated she only care planned care areas that triggered on a resident's MDS. The unit manager was responsible for developing a care plan for a behavior that occurred while the resident was at the facility, such as medication refusal. During an interview on 10/06/2021 at 10:35 AM, Unit Manager (UM) #4 stated if a resident refused a medication for two or more days, she would initiate a care plan for medication refusal. UM #4	F 656	the behavior of medication refusal noted and corresponding patient centered interventions will be initiated. 3. The staff educator will conduct education with Licensed nursing staff on comprehensive care plan development with emphasis on behavior care plans specifically focusing on medication refusal. 4. The ADON/ designee will audit medication administration daily for medication refusal and corresponding behavior care plans for medication refusal weekly X 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The DON is responsible for execution and monitoring of this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 further stated she did not know why Resident #4 was not care planned for refusing their routine furosemide medication. During an interview on 10/05/2021 at 9:35 AM, the Director of Nursing (DON) revealed she expected behaviors such as medication refusal to be in a resident's care plan. The DON then stated it was important to care plan behaviors because it showed what interventions were in place to address a certain behavior. She further stated she could not be the only person answering questions on why people were not doing what they were supposed to be doing. During an interview on 10/05/2021 at 10:13 AM, the Administrator revealed he expected staff to use updated care plans with interventions in place to show how they were addressing resident needs. He further stated if a resident had a specific behavior such as medication refusal, that should be in the care plan. A review of the facility's policy titled, "Behavior Management Policy," revised 05/2020, revealed, "Behavioral symptoms and approaches shall be placed in the resident specific plan of care and communicated to the care staff and other departments, as appropriate. It shall be placed in the 24-hour report and communicated in the shift to shift	F 656		
F 658 SS=G	New Jersey Administrative Code: § 8:39-11.2(e)2 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 19 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ148720 Based on record review and interviews, the facility failed to ensure residents were provided care and services according to standards of practice on one [redacted] Hall) of eight hallways in the facility. Specifically, the facility failed to ensure medications were passed to all residents on the [redacted] floor [redacted] Hall on the evening of 10/03/2021. This affected 22 out of 27 residents on the [redacted] Hall. This failure resulted in Residents #14 and #17 having unnecessary [redacted] and [redacted] on [redacted] and [redacted]. Findings included: 1. A review of the Face Sheet indicated the facility admitted Resident #14 with diagnoses of [redacted] A review of the annual Minimum Data Set (MDS) assessment, dated [redacted], indicated the resident's Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], indicating the resident was [redacted] The MDS indicated Resident #14 received insulin, antipsychotic medications, an [redacted] medication, an [redacted] medication, and [redacted] seven out of seven day during the assessment period and opioids four out of seven days during the assessment period.	F 658	1. Resident #14 was administered [redacted] medication on the following shift with resolution of [redacted] The NP evaluated resident #14 with no noted lasting negative effect from the omission of scheduled medications. Resident #17 was administered [redacted] medication on the following shift with resolution of [redacted] documented. The NP evaluated resident #17 with no noted lasting negative effects. 2. All residents on [redacted] wing have the potential to be affected by this deficient practice. The missed medication report was reviewed and residents with medication omissions were evaluated with no negative outcome was noted for any identified resident. Medication errors were completed for each resident. The supervisor/ staffing coordinator were counseled on notifying the DON if there is no nurse to administered scheduled medication. 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 20 A review of the comprehensive care plan, dated [redacted], indicated Resident #14 had an alteration in comfort related to [redacted]. Interventions included the following: administer medications as ordered, evaluate the effectiveness of [redacted] interventions as needed, monitor for signs and symptoms of [redacted] with each interaction and if the resident appeared to be in [redacted] utilized appropriate non-pharmacological and pharmacological interventions. Resident #14 was interviewed on 10/04/2021 at 9:00 AM. Resident #14 stated the resident did not receive their medications that were due between 9:00 PM and 10:00 PM on the night of [redacted], which caused the resident increased [redacted] and the [redacted]. The resident stated they did not get their [redacted] checked or receive their [redacted]. The resident stated a nurse finally came in between 1:00 AM to 2:00 AM on [redacted] and gave them some as needed (PRN) [redacted] medication which helped a little. According to the physician orders for [redacted], Resident #14 had orders for the following medications to be administered between 8:00 PM and 10:00 PM: -[redacted] milligrams (mg). Give one tablet by mouth with one [redacted] mg tablet ([redacted]mg) for [redacted], -[redacted] mg. Give one tablet by mouth for [redacted] -[redacted] mg. Give one tablet by mouth for [redacted] -[redacted] mg. Give 2 tablets by mouth for [redacted] [redacted] mg. Give one tablet by mouth for [redacted]	F 658	Licensed nurses will be educated on professional standards with emphasis on medication administration. Course content will include ensuring scheduled and PRN medications to all residents are administered and notifying the DON if a nurse is unavailable to administer scheduled and PRN medications. The staffing coordinator was educated on the importance of ensuring licensed nurses are available to distribute medications to all residents. 4. The DON/ designee will audit medication administration daily for missed administration x 4 weeks, then weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The DON/ designee will conduct pain management audits of residents with PRN pain medication to ensure that PRN pain medication is provided when requested. Audits will be completed weekly x 4 weeks and then monthly until compliance is met. The administrator will audit licensed nursing staff to ensure that scheduled licensed nurses are available to administer all necessary schedule medications and PRN medications. The results of these audits will be submitted at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 21 - [redacted]. [redacted] [redacted]) for [redacted], - [redacted] for [redacted] - [redacted]. Instill [redacted] in [redacted] for [redacted], - [redacted]00 mg. Give one tablet by mouth for [redacted], - [redacted] mg. Give one tablet by mouth for [redacted]. A further review of the record revealed orders for [redacted] mg. The order indicated to give two tablets by mouth every six hours as needed for [redacted]. There was also an order for [redacted] mg. The order indicated to give one tablet by mouth every eight hours as needed for [redacted] than [redacted] A review of the Medication Administration Record (MAR) for [redacted] indicated Resident #14 did not receive their [redacted] mg scheduled to be given at 8:00 PM, the [redacted] mg, [redacted] mg, [redacted] mg, [redacted], [redacted] and [redacted] scheduled to be given at 9:00 PM or [redacted] mg, [redacted] mg, [redacted] mg scheduled to be given at 10:00 PM on 10/03/2021. A further review of the record revealed the resident received two [redacted] tablets at 1:15 AM on 10/04/2021 for [redacted] rated [redacted] and an as-needed [redacted] on 10/04/2021 at 10:27 AM. No [redacted] reading was documented. The Staffing Coordinator (SC) was interviewed on 10/04/2021 at 11:27 AM. She stated she had a nurse call off for the evening shift on [redacted]. She stated she thought she had it covered but the nurse never showed up. She stated she was not	F 658	The Administrator is responsible for execution and monitoring of this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 22	F 658		

aware some of the residents did not receive their medications the night before. She stated they used to offer bonuses but not recently. She stated they had contracts with two staffing agencies, but they did not have any nurses available to send to them. She stated she was not aware if the facility was attempting to get contracts with any other staffing agencies.

The Director of Nursing (DON) was interviewed on 10/05/2021 at 1:58 PM. The DON stated they had a supervisor at night who was responsible to ensure medication was administered and proper care was given. She stated they scheduled four nurses and a supervisor each night, but sometimes the supervisor would have to take a medication cart if they were short staffed. She stated she was not aware of any evenings in the past week where they had no floor nurses. The DON then stated she was at the facility until 8:00 PM on 10/03/2021, and the floor nurse stayed until 7:00 PM when relief came in. The DON then stated they sometimes had three to four nurses on the night shift, and a nurse supervisor could not properly supervise if she was on a medication cart. She stated their census was about [redacted], and [redacted] residents to a nurse was a standard in long-term care. The DON then stated if there was a blank on the MAR next to a medication, it meant it was not administered. She stated when looking at the documentation on Resident #14's MAR, it looked like medications scheduled for 9:00 PM on 10/03/2021 were not administered. She further stated that according to the regulations, if it was not documented, it was not done. She stated she would have to look into why the residents did not receive their medications as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 23	F 658		

The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. He stated he was not aware that [redacted] of the [redacted] residents on the [redacted] Hall had not received their 9:00 PM medications on 10/03/2021. The NHA further stated he would have to be notified if that happened. He then stated they were meeting the new regulations for staffing ratios, and staff in the building could adequately cover the care. He further stated it was his responsibility if staff were not able to meet the needs of the residents.

Registered Nurse (RN) #3 was interviewed on 10/05/2021 at 6:16 PM. She stated she was the RN on duty doing a double shift on 10/03/2021 from 3:00 PM until 7:00 AM. She stated she was the medication nurse for Halls [redacted] on the [redacted] floor the entire 16 hours. She stated there was a nurse on the [redacted] hall from 3:00 PM until 11:00 PM, and the day nurse stayed over and worked the [redacted] Hall cart until 7:00 PM and administered all medications that were due until 8:00 PM. She stated the nurse came to her at 7:00 PM and told her she was only scheduled until 7:00 PM and was leaving, so the RN supervisor did a narcotic count with the off-going nurse and took the keys. The off-going nurse told her that she did not know if there was someone coming in to replace her. The RN supervisor stated she texted the scheduler and the scheduler stated she was trying to get one of the 11:00 PM to 7:00 AM nurses to come in early. She stated the nurse did not come in until his scheduled time at 11:00 PM. She stated she was aware not all residents' medications were passed on the [redacted] Hall. She stated she had to finish the medication pass on the two halls she was assigned first. She stated a couple of residents from the [redacted] Hall came and asked for their medications, so she did administer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 24	F 658		

theirs, but the rest of the residents on the [redacted] Hall did not get their bedtime medications. She stated she did not notify any of the management.

RN #3 stated the management was aware of the staffing issues at night and had told her they were hiring travel nurses to come in, but she did not know when that was supposed to happen. She stated there used to be an RN supervisor on each floor, but that had not happened in about two months. She stated the management would come in and help pass medications at times, and a unit manager had come in at 5:00 AM on 10/03/2021 to help her pass the morning medications. She stated she worked on a medication cart 95% of the time and always took the [redacted] and [redacted] Halls medication carts because the medication pass was not as heavy so that she could still try to accomplish as much of the supervisor duties and paperwork that she could. She stated if she was the only nurse on the [redacted] floor and she had to go to the [redacted] floor for an emergency, the [redacted] floor was monitored by the CNAs. She stated she tried to round on the halls to make sure the CNAs were providing the needed care and would help the CNAs when she could. She stated many times she was the only nurse with only two CNAs, and they were not able to always provide the care that was needed when they were short-staffed. She stated they were supposed to have two CNAs for every hall, but most of the time they worked with only two to four CNAs for the entire floor. She stated the staff they had did the best they could, but there was just not enough help to care for the residents the way they should be. She stated she would have been ultimately responsible for passing the medications on the [redacted] Hall, but she thought a nurse was coming in to do it. She stated she did not notify the physician of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 25	F 658		

the residents not receiving their medications.

A review of the facility's policy titled, "Medication Administration," last revised 12/2019, indicated, "Medication must be administered in accordance with the orders, including any required time frame. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose."

A review of the facility's policy titled, "Medication Administration - Documentation," last revised 01/2019, indicated, "Documentation must include reason why a medication was withheld, not administered, or refused."

2. A review of the Face Sheet indicated the facility admitted Resident #17 with diagnoses of [redacted]. A review of the quarterly Minimum Data Set (MDS) assessment, dated [redacted], indicated the resident's Brief Interview for Mental Status (BIMS) score was [redacted], which indicated the resident was [redacted]. The MDS indicated the resident took [redacted] medications, [redacted] medications, [redacted] and [redacted] seven out of seven days during the assessment period.

A review of the comprehensive care plan, dated [redacted], indicated Resident #17 had an [redacted] related to [redacted] and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 26 uses [redacted] medications related to [redacted] and [redacted]. Intervention included to administer medications as ordered, monitor for signs and symptoms of [redacted] with each interaction and if the resident appears to be in [redacted] utilize appropriate non-pharmacological and pharmacological interventions and monitor and document side effects and effectiveness of [redacted] medications. Resident #17 was interviewed on 10/04/2021 at 9:24 AM. The resident stated they did not receive their bedtime medications due between 9:00 PM and 10:00 PM on [redacted] because there was not a nurse to administer them. The resident stated that because they did not receive their medications, they were not able to sleep well and had increased [redacted] Resident #17 stated a nurse finally came in around 4:00 AM and gave them some PRN [redacted] medications, and they were able to rest a little after that. According to the physician orders for [redacted] r [redacted], the resident had orders for the following medications to be given between 9:00 PM and 10:00 PM: - [redacted] for [redacted], [redacted] mg. Give on tablet by mouth for [redacted], [redacted] orally for [redacted] - [redacted] mg. Give one tablet by mouth for [redacted] [redacted] mg. Give one tablet by mouth for [redacted] [redacted] mg. Give one tablet by mouth for [redacted],	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 27 - [redacted] mg. Give one tablet by mouth for [redacted], and - [redacted] mg. Give one-half tablet [redacted] mg) by mouth for [redacted]. The resident also had a PRN (as needed) order for [redacted] (a [redacted] medication) 5 mg. The order indicated to give one capsule every six hours as needed for [redacted]. There was also a PRN order for [redacted] [redacted]mg. The order indicated to give two tablets by mouth every six hours as needed for [redacted] A review of the MAR for [redacted] revealed Resident #17 did not receive their [redacted] mg, [redacted] mg, and [redacted] mg on 10/03/2021 due to be given at 9:00 PM or [redacted] mg, [redacted] mg, and [redacted] mg, due to be given 10:00 PM. A further review of the record revealed the resident received one dose of [redacted] and [redacted] on 10/04/2021 at 4:07 AM for [redacted] rated [redacted]. The Staffing Coordinator (SC) was interviewed on 10/04/2021 at 11:27 AM. She stated she had a nurse call off for the evening shift on 10/03/2021. She stated she thought she had it covered but the nurse never showed up. She stated she was not aware some of the residents did not receive their medications the night before. She stated they used to offer bonuses but not recently. She stated they had contracts with two staffing agencies, but they did not have any nurses available to send to them. She stated she was not aware if the facility was attempting to get contracts with any other staffing agencies. The Director of Nursing (DON) was interviewed	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 28 on 10/05/2021 at 1:58 PM. The DON stated they had a supervisor at night who was responsible to ensure medication was administered and proper care was given. She stated they scheduled four nurses and a supervisor each night, but sometimes the supervisor would have to take a medication cart if they were short staffed. She stated she was not aware of any evenings in the past week where they had no floor nurses. The DON then stated she was at the facility until 8:00 PM on 10/03/2021, and the floor nurse stayed until 7:00 PM when relief came in. The DON then stated they sometimes had three to four nurses on the night shift, and a nurse supervisor could not properly supervise if she was on a medication cart. She stated their census was about [redacted] and [redacted] residents to a nurse was a standard in long-term care. The DON then stated if there was a blank on the MAR next to a medication, it meant it was not administered. She further stated that according to the regulations, if it was not documented, it was not done. She stated she would have to look into why the residents did not receive their medications as ordered. The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. He stated he was not aware that [redacted] of the [redacted] residents on the [redacted] Hall had not received their 9:00 PM medications on 10/03/2021. The NHA further stated he would have to be notified if that happened. He then stated they were meeting the new regulations for staffing ratios, and staff in the building could adequately cover the care. He further stated it was his responsibility if staff were not able to meet the needs of the residents. Registered Nurse (RN) #3 was interviewed on 10/05/2021 at 6:16 PM. She stated she was the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 29	F 658		

RN on duty doing a double shift on 10/03/2021 from 3:00 PM until 7:00 AM. She stated she was the medication nurse for [redacted] and [redacted] on the [redacted] floor the entire 16 hours. She stated there was a nurse on the [redacted] hall from 3:00 PM until 11:00 PM, and the day nurse stayed over and worked the [redacted] Hall cart until 7:00 PM and administered all medications that were due until 8:00 PM. She stated the nurse came to her at 7:00 PM and told her she was only scheduled until 7:00 PM and was leaving, so the RN supervisor did a narcotic count with the off-going nurse and took the keys. The off-going nurse told her that she did not know if there was someone coming in to replace her. The RN supervisor stated she texted the scheduler and the scheduler stated she was trying to get one of the 11:00 PM to 7:00 AM nurses to come in early. She stated the nurse did not come in until his scheduled time at 11:00 PM. She stated she was aware not all residents' medications were passed on the [redacted] Hall. She stated she had to finish the medication pass on the two halls she was assigned first. She stated a couple of residents from the [redacted] Hall came and asked for their medications, so she did administer theirs, but the rest of the residents on the [redacted] Hall did not get their bedtime medications. She stated she did not notify any of the management.

RN #3 stated the management was aware of the staffing issues at night and had told her they were hiring travel nurses to come in, but she did not know when that was supposed to happen. She stated there used to be an RN supervisor on each floor, but that had not happened in about two months. She stated the management would come in and help pass medications at times, and a unit manager had come in at 5:00 AM on 10/03/2021 to help her pass the morning medications. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 30	F 658		

stated she worked on a medication cart 95% of the time and always took the [redacted] Halls medication carts because the medication pass was not as heavy so that she could still try to accomplish as much of the supervisor duties and paperwork that she could. She stated if she was the only nurse on the[redacted] floor and she had to go to the [redacted] floor for an emergency, the [redacted]t floor was monitored by the CNAs. She stated she tried to round on the halls to make sure the CNAs were providing the needed care and would help the CNAs when she could. She stated many times she was the only nurse with only two CNAs, and they were not able to always provide the care that was needed when they were short-staffed. She stated they were supposed to have two CNAs for every hall, but most of the time they worked with only two to four CNAs for the entire floor. She stated the staff they had did the best they could, but there was just not enough help to care for the residents the way they should be. She stated she would have been ultimately responsible for passing the medications on the[redacted] Hall, but she thought a nurse was coming in to do it. She stated she did not notify the physician of the residents not receiving their medications.

A review of the facility's policy titled, "Medication Administration," last revised 12/2019, indicated, "Medication must be administered in accordance with the orders, including any required time frame. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose."

A review of the facility's policy titled, "Medication Administration - Documentation," last revised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 31	F 658		

01/2019, indicated, "Documentation must include reason why a medication was withheld, not administered, or refused."

3. A review of the MARs for the residents residing on [redacted] Hall revealed [redacted] out of [redacted] residents did not receive their medications at bedtime on 10/03/2021. There was one resident on the hall with a [redacted] that did not receive [redacted] care on the evening shift on 10/03/2021.

The Staffing Coordinator (SC) was interviewed on 10/04/2021 at 11:27 AM. She stated she had a nurse call off for the evening shift on 10/03/2021. She stated she thought she had it covered but the nurse never showed up. She stated she was not aware some of the residents did not receive their medications the night before. She stated they used to offer bonuses but not recently. She stated they had contracts with two staffing agencies, but they did not have any nurses available to send to them. She stated she was not aware if the facility was attempting to get contracts with any other staffing agencies.

The Director of Nursing (DON) was interviewed on 10/05/2021 at 1:58 PM. The DON stated they had a supervisor at night who was responsible to ensure medication was administered and proper care was given. She stated they scheduled four nurses and a supervisor each night, but sometimes the supervisor would have to take a medication cart if they were short staffed. She stated she was not aware of any evenings in the past week where they had no floor nurses. The DON then stated she was at the facility until 8:00 PM on 10/03/2021, and the floor nurse stayed until 7:00 PM when relief came in. The DON then stated they sometimes had three to four nurses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 32	F 658		

on the night shift, and a nurse supervisor could not properly supervise if she was on a medication cart. She stated their census was about [redacted], and [redacted] residents to a nurse was a standard in long-term care. The DON then stated if there was a blank on the MAR next to a medication, it meant it was not administered. She further stated that according to the regulations, if it was not documented, it was not done. She stated she would have to look into why the residents did not receive their medications as ordered.

The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. He stated he expected 16 CNAs, eight nurses, and one supervisor for the 3:00 PM to 11:00 PM shift. He further stated if they were short nurses, the supervisor would take the cart that shift. He was not aware that [redacted] of the [redacted] residents on the [redacted] floor [redacted] Hall had not received their 9:00 PM medications on 10/03/2021. The NHA further stated he would have to be notified if that happened. He stated they were still accepting new admissions and got about 8-12 per month. He then stated they were meeting the new regulations for staffing ratios, and staff in the building could adequately cover the care.

Registered Nurse (RN) #3 was interviewed on 10/05/2021 at 6:16 PM. She stated she was the RN on duty on 10/03/2021 from 3:00 PM until 7:00 AM. She stated she was the medication nurse for Halls [redacted] on the [redacted] floor the entire 16 hours. She stated there was a nurse on the [redacted] hall from 3:00 PM until 11:00 PM, and the day nurse stayed over and worked the [redacted] Hall cart until 7:00 PM and administered all medications that were due until 8:00 PM. She stated the nurse came to her at 7:00 PM and told her she was only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 33	F 658		

scheduled until 7:00 PM and was leaving, so the RN supervisor did a narcotic count with the off-going nurse and took the keys. The off-going nurse told her that she did not know if there was someone coming in to replace her. The RN supervisor stated she texted the scheduler and the scheduler stated she was trying to get one of the 11:00 PM to 7:00 AM nurses to come in early. She stated the nurse did not come in until his scheduled time at 11:00 PM. She stated she was aware not all residents' medications were passed on the [redacted] Hall. She stated she had to finish the medication pass on the two halls she was assigned first. She stated a couple of residents from the [redacted] Hall came and asked for their medications, so she did administer theirs, but the rest of the residents on the [redacted] Hall did not get their bedtime medications. She stated she did not notify any of the management.

RN #3 stated the management was aware of the staffing issues at night and had told her they were hiring travel nurses to come in, but she did not know when that was supposed to happen. She stated there used to be an RN supervisor on each floor, but that had not happened in about two months. She stated the management would come in and help pass medications at times, and a unit manager had come in at 5:00 AM on 10/03/2021 to help her pass the morning medications. She stated she worked on a medication cart 95% of the time and always took the [redacted] Halls medication carts because the medication pass was not as heavy so that she could still try to accomplish as much of the supervisor duties and paperwork that she could. She stated at the beginning of her shift, she would make rounds and make sure everyone was okay before she started her medication pass. She stated she tried

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 34 to go to the [redacted] floor at least twice a shift to see if everything was okay, but the nurses would call her if they needed her for something, and she would go right away. She stated if she was the only nurse on the [redacted] floor and she had to go to the [redacted] floor for an emergency, the [redacted] floor was monitored by the CNAs. She stated she tried to round on the halls to make sure the CNAs were providing the needed care and would help the CNAs when she could. She stated many times she was the only nurse with only two CNAs, and they were not able to always provide the care that was needed when they were short-staffed. She stated they were supposed to have two CNAs for every hall, but most of the time they worked with only two to four CNAs for the entire floor. She stated she came in early to help the evening shift several times a week and worked doubles once or twice during the week. She stated she was not sure when her last day off was, and on Tuesdays and Thursdays she did not sleep because she must babysit her grandchild. She stated the staff they had did the best they could, but there was just not enough help to care for the residents the way they should be. She stated she would have been ultimately responsible for passing the medications on the [redacted] Hall, but she thought a nurse was coming in to do it. She stated she did not notify the physician of the residents not receiving their medications. A review of the facility's policy titled, "Medication Administration," last revised 12/2019, indicated, "Medication must be administered in accordance with the orders, including any required time frame. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 35 dose." A review of the facility's policy titled, "Medication Administration - Documentation," last revised 01/2019, indicated, "Documentation must include reason why a medication was withheld, not administered, or refused."	F 658		
F 677 SS=D	New Jersey Administrative Code § 8:39-11.2(b) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ146250 Based on observations, record review, interviews, and facility policy review, it was determined that the facility failed to provide dependent residents the assistance needed for activities of daily living (ADLs) for one (Resident #9) of three residents reviewed for ADL care. Specifically, the facility failed to provide timely incontinent care for Resident #9. This had the potential to affect 16 out of 27 residents that resided on the same hall as Resident #9 or 62[redacted] residents out of 181 total residents in the facility. Findings included: 1. A review of the Face Sheet indicated the facility admitted Resident #9 with diagnoses including [redacted]	F 677	1. Resident #9 received Immediate [redacted] care when identified. Resident #9 was skin was evaluated with no noted [redacted] or lasting negative effect. The C.N.A. assigned to resident #9 received counseling on responding to call bells, assisting with bed pans, and incontinence care 2. All resident's dependent on staff for ADL care have potential to be affected by this deficient practice. There was no other identified resident that did not receive[redacted] care on the 11-7 shift. All residents had [redacted] evaluations and there were no identified new [redacted]	11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 36 [redacted]. A review of the quarterly Minimum Data Set (MDS) assessment, dated [redacted] indicated the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of [redacted], which indicated the resident was [redacted]. A further review of the MDS indicated Resident #9 required extensive assistance of two staff for bed mobility and transfers and extensive assistance of one staff for toileting and personal care. The resident was always [redacted] and [redacted]. Resident #9 was interviewed on 10/02/2021 at 1:45 PM. The resident stated they were [redacted] and [redacted] and required assistance to be changed but only got changed once a shift. The resident stated that on the 11:00 PM to 7:00 AM shift the resident would not get changed until the morning. During an interview on 10/03/2021 at 6:00 AM, Resident #9 stated they had not had [redacted] care provided since being assisted to bed around 8:00 PM on the 3:00 PM to 11:00 PM shift the night before. This was confirmed by the resident's roommate, Resident #17, who had a BIMS of [redacted] indicating they were [redacted]. There was a [redacted] in the room. Licensed Practical Nurse (LPN) #6 was interviewed on 10/03/2021 at 6:00 AM. She stated they currently had two nurses and three certified nursing assistants (CNA) on the [redacted] floor. She stated the CNAs each took a hall and then split the [redacted] hall. CNA #5 was interviewed on 10/03/2021 at 6:10 AM. She stated they were currently working with	F 677	[redacted] or [redacted] 3. The facility policy on Providing ADL Care was reviewed and considered to be in compliance with state and federal guidelines. An in-service will be conducted with all nursing staff on ADL care provided for dependent residents specifically focusing on providing timely [redacted] care. 4. The DON/ Designee will complete weekly random audits of incontinent residents to ensure that [redacted] care is rendered to residents through interview and visual inspection. Negative findings will have immediate corrective actions. The audits will be completed weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be presented at QAPI. The DON is responsible for the oversight of this POC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 37	F 677		

three CNAs on the floor. She stated sometimes there were only one or two of them, and when they got to work with four CNAs on the floor, it felt like Christmas. The CNA stated she was too busy to answer any further questions at that time.

On 10/03/2021 at 6:19 AM, CNA #5 provided [redacted] care for Resident #9, and the [redacted] care was observed. The resident's [redacted] was [redacted] and had leaked onto the sheets. CNA #5 stated the resident had not been changed since the 3:00 PM -11:00 PM shift. She stated they were shorthanded and did not have time to change the residents on Hall [redacted] until the morning. CNA #5 stated residents should be checked every two hours for incontinence and changed as needed.

The Director of Nursing (DON) was interviewed on 10/05/2021 at 1:58 PM. She stated [redacted] residents should be provided [redacted] care at least every two hours and more frequently if needed. She stated if the staff were working with only three CNAs, she would expect the other hallway to be divided between the CNAs, and those residents would receive the care they needed and deserved. She stated it was not acceptable to leave a resident wet all night long.

The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. The NHA stated each resident should be checked every two hours for [redacted] care, but some residents did not need to be changed in a shift if they were not soiled. He further stated it was his responsibility if staff were not able to meet the needs of the residents.

A review of the facility's policy, titled, "ADL -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 38 Personal Hygiene," last revised 10/2019, revealed, "Peri-care will be given with each [redacted] episode, with morning and bedtime care and shower day. Toileting/[redacted] care for a resident will occur every two to four hours or as needed for each individual resident per care plan."	F 677		
F 689 SS=G	New Jersey Administrative Code § 8:39-27.2(h) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ147766 Based on observations, record review, interviews, and facility policy review, it was determined that the facility failed to provide the proper supervision to ensure the safety of one (Resident #5) of three residents reviewed for accidents. Specifically, the facility failed to ensure Resident #5 was not able to gain access to a substance that was unsafe to ingest. Resident #5 ingested soap and started [redacted] and had a change in their [redacted] status requiring the resident be sent to the hospital. This had the potential to affect all [redacted] residents on the [redacted] floor of the facility.	F 689	1. The [redacted] was removed from the resident #5. Resident #5 was sent to the ER and admitted, the resident has not returned to the facility. Room [redacted], bed [redacted], had all non-ingestible items secured. Room [redacted] bed [redacted], had all non-ingestible items secured. Room [redacted], bed [redacted] had all non-ingestible items secured. Room [redacted] bed [redacted] had all non-ingestible items secured. Room [redacted], bed [redacted], the nightstand draw was repaired and all non-ingestible items	11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39 Findings included: 1. A review of the face sheet revealed Resident #5 had diagnoses that included [redacted]. A review of the readmission/5-day Minimum Data Set (MDS) assessment, dated [redacted], revealed the resident had [redacted], was [redacted] and had no behaviors. A further review of the MDS revealed the resident required extensive assistance of two staff for transfers, walking in the room and corridors and was dependent on two staff for bed mobility, dressing, toileting, personal hygiene, bathing, and locomotion on and off the unit. A review of Resident #5's comprehensive care plan, dated [redacted], revealed the resident exhibited behavior symptoms such as [redacted] and placing [redacted] in their mouth such as [redacted] and [redacted]. Interventions included initiating [redacted] and [redacted] evaluation as needed, notifying the physician of inappropriate behavior and no [redacted], or [redacted] at bedside. A review of the investigation form, dated 07/30/2021, revealed at approximately 9:15 AM the speech therapist was feeding Resident #5 a banana while being evaluated, and the resident began [redacted] up the [redacted] Unit Manager (UM) #2 was notified by the speech therapist and assessed the resident. Licensed Practical Nurse (LPN) #5 reported that Resident #18 told her that Resident #5 was observed drinking from a [redacted] bottle, but a Certified Nurse Aide (CNA #6) quickly removed the bottle from the resident and	F 689	were secured. Room [redacted], bed [redacted], the nightstand draw was repaired and all non-ingestible items were secured. The [redacted] cream was placed in the locked treatment cart. 2. This had the potential to affect all [redacted] residents on the [redacted] floor of the facility. Environmental rounds were completed with no unsafe non-ingestible substances were available to [redacted] residents noted. 3. The nurse responsible for room [redacted] received counseling on ensuring that all non-ingestible substances are placed in a secure location away from [redacted] residents. The nurse received education on self-administration evaluation and obtaining a doctor's order for self-administration of treatments and medications. The staff educator will conduct education with all staff on providing an environment free of accident hazards specifically focusing on [redacted] residents not having access to substances that are unsafe to ingest. Staff will be educated to ensure that non-ingestible items are placed in a basin with the resident's name on it in a secure location. The staff educator will provide education	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 discarded it. The staff notified 911 immediately. The resident's vital signs were stable at the time of the assessment, and the UM stayed with the resident for close monitoring. During that time, the resident's [redacted] levels started to drop into the low [redacted], and the resident was placed on [redacted] until EMS arrived and transported the resident to the hospital. A further review of the investigation form revealed that staff interviews indicated Resident #5 was placed in a lounge chair in a visible area with no items in reach of the resident, and no [redacted] bottles were left accessible in common areas. It indicated a further review and evaluation of the environment did not identify any areas in which supplies were accessible to residents with [redacted] who were at risk for harm. The investigation form revealed environmental rounds would be completed by administration to ensure no toxic items were in reach of residents. An in-service was given to all staff to ensure all toiletries were placed in a secure basin in each resident's drawer with the resident's name on it, all other toiletries were to be kept in a locked cabinet with no accessibility to residents. Documentation of the environmental rounds was requested from the DON but were not provided by the end of the survey. A review of a hand-written statement of a verbal statement of Speech Therapist (ST) #1 taken over the phone by the Director of Rehab (DOR) on [redacted] at 2:50 PM revealed that on [redacted] at 9:15 AM, a CNA was feeding Resident #5 breakfast when the ST started therapy. The statement indicated Resident #5	F 689	on the MSD, location of the MSD, and procedure if a non-ingestible item is ingested including notifying poison control and the physician. 4. The administrator/ designee will conduct environmental rounds specifically focusing on all non-ingestible items placed in a secure location. The audits will be completed weekly X 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The administrator is responsible for execution and monitoring of this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41	F 689		

was given two bites of [redacted] with no difficulty swallowing, but Resident #5 started [redacted]. It indicated UM #2 was notified and assessed the situation. The ST session was discontinued, and the nurse remained with the resident.

A review of a hand-written witness statement by Licensed Practical Nurse (LPN) #5, dated [redacted], revealed LPN #5 gave Resident #5 their medications with [redacted] without incident and later Resident #18 told LPN #5 that Resident #5 had ingested facility [redacted] The statement indicated the UM (#2) was notified, and the UM assessed the resident.

A review of a hand-written witness statement by Certified Nurse Aide (CNA) #6, dated [redacted], revealed Resident #5 was sitting in the chair, and Resident #18 told the CNA that Resident #5 had [redacted] and was drinking it. The statement indicated CNA #6 found the empty bottle of [redacted] on the right side of the resident when he grabbed it.

A review of a resident statement taken by the Director of Social Services (DSS) on [redacted] revealed Resident #5 was sitting nearby at the nurse's station, calling out for milk. Over a minute later, Resident #18 saw Resident #5 with what was thought to be a [redacted] bottle. Resident #18 yelled for CNA #6 and told him. CNA #6 immediately took the bottle away. It indicated Resident #18 did not see where Resident #5 got the bottle.

A review of in-service education titled, "Toiletries and Storage," provided to all staff on 07/30/2021 revealed all toiletries should be stored in a locked closet. Toiletries were not to be stored on linen carts, bathrooms, or shower rooms. Staff needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42	F 689		

to ensure all toiletries were placed in a secure area (in a labeled basin) in residents' rooms to avoid accidental ingestion and promote infection control.

A record review of the incident and interviews with staff that were present during the incident revealed the investigation report was inaccurate as to the timing of events and when notifications occurred.

A review of a charting by exception note, written by Unit Manager (UM) #2 and dated [redacted] at 9:20 AM, revealed Certified Nurse Aide (CNA) #6 and the speech therapist (ST) informed UM #2 that Resident #5 was [redacted] again. The note indicated that UM #2 was not aware of the previous episodes of [redacted]. It indicated when UM #2 arrived at the room, pieces of [redacted] were coming out of Resident #5's [redacted] with a small amount of clear [redacted] noted on the chair and on the resident's [redacted] UM #2 informed LPN #5 to notify the physician and obtain a [redacted] to rule out [redacted] At that time, LPN #5 informed UM #2 that Resident #5 may have ingested [redacted] as it was reported to her by Resident #18, that Resident #18had seen Resident #5 holding a [redacted] bottle close to Resident #5's [redacted]. The UM immediately notified the physician, and the physician gave orders to monitor the resident closely and report any changes.

A review of an initial event documentation note, completed by LPN #5 and dated [redacted] at 10:00 AM, revealed Resident #5 had a [redacted] event. It indicated LPN #5 was notified by Resident #18 that Resident #5 had drank an inedible substance, and upon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 43	F 689		

assessment, Resident #5 was [redacted] up a [redacted] substance. It indicated the physician was notified, and an order was received to send the resident to the emergency room related to [redacted] and ingestion of a harmful substance.

A review of a charting by exception note, written by LPN #5 and dated [redacted] at 11:00 AM, revealed LPN #5 was notified by Resident #18 that they had witnessed Resident #5 ingesting facility [redacted] It indicated UM #2 was notified and Resident #5 was assessed. Upon assessment, the resident was using [redacted] and the resident was placed on [redacted] at [redacted] The resident's [redacted] increased to [redacted].

During an interview on 10/03/2021 at 1:10 PM, LPN #5 stated she was the medication nurse on duty when the incident with Resident #5 occurred. She stated she did not witness it occurring. She was told by Resident #18 while passing the resident's medications, that they had seen Resident #5 with a bottle of [redacted] and thought the resident had drunk it. She stated about 15 minutes later she was told Resident #5 was [redacted] and went to check on the resident and that was when she told UM #2 about what Resident #18 had said.

Resident #18, who was [redacted] with a BIMS of [redacted] was interviewed on 10/3/2021 at 1:18 PM. Resident #18 stated they did not see Resident #5 drink the [redacted] but saw the resident holding a bottle of [redacted] and told CNA #6, who removed the bottle and threw it in the trash.

An observation on 10/03/2021 at 3:15 PM in Room [redacted], bed [redacted], revealed the top drawer of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44	F 689		

the nightstand was open and bottles of [redacted] and mouthwash were observed in a basin. A record review revealed this resident had a BIMS of [redacted] indicating the resident had [redacted].

An observation on 10/03/2021 at 3:17 PM in Room [redacted], bed [redacted], revealed the top drawer of the nightstand was open and bottles of [redacted] and [redacted] were observed in a basin. A record review revealed this resident had a BIMS of [redacted] indicating the resident was [redacted].

An observation on 10/03/2021 at 3:19 PM in Room [redacted], bed [redacted] revealed the top drawer of the nightstand was open and a bottle of [redacted] and mouthwash were observed in a basin. On top of the nightstand was a [redacted] of [redacted] cream. A record review revealed this resident had a BIMS of [redacted], indicating the resident had [redacted].

During an interview on 10/03/2021 at 3:37 PM, Resident #5's family stated the facility told them the resident was sent to the hospital because the resident said they were [redacted] and the resident in the other room gave them a bottle of [redacted]. They stated the facility told them poison control was called and told them the resident would have [redacted], but the facility wanted the resident to have [redacted] done to make sure the resident had not [redacted].

An observation on 10/04/2021 at 10:00 AM in Room [redacted], bed [redacted] revealed the top drawer of the nightstand was open and a bottle of [redacted] was observed lying in the drawer. A record review revealed this resident had a BIMS of [redacted] indicating the resident was [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45 During an interview on 10/04/2021 at 11:26 AM, CNA #6 stated that after Resident #5 was dressed and put in a [redacted], the resident was brought out by the nurse's station. He stated about two minutes later, Resident #18 told him that Resident #5 had a bottle of [redacted]. He grabbed the bottle and threw it away and told UM #2 right away. He stated the UM asked him to get the bottle out of the trash and then the UM went and assessed the resident. He stated the bottle was approximately an [redacted] when he took it from the resident. He did not know if the resident drank it and if they did, how much they drank. He stated a couple of hours later, Resident #5 started getting [redacted], and the nurses called 911. During an interview on 10/04/2021 at 11:38 AM, speech therapist (ST) #1 stated at approximately 9:00 AM on [redacted], she went to Resident #5's room to start therapy. She stated she was feeding the resident pieces of banana with thickened water, which was within the resident's ordered diet, and the resident started [redacted]. She alerted CNA #6 to get the UM, and UM #2 assessed the resident. She stated she stopped therapy at that point and left the resident to be monitored by the UM at approximately 9:15 AM. During an interview on 10/04/2021 at 11:48 AM, UM #2 stated she was getting ready to go the morning meeting at approximately 9:30 AM, when CNA #6 called her and told her Resident #5 was [redacted] in their room while getting therapy from the ST. She stated when she assessed Resident #5, the resident had [redacted] up the banana, so she thought the resident had aspirated and told LPN #5 to call the doctor and get an order for an	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 46	F 689		

[redacted]. That was when LPN #5 told her Resident #18 had told her Resident #5 had drank [redacted] She stated she went and questioned Resident #18 and then she told the Director of Nursing (DON). She texted the physician and the physician told her to monitor the resident. She stated she went to the morning meeting around 10:00 AM and when she returned around 11:00 AM she noted Resident #5 was not doing so good. She stated the resident's [redacted] and their breathing was [redacted] so she called 911. Prior to this incident, [redacted], [redacted] and other personal care items were kept in a basin in the resident's rooms. She stated Resident #5 was constantly saying that they were thirsty, and she believed that a [redacted] resident (Resident #20) gave the resident the bottle to drink. She stated Resident #20 would wander into other resident's rooms if something caught the resident's eye and was always grabbing things and walking away with them. After the incident, the facility kept all [redacted] resident's personal care items in a locked closet on the unit. She stated if the resident was [redacted] they kept their personal care items in a basin in the top drawer of the resident's nightstand, which could be locked, and the resident had the key. She stated they did frequent rounds to ensure no soaps or other chemicals were being left out in the bathrooms and on the linen carts. Resident #1 and Resident #20 were the only residents that wandered into other residents' rooms. She stated Resident #21 and Resident #22 [redacted] the hallways, but they would usually just poke their heads in the doorway. She stated if an oriented resident did not lock the top drawer of the nightstand and left the drawer open, it would be possible for one of the [redacted] residents to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 47	F 689		

ahold of items such as [redacted], and other personal care items that were being kept in the drawer it they wandered into the room.

During an interview on 10/04/2021 at 2:05 PM, the Director of Nursing (DON) stated she was unable to determine where Resident #5 got the bottle of [redacted] that was ingested but because Resident #5 constantly verbalized that they were thirsty, the DON thought a [redacted] resident gave it to Resident #5. She stated when she was notified, she went to assess the resident and had the nurses call poison control. When the resident's status started to decline, 911 was called and the resident was sent to the hospital. She stated the last she knew; the resident was in the [redacted] on a [redacted]. She stated the management team was doing rounds in the common areas, shower rooms and linen carts to ensure [redacted] and other personal care items were not left out. She stated they would have to re-educate the staff to ensure resident drawers were kept closed. The DON stated the [redacted] should not have been left out and should have been secured in the treatment cart.

The hospital records were requested on 10/04/2021 and were not received by the end of the survey on 10/06/2021.

An observation on 10/05/2021 at 12:16 PM in Room [redacted], bed [redacted], revealed the top drawer of the nightstand was open and broken and unable to be shut. Bottles of [redacted] and [redacted] were visible in a basin in the drawer. The resident was not in the room. This resident had a BIMS of [redacted], indicating [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 48	F 689		

An observation on 10/6/2021 at 8:04 AM in Room [redacted], bed [redacted], revealed the top drawer of the nightstand was open and broken and unable to be shut. Bottles of [redacted] and [redacted] were visible. A tube of [redacted] was on top of the nightstand. The resident was not in the room.

During an interview on 10/06/2021 at 11:20 AM, LPN #5 stated the tube of [redacted] cream should not be stored in the resident's room. She stated the resident would be capable of self-administering it and would not eat it, but for the safety of other residents, it should be locked up. The LPN also confirmed that the drawer was broken and unable to be shut or locked. She removed the tube of [redacted] cream from the room.

During an interview on 10/06/2021 at 4:54 PM, the Nursing Home Administrator (NHA) stated the investigation for Resident #5 revealed that another [redacted] resident must have given Resident #5 the bottle of [redacted] for them to ingest. He stated that since then, the facility administrative staff did environmental tours to ensure no harmful items were accessible to the residents. He stated medications and treatment supplies should not be kept at the residents' bedside.

A review of the facility's policy, titled, "Personal Property", revised 08/2019, revealed, "A locked drawer in the resident's room was available if needed to secure personal items."

A review of the facility's policy, titled, "Medication - Self Administration," revised 07/2019, revealed, "Medications must be stored in a safe and secure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 49 place, which is not accessible by other residents." New Jersey Administrative Code § 8:39-4.1(a)5	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint Intakes #NJ146520, #NJ148438, #NJ147973	F 725	1. The resident in Room [redacted] was attended to with no lasting negative effect. The resident in Room [redacted] was	11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 50 Based on observations, record review, interviews, and facility policy review, it was determined that the facility failed to have sufficient nursing staff to meet the needs of the residents. Specifically, the facility did not schedule enough staff to ensure residents did not have to wait long periods of time for a response to their call bell. The facility also failed to ensure medications were administered and incontinent care was provided for residents on the [redacted] Hall [redacted]. This had the potential to affect all residents. Findings included: 1. Observations on 10/02/2021 at 9:30 AM revealed call bells were on for Rooms [redacted], and [redacted]. Two call bells [redacted] and [redacted]) were on the [redacted] Hall (quarantine rooms for unknown [redacted] status). A nurse was standing at the medication cart under one of the lights that was on in the hallway indicating a call bell was activated. The following continuous observations revealed: - The call bell in Room [redacted] was turned off at 10:13 AM, which was 43 minutes after it was first observed. - The call bell in Room [redacted] was turned off at 10:20 AM, which was 50 minutes after it was first observed. - The call bell in Room [redacted] was turned off at 10:36 AM, which was one hour and six minutes after it was first observed. - The call bell in Room [redacted] was turned off at 10:37 AM, which was one hour and seven minutes after it was first observed. An observation and an interview with Resident #8 in Room [redacted] on 10/02/2021 at 9:58 AM	F 725	attended to with no lasting negative effect. The resident in Room [redacted] was attended to with no lasting negative effect. The resident #8 in Room [redacted] was attended to; repositioned with no lasting negative effect. Resident #7 was evaluated with no immediate physical or emotional needs requiring attention. Resident #15 was attended to and ADL care as well as medical interventions were rendered. Resident #16 was attended to with no lasting physical or emotional effect noted. Resident #6 was attended to with no lasting physical or emotional effects noted. Resident #6 was reassured that the facility was doing its due diligence to ensure care is rendered to all residents. Resident #9 was attended to with no lasting physical or emotional effects noted. Resident #9 was reassured that the facility was doing its due diligence to ensure care is rendered to all residents. Resident #14 was evaluated by the NP with no documented lasting negative effect. Resident #6 was attended to with no lasting physical or emotional effects noted. Resident #6 was reassured that the facility was doing its due diligence to ensure care is rendered to all residents. 2. All residents have the potential to be affected by this deficient practice. Facility schedules were evaluated with adequate staffing noted to provide medications and ADL care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 51 revealed the resident was leaning far to the [redacted] and was needing assistance to straighten up on the bed. The resident stated they were not able to do it unassisted. Licensed Practical Nurse (LPN) #1 was interviewed on 10/02/2021 at 9:45 AM. LPN #1 stated they were short staffed, especially on the weekend and on the 3:00 PM to 11:00 PM shift. She stated it was especially hard if they got a new admission on that shift, because then she was not able to help the CNAs. Certified Nurse Aide (CNA) #12 was observed sitting at the nurse's station on the [redacted] floor on 10/02/2021 at 10:00 AM (at the time all the above call bells were on.). She stated there were two CNAs assigned to each hall, and she was assigned eight residents on Hall [redacted]. She stated the call bells that were on at that time were not those of the residents she was assigned to. Resident #7 was interviewed on 10/02/2021 at 10:05 AM. Resident #7 stated sometimes there was no nurses and there was no one to tell their concerns to. During an interview on 10/02/2021 at 12:40 PM, Certified Nurse Aide (CNA) #1 on the [redacted] floor stated there was not enough staff to take care of everyone. An observation on 10/03/2021 at 6:00 AM revealed two CNAs and one LPN on the [redacted] floor. A review of the facility's daily census, dated 10/03/2021, revealed 95 residents were on the [redacted] floor. At 6:00 AM, the call light was on for Room [redacted]	F 725	3. Certified Nurse Aide (CNA) #12 was counseled that call bells needed to be answered regardless of assigned residents. The staffing coordinator was educated on ensuring that adequate staffing levels are reached to provide care and medications to all residents. The staff educator in- serviced nursing staff on ensuring that residents needs were met and medications are administered. Nursing supervisors were educated to notify administration and the MD if there was not enough staff to render medications and ADL care. Additional recruiting efforts were initiated to attract and maintain nursing staff including new contracts with traveling agencies, additional ads to attract nursing staff. 4. The administrator will audit schedules to actual payroll punches to ensure that adequate nursing staff is provided to meet the medication and ADL needs of the residents. Nurse to resident ratios will be evaluated on the audits. Audits will be completed weekly x 4 weeks and monthly until compliance is met. The results of these audits will be presented at monthly QAPI. The DON/ Designee will complete call bell audits of residents to ensure that care is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 52 LPN #6 was interviewed on 10/03/2021 at 6:00 AM. She stated they currently had two nurses and three CNAs on the [redacted] floor. She stated the CNAs each took a hall and then split the [redacted] hall. CNA #5 was interviewed on 10/03/2021 at 6:10 AM. She stated they were currently working with three CNAs on the [redacted] floor. She stated sometimes there was only one or two of them, and when they got to work with four CNAs on the floor, it was a good day and they could get all of their work done. The CNA stated she was too busy to answer any further questions at that time CNA #7 was interviewed on 10/03/2021 at 6:12 AM. He stated that lately they had only been working with three CNAs on each floor during the night shift. He stated he was too busy to answer any further questions at that time. CNA #13 was interviewed on 10/03/2021 at 6:17 AM. She stated they were short staffed all the time on both floors, and she did not have time to answer questions at that time. CNA #3 was interviewed on 10/03/2021 at 6:30 AM. CNA #3 stated it was only she and one other CNA on the [redacted] floor on the night shift. She further stated she wished she had at least one more aide to help them get everything done. An observation on 10/03/2021 at 6:40 AM of Room [redacted] revealed Resident #15 was asleep in the bed closest to the door with a dark substance on the resident's [redacted] and on the sheets. The call light was still on after it had initially been observed at 6:00 AM. Room [redacted] was continuously observed from 6:00 AM to 6:40 AM and no staff went to the room during that time.	F 725	rendered to residents timely. Audits will be completed weekly x 4 weeks and then monthly until compliance is met. Negative findings will have immediate corrective actions. The audits will be completed weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be presented at QAPI. The DON/ designee will audit medication administration daily for missed administration x 4 weeks and then weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The Administrator is responsible for execution and monitoring of this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 53	F 725		

During an interview on 10/03/2021 at 6:40 AM, Resident #16, who was in the bed by the window in Room [redacted], stated the resident pushed the call light a while ago because their roommate had vomited. No staff had come to the room since the call light had been on.

LPN #3 was interviewed on 10/03/2021 at 6:45 AM. She stated she was the only nurse on the [redacted] floor, and she was responsible for all the halls. She had only two CNAs with her on that shift, and that was not enough to change the residents who needed it and check on all residents. She further stated they needed more staff on the 11:00 PM to 7:00 shift to get everything done.

Resident #6 was interviewed on 10/03/2021 at 8:30 AM. Resident #6, who resided on the [redacted] floor, stated the resident had to use a [redacted] twice over the night shift because staff did not answer the call light. Resident #6 then stated staff did not answer call lights on the 11:00 PM to 7:00 AM shift, so the resident had to use a [redacted] unassisted. When the resident used the [redacted], they would transfer themselves to the wheelchair, move to the bathroom, and clean up the [redacted] themselves. The resident stated it was very challenging as a [redacted]. The resident further stated they only put the call light on for someone to help them clean up afterwards. Resident #6 stated they could do some things on their own but was concerned for dependent residents. The resident stated there were not enough staff to help everyone when they needed it.

LPN #2 was interviewed on 10/03/2021 at 9:31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 54	F 725		

AM. She stated they were short staffed and could not give adequate care when there weren't enough staff. LPN #2 further stated they needed at least three CNAs but had only two CNAs on the floor.

The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. He stated he expected 16 CNAs, eight nurses, and one supervisor for the 3:00 PM to 11:00 PM shift. He further stated if they were short nurses, the supervisor would take the cart that shift. He stated they were still accepting new admissions and got about 8-12 per month. He then stated they were meeting the new regulations for staffing ratios, and staff in the building could adequately cover the care. He further stated it was his responsibility if staff were not able to meet the needs of the residents.

A review of the facility's policy, titled, "Call Light System - Resident Response," last revised 12/2017, revealed, "Providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes. Answer the resident's call as soon as possible. If able to perform task/request, turn call light off and complete task/request. If the task/request cannot be fulfilled leave the call light on and ask for assistance."

2. A review of the Face Sheet indicated the facility admitted Resident #9 with diagnoses including [redacted] A review of the quarterly Minimum Data Set (MDS) assessment, dated [redacted], indicated the resident's Brief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 55	F 725		

Interview for Mental Status (BIMS) score was [redacted] out of [redacted] which indicated the resident was [redacted]. A further review of the MDS indicated Resident #9 required extensive assistance of two staff for bed mobility and transfers and extensive assistance of one staff for toileting and personal care. The resident was always[redacted] and[redacted].

Resident #9 was interviewed on 10/02/2021 at 1:45 PM. The resident stated they were [redacted] and[redacted] and required assistance to be changed but only got changed once a shift. The resident stated that on the 11:00 PM to 7:00 AM shift the resident would not get changed until the morning.

During an interview on 10/03/2021 at 6:00 AM, Resident #9 stated they had not had [redacted] care provided since being assisted to bed around 8:00 PM on the 3:00 PM to 11:00 PM shift the night before. This was confirmed by the resident's roommate, Resident #17, who had a BIMS of [redacted], indicating they were [redacted]. There was a [redacted] in the room.

On 10/03/2021 at 6:19 AM, CNA #5 provided [redacted] care for Resident #9, and the [redacted] was [redacted] and had leaked onto the sheets. CNA #5 stated the resident had not been changed since the 3:00 PM -11:00 PM shift. She stated they were shorthanded and did not have time to change the residents on Hall [redacted] until the morning. CNA #5 stated residents should be checked every two hours for [redacted] and changed as needed.

A review of the MDS assessments for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 56 residents on the [redacted] floor [redacted] Hall revealed [redacted] out of [redacted] residents were [redacted] and [redacted] r occasionally, frequently, or always. According to documentation provided by the DON, regarding incontinent residents: Hall [redacted] had [redacted] out of [redacted] residents that were incontinent Hall [redacted] had [redacted] out of [redacted] residents that were incontinent Hall [redacted] had [redacted] out of [redacted] residents that were incontinent Hall [redacted] had [redacted] out of [redacted] residents that were incontinent Hall [redacted] had [redacted] out of [redacted] residents that were incontinent Hall [redacted] had [redacted] out of [redacted] residents that were incontinent Hall [redacted] had [redacted] out of [redacted] residents that were incontinent Hall [redacted] had [redacted] out of [redacted] residents that were incontinent The Director of Nursing (DON) was interviewed on 10/05/2021 at 1:58 PM. She stated the facility scheduled eight nurses for the 7:00 AM to 3:00 PM shift, eight nurses for the 3:00 PM to 11:00 shift, and four nurses for the 11:00 PM to 7:00 AM shift. They scheduled 21 CNAs for the 7:00 AM to 3:00 PM shift, 16 CNAs for the 3:00 PM to 11:00 PM shift, and 16 CNAs for the 11:00 PM to 7:00 AM shift. Their census ranged from 175 to 182 residents. The facility had a census of 180 residents on 10/03/2021. They were accepting new admissions, and on average they got 15 to 30 admissions each month. The DON stated they had a supervisor at night who was responsible to ensure medication was administered and proper care was given.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 57	F 725		

The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. He stated he expected 16 CNAs, eight nurses, and one supervisor for the 3:00 PM to 11:00 PM shift. The NHA stated each resident should be checked every two hours for incontinent care, and some residents don't need to be changed in a shift if they are not soiled. He further stated it was his responsibility if staff were not able to meet the needs of the residents.

Registered Nurse (RN) #3 was interviewed on 10/05/2021 at 6:16 PM. She stated she was the RN on duty doing a double shift on 10/03/2021 from 3:00 PM until 7:00 AM. RN #3 stated the management was aware of the staffing issues at night and had told her they were hiring travel nurses to come in, but she did not know when that was supposed to happen. She stated she tried to round on the halls to make sure the CNAs were providing the needed care and would help the CNAs when she could. She stated many times she was the only nurse with only two CNAs, and they were not able to always provide the care that was needed when they were short-staffed. She stated they were supposed to have two CNAs for every hall, but most of the time they worked with only two to four CNAs for the entire floor. She stated the staff they had did the best they could, but there was just not enough help to care for the residents the way they should be.

A review of the facility's policy, titled, "Call Light System - Resident Response," last revised 12/2017, revealed, "Providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes. Answer the resident's call as soon as possible. If able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 58	F 725		

perform task/request, turn call light off and complete task/request. If the task/request cannot be fulfilled leave the call light on and ask for assistance."

3. A review of the Face Sheet indicated the facility admitted Resident #14 with diagnoses of [redacted]. A review of the annual Minimum Data Set (MDS) assessment, dated [redacted], indicated the resident's Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], indicating the resident was [redacted]. The MDS indicated Resident #14 received [redacted] medications, an [redacted] medication, an [redacted] medication, and [redacted] seven out of seven day during the assessment period and opioids four out of seven days during the assessment period.

A review of the comprehensive care plan, dated [redacted], indicated Resident #14 had an [redacted] related to [redacted]. Interventions included the following: administer medications as ordered, evaluate the effectiveness of [redacted] interventions as needed, monitor for signs and symptoms of [redacted] with each interaction and if the resident appeared to be in [redacted] utilize appropriate non-pharmacological and pharmacological interventions.

Resident #14 was interviewed on 10/04/2021 at 9:00 AM. Resident #14 stated the resident did not receive their medications that were due between 9:00 PM and 10:00 PM on the night of 10/03/2021, which caused the resident increased

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 59	F 725		

and the . The resident stated they did not get their checked or receive their . The resident stated a nurse finally came in between 1:00 AM to 2:00 AM on 10/04/2021 and gave them some as needed (PRN) medication which helped a little.

According to the physician orders for , Resident #14 had orders for the following medications to be administered between 8:00 PM and 10:00 PM:
- milligrams (mg). Give one tablet by mouth with one mg tablet (mg) for
- mg. Give one tablet by mouth for
mg. Give one tablet by mouth for ,
- mg. Give 2 tablets by mouth for ,
- mg. Give one tablet by mouth for
-) for ,
for ,
- . Instill in for
- mg. Give one tablet by mouth for
- mg. Give one tablet by mouth for

A further review of the record revealed orders for mg. The order indicated to give two tablets by mouth every six hours as needed for . There was also an order for mg. The order indicated to give one tablet by mouth every eight hours as needed for .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 60 A review of the Medication Administration Record (MAR) for [redacted] indicated Resident #14 did not receive their [redacted] mg scheduled to be given at 8:00 PM, the [redacted] mg, [redacted] mg, [redacted] mg, [redacted] and [redacted] scheduled to be given at 9:00 PM or [redacted] mg, [redacted] mg, [redacted] mg scheduled to be given at 10:00 PM on 10/03/2021. A further review of the record revealed the resident received two [redacted] tablets at 1:15 AM on 10/04/2021 for [redacted] rated [redacted] and an as-needed [redacted] on 10/04/2021 at 10:27 AM. No [redacted] was documented. The Staffing Coordinator (SC) was interviewed on 10/04/2021 at 11:27 AM. She stated she had a nurse call off for the evening shift on 10/03/2021. She stated she thought she had it covered but the nurse never showed up. She stated she was not aware some of the residents did not receive their medications the night before. She stated they used to offer bonuses but not recently. She stated they had contracts with two staffing agencies, but they did not have any nurses available to send to them. She stated she was not aware if the facility was attempting to get contracts with any other staffing agencies. The Director of Nursing (DON) was interviewed on 10/05/2021 at 1:58 PM. She stated the facility scheduled eight nurses for the 7:00 AM to 3:00 PM shift, eight nurses for the 3:00 PM to 11:00 shift, and four nurses for the 11:00 PM to 7:00 AM shift. They scheduled 21 CNAs for the 7:00 AM to 3:00 PM shift, 16 CNAs for the 3:00 PM to 11:00 PM shift, and 16 CNAs for the 11:00 PM to 7:00	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 61	F 725		

AM shift. Their census ranged from [redacted] to [redacted] residents. The facility had a census of [redacted] residents on 10/03/2021. They were accepting new admissions, and on average they got 15 to 30 admissions each month. The DON stated they had a supervisor at night who was responsible to ensure medication was administered and proper care was given. She stated they scheduled four nurses and a supervisor each night, but sometimes the supervisor would have to take a medication cart if they were short staffed. She stated she was not aware of any evenings in the past week where they had no floor nurses. The DON then stated she was at the facility until 8:00 PM on 10/03/2021, and the floor nurse stayed until 7:00 PM when relief came in. The DON then stated they sometimes had three to four nurses on the night shift, and a nurse supervisor could not properly supervise if she was on a medication cart. She stated their census was about [redacted], and [redacted] residents to a nurse was a standard in long-term care. The DON then stated if there was a blank on the MAR next to a medication, it meant it was not administered. She stated when looking at the documentation on Resident #14's MAR, it looked like medications scheduled for 9:00 PM on 10/03/2021 were not administered. She further stated that according to the regulations, if it was not documented, it was not done. She stated she would have to look into why the residents did not receive their medications as ordered.

The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. He stated he expected 16 CNAs, eight nurses, and one supervisor for the 3:00 PM to 11:00 PM shift. He further stated if they were short nurses, the supervisor would take the cart that shift. He was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 62	F 725		

not aware that [redacted] of the [redacted] residents on the [redacted] floor [redacted] Hall had not received their 9:00 PM medications on 10/03/2021. The NHA further stated he would have to be notified if that happened. He stated they were still accepting new admissions and got about 8-12 per month. He then stated they were meeting the new regulations for staffing ratios, and staff in the building could adequately cover the care. He further stated it was his responsibility if staff were not able to meet the needs of the residents.

Registered Nurse (RN) #3 was interviewed on 10/05/2021 at 6:16 PM. She stated she was the RN on duty doing a double shift on 10/03/2021 from 3:00 PM until 7:00 AM. She stated she was the medication nurse for Halls [redacted] and [redacted] on the [redacted] floor the entire 16 hours. She stated there was a nurse on the [redacted] hall from 3:00 PM until 11:00 PM, and the day nurse stayed over and worked the [redacted] Hall cart until 7:00 PM and administered all medications that were due until 8:00 PM. She stated the nurse came to her at 7:00 PM and told her she was only scheduled until 7:00 PM and was leaving, so the RN supervisor did a narcotic count with the off-going nurse and took the keys. The off-going nurse told her that she did not know if there was someone coming in to replace her. The RN supervisor stated she texted the scheduler and the scheduler stated she was trying to get one of the 11:00 PM to 7:00 AM nurses to come in early. She stated the nurse did not come in until his scheduled time at 11:00 PM. She stated she was aware not all residents' medications were passed on the [redacted] Hall. She stated she had to finish the medication pass on the two halls she was assigned first. She stated a couple of residents from the [redacted] Hall came and asked for their medications, so she did administer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 63	F 725		

theirs, but the rest of the residents on the [redacted] Hall did not get their bedtime medications. She stated she did not notify any of the management.

RN #3 stated the management was aware of the staffing issues at night and had told her they were hiring travel nurses to come in, but she did not know when that was supposed to happen. She stated there used to be an RN supervisor on each floor, but that had not happened in about two months. She stated the management would come in and help pass medications at times, and a unit manager had come in at 5:00 AM on 10/03/2021 to help her pass the morning medications. She stated she worked on a medication cart 95% of the time and always took the [redacted] Halls medication carts because the medication pass was not as heavy so that she could still try to accomplish as much of the supervisor duties and paperwork that she could. She stated if she was the only nurse on the [redacted] floor and she had to go to the [redacted] floor for an emergency, the [redacted] floor was monitored by the CNAs. She stated she tried to round on the halls to make sure the CNAs were providing the needed care and would help the CNAs when she could. She stated many times she was the only nurse with only two CNAs, and they were not able to always provide the care that was needed when they were short-staffed. She stated they were supposed to have two CNAs for every hall, but most of the time they worked with only two to four CNAs for the entire floor. She stated the staff they had did the best they could, but there was just not enough help to care for the residents the way they should be. She stated she would have been ultimately responsible for passing the medications on the [redacted] Hall, but she thought a nurse was coming in to do it. She stated she did not notify the physician of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 64	F 725		

the residents not receiving their medications.

A review of the facility's policy, titled, "Call Light System - Resident Response," last revised 12/2017, revealed, "Providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes. Answer the resident's call as soon as possible. If able to perform task/request, turn call light off and complete task/request. If the task/request cannot be fulfilled leave the call light on and ask for assistance."

4. A review of the Face Sheet indicated the facility admitted Resident #17 with diagnoses of [redacted]. A review of the quarterly Minimum Data Set (MDS) assessment, dated [redacted], indicated the resident's Brief Interview for Mental Status (BIMS) score was [redacted], which indicated the resident was cognitively intact. The MDS indicated the resident took [redacted] medications, [redacted] medications, [redacted], and [redacted] seven out of seven days during the assessment period.

A review of the comprehensive care plan, dated [redacted], indicated Resident #17 had an alteration in comfort related to [redacted] and used [redacted] medications related to [redacted] and [redacted] and [redacted] Interventions included the following: administer medications as ordered, monitor for signs and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 65	F 725		

symptoms of [redacted] with each interaction and if the resident appears to be in [redacted] utilize appropriate non-pharmacological and pharmacological interventions and monitor and document side effects and effectiveness of [redacted] medications.

Resident #17 was interviewed on 10/04/2021 at 9:24 AM. The resident stated they did not receive their bedtime medications that were due between 9:00 PM and 10:00 PM on 10/03/2021 because there was not a nurse to administer them. The resident stated that because they did not receive their medications, they were not able to sleep well and had increased [redacted]. Resident #17 stated a nurse finally came in around 4:00 AM and gave them some PRN[redacted] medications, and they were able to rest a little after that.

According to the physician orders for [redacted], the resident had orders for the following medications to be given between 9:00 PM and 10:00 PM:

- [redacted]. Give [redacted] for [redacted],
- [redacted] mg. Give on tablet by mouth for [redacted],
- [redacted] mg. Give one tablet by mouth for [redacted],
- [redacted] mg. Give one tablet by mouth for [redacted],
- [redacted] mg. Give one tablet by mouth for [redacted],
- [redacted] mg. Give one tablet by mouth for [redacted], and
- [redacted] mg. Give one-half tablet ([redacted] mg) by mouth for [redacted] and [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 66	F 725		

The resident also had a PRN (as needed) order for [redacted] (a [redacted] medication) [redacted] mg. The order indicated to give one capsule every six hours as needed for [redacted] to [redacted]. There was also a PRN order for [redacted] mg. The order indicated to give two tablets by mouth every six hours as needed for [redacted]

A review of the MAR for [redacted] revealed Resident #17 did not receive their [redacted] units, [redacted] mg, [redacted] mg, and [redacted] mg on [redacted] due to be given at 9:00 PM or [redacted] mg, [redacted] mg, and [redacted] mg, due to be given 10:00 PM. A further review of the record revealed the resident received one dose of [redacted] and [redacted] on 10/04/2021 at 4:07 AM for [redacted] rated [redacted] out of [redacted]

The Staffing Coordinator (SC) was interviewed on 10/04/2021 at 11:27 AM. She stated she had a nurse call off for the evening shift on 10/03/2021. She stated she thought she had it covered but the nurse never showed up. She stated she was not aware some of the residents did not receive their medications the night before. She stated they used to offer bonuses but not recently. She stated they had contracts with two staffing agencies, but they did not have any nurses available to send to them. She stated she was not aware if the facility was attempting to get contracts with any other staffing agencies.

The Director of Nursing (DON) was interviewed on 10/05/2021 at 1:58 PM. She stated the facility scheduled eight nurses for the 7:00 AM to 3:00 PM shift, eight nurses for the 3:00 PM to 11:00 shift, and four nurses for the 11:00 PM to 7:00 AM shift. They scheduled 21 CNAs for the 7:00 AM to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 67	F 725		

3:00 PM shift, 16 CNAs for the 3:00 PM to 11:00 PM shift, and 16 CNAs for the 11:00 PM to 7:00 AM shift. Their census ranged from 175 to 182 residents. The facility had a census of 180 residents on 10/03/2021. They were accepting new admissions, and on average they got 15 to 30 admissions each month. The DON stated they had a supervisor at night who was responsible to ensure medication was administered and proper care was given. She stated they scheduled four nurses and a supervisor each night, but sometimes the supervisor would have to take a medication cart if they were short staffed. She stated she was not aware of any evenings in the past week where they had no floor nurses. The DON then stated she was at the facility until 8:00 PM on 10/03/2021, and the floor nurse stayed until 7:00 PM when relief came in. The DON then stated they sometimes had three to four nurses on the night shift, and a nurse supervisor could not properly supervise if she was on a medication cart. She stated their census was about [redacted], and [redacted] residents to a nurse was a standard in long-term care. The DON then stated if there was a blank on the MAR next to a medication, it meant it was not administered. She further stated that according to the regulations, if it was not documented, it was not done. She stated she would have to look into why the residents did not receive their medications as ordered.

The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. He stated he expected 16 CNAs, eight nurses, and one supervisor for the 3:00 PM to 11:00 PM shift. He further stated if they were short nurses, the supervisor would take the cart that shift. He was not aware that [redacted] of the [redacted] residents on the [redacted] floor [redacted] Hall had not received their 9:00 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 68	F 725		

medications on 10/03/2021. The NHA further stated he would have to be notified if that happened. He stated they were still accepting new admissions and got about 8-12 per month. He then stated they were meeting the new regulations for staffing ratios, and staff in the building could adequately cover the care. He further stated it was his responsibility if staff were not able to meet the needs of the residents.

Registered Nurse (RN) #3 was interviewed on 10/05/2021 at 6:16 PM. She stated she was the RN on duty doing a double shift on 10/03/2021 from 3:00 PM until 7:00 AM. She stated she was the medication nurse for Halls [redacted] and [redacted] on the [redacted] floor the entire 16 hours. She stated there was a nurse on the [redacted] hall from 3:00 PM until 11:00 PM, and the day nurse stayed over and worked the [redacted] Hall cart until 7:00 PM and administered all medications that were due until 8:00 PM. She stated the nurse came to her at 7:00 PM and told her she was only scheduled until 7:00 PM and was leaving, so the RN supervisor did a narcotic count with the off-going nurse and took the keys. The off-going nurse told her that she did not know if there was someone coming in to replace her. The RN supervisor stated she texted the scheduler and the scheduler stated she was trying to get one of the 11:00 PM to 7:00 AM nurses to come in early. She stated the nurse did not come in until his scheduled time at 11:00 PM. She stated she was aware not all residents' medications were passed on the [redacted] Hall. She stated she had to finish the medication pass on the two halls she was assigned first. She stated a couple of residents from the [redacted] Hall came and asked for their medications, so she did administer theirs, but the rest of the residents on the [redacted] Hall did not get their bedtime medications. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 69	F 725		

she did not notify any of the management.

RN #3 stated the management was aware of the staffing issues at night and had told her they were hiring travel nurses to come in, but she did not know when that was supposed to happen. She stated there used to be an RN supervisor on each floor, but that had not happened in about two months. She stated the management would come in and help pass medications at times, and a unit manager had come in at 5:00 AM on 10/03/2021 to help her pass the morning medications. She stated she worked on a medication cart 95% of the time and always took the [redacted] and [redacted] Halls medication carts because the medication pass was not as heavy so that she could still try to accomplish as much of the supervisor duties and paperwork that she could. She stated if she was the only nurse on the [redacted] floor and she had to go to the [redacted] floor for an emergency, the [redacted] floor was monitored by the CNAs. She stated she tried to round on the halls to make sure the CNAs were providing the needed care and would help the CNAs when she could. She stated many times she was the only nurse with only two CNAs, and they were not able to always provide the care that was needed when they were short-staffed. She stated they were supposed to have two CNAs for every hall, but most of the time they worked with only two to four CNAs for the entire floor. She stated the staff they had did the best they could, but there was just not enough help to care for the residents the way they should be. She stated she would have been ultimately responsible for passing the medications on the [redacted] Hall, but she thought a nurse was coming in to do it. She stated she did not notify the physician of the residents not receiving their medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 70	F 725		

A review of the facility's policy, titled, "Call Light System - Resident Response," last revised 12/2017, revealed, "Providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes. Answer the resident's call as soon as possible. If able to perform task/request, turn call light off and complete task/request. If the task/request cannot be fulfilled leave the call light on and ask for assistance."

5. A review of the MARs revealed [redacted] out of [redacted] residents on the [redacted] floor [redacted] Hall did not receive their medications at bedtime on 10/03/2021. There was one resident on the hall with a [redacted] that did not receive [redacted] care on the evening shift on 10/03/2021.

The Staffing Coordinator (SC) was interviewed on 10/04/2021 at 11:27 AM. She stated she had a nurse call off for the evening shift on 10/03/2021. She stated she thought she had it covered but the nurse never showed up. She stated she was not aware some of the residents did not receive their medications the night before. She stated they used to offer bonuses but not recently. She stated they had contracts with two staffing agencies, but they did not have any nurses available to send to them. She stated she was not aware if the facility was attempting to get contracts with any other staffing agencies.

The Director of Nursing (DON) was interviewed on 10/05/2021 at 1:58 PM. She stated the facility scheduled eight nurses for the 7:00 AM to 3:00 PM shift, eight nurses for the 3:00 PM to 11:00 shift, and four nurses for the 11:00 PM to 7:00 AM shift. They scheduled 21 CNAs for the 7:00 AM to 3:00 PM shift, 16 CNAs for the 3:00 PM to 11:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 71	F 725		

PM shift, and 16 CNAs for the 11:00 PM to 7:00 AM shift. Their census ranged from [redacted] to [redacted] residents. The facility had a census of [redacted] residents on 10/03/2021. They were accepting new admissions, and on average they got [redacted] to [redacted] admissions each month. The DON stated they had a supervisor at night who was responsible to ensure medication was administered and proper care was given. She stated they scheduled four nurses and a supervisor each night, but sometimes the supervisor would have to take a medication cart if they were short staffed. She stated she was not aware of any evenings in the past week where they had no floor nurses. The DON then stated she was at the facility until 8:00 PM on 10/03/2021, and the floor nurse stayed until 7:00 PM when relief came in. The DON then stated they sometimes had three to four nurses on the night shift, and a nurse supervisor could not properly supervise if she was on a medication cart. She stated their census was about [redacted], and [redacted] residents to a nurse was a standard in long-term care. The DON then stated if there was a blank on the MAR next to a medication, it meant it was not administered. She stated when looking at the documentation on Resident #14's MAR, it looked like medications scheduled for 9:00 PM on 10/03/2021 were not administered. She further stated that according to the regulations, if it was not documented, it was not done. She stated she would have to look into why the residents did not receive their medications as ordered.

The Nursing Home Administrator (NHA) was interviewed on 10/05/2021 at 2:31 PM. He stated he expected 16 CNAs, eight nurses, and one supervisor for the 3:00 PM to 11:00 PM shift. He further stated if they were short nurses, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 72	F 725		

supervisor would take the cart that shift. He was not aware that [redacted] of the [redacted] residents on the [redacted] floor [redacted] Hall had not received their 9:00 PM medications on 10/03/2021. The NHA further stated he would have to be notified if that happened. He stated they were still accepting new admissions and got about 8-12 per month. He then stated they were meeting the new regulations for staffing ratios, and staff in the building could adequately cover the care. He further stated it was his responsibility if staff were not able to meet the needs of the residents.

Resident #19 was interviewed on 10/05/2021 at 4:30 PM. Resident #19 stated they normally got evening [redacted] care but did not get it on 10/03/2021. They further stated no nurse was scheduled to work 3:00 PM to 11:00 PM, so the day shift nurse stayed until 7:00 PM. The resident woke up at 1:00 AM in [redacted] because they did not get their evening medications and was given as needed (PRN) pain medication, but it was too late for the rest of the night medications that were due between 9:00 PM and 10:00 PM. The resident then stated that not receiving the daily treatment to the right and left ischium did not cause extra [redacted] but Resident #19 knew it is not good for healing. Resident #19 further stated they did not feel good the next morning.

Registered Nurse (RN) #3 was interviewed on 10/05/2021 at 6:16 PM. She stated she was the RN on duty doing a double shift on 10/03/2021 from 3:00 PM until 7:00 AM. She stated she was the medication nurse for Halls [redacted] and [redacted] on the [redacted] floor the entire 16 hours. She stated there was a nurse on the [redacted] hall from 3:00 PM until 11:00 PM, and the day nurse stayed over and worked the [redacted] Hall cart until 7:00 PM and administered all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 73	F 725		

medications that were due until 8:00 PM. She stated the nurse came to her at 7:00 PM and told her she was only scheduled until 7:00 PM and was leaving, so the RN supervisor did a narcotic count with the off-going nurse and took the keys. The off-going nurse told her that she did not know if there was someone coming in to replace her. The RN supervisor stated she texted the scheduler and the scheduler stated she was trying to get one of the 11:00 PM to 7:00 AM nurses to come in early. She stated the nurse did not come in until his scheduled time at 11:00 PM. She stated she was aware not all residents' medications were passed on the [redacted] Hall. She stated she had to finish the medication pass on the two halls she was assigned first. She stated a couple of residents from the [redacted] Hall came and asked for their medications, so she did administer theirs, but the rest of the residents on the [redacted] Hall did not get their bedtime medications. She stated she did not notify any of the management.

RN #3 stated the management was aware of the staffing issues at night and had told her they were hiring travel nurses to come in, but she did not know when that was supposed to happen. She stated there used to be an RN supervisor on each floor, but that had not happened in about two months. She stated the management would come in and help pass medications at times, and a unit manager had come in at 5:00 AM on 10/03/2021 to help her pass the morning medications. She stated she worked on a medication cart 95% of the time and always took the [redacted] and [redacted] Halls medication carts because the medication pass was not as heavy so that she could still try to accomplish as much of the supervisor duties and paperwork that she could. She stated if she was the only nurse on the [redacted] floor and she had to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 74	F 725		

to the [redacted] floor for an emergency, the [redacted] floor was monitored by the CNAs. She stated she tried to round on the halls to make sure the CNAs were providing the needed care and would help the CNAs when she could. She stated many times she was the only nurse with only two CNAs, and they were not able to always provide the care that was needed when they were short-staffed. She stated they were supposed to have two CNAs for every hall, but most of the time they worked with only two to four CNAs for the entire floor. She stated the staff they had did the best they could, but there was just not enough help to care for the residents the way they should be. She stated she would have been ultimately responsible for passing the medications on the [redacted] Hall, but she thought a nurse was coming in to do it. She stated she did not notify the physician of the residents not receiving their medications.

Resident #6 was interviewed on 10/06/2021 at 10:07 AM and stated the facility was always short staffed on the 11:00 PM to 7:00 AM shift and call lights were not answered during that time. Resident #6 was worried that if the resident were tired when using the bed pan at 2:00 AM and missed a step and fell, the resident would be lying on the floor until the 7:00 AM shift. Resident #6 further stated it made them feel helpless and hopeless knowing staff would not help.

A review of the facility's policy, titled, "Call Light System - Resident Response," last revised 12/2017, revealed, "Providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes. Answer the resident's call as soon as possible. If able to perform task/request, turn call light off and complete task/request. If the task/request cannot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 75 be fulfilled leave the call light on and ask for assistance." New Jersey Administrative Code: 8:39-5.1(a)	F 725		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ148720 Based on observations, record review, and interviews, it was determined that the facility failed to provide behavioral health services for one (Resident #1) out of three residents reviewed for unnecessary medications. Specifically, the facility failed to: - Address and obtain necessary services for the behavioral health needs of Resident #1; - Develop and implement a person-centered care plan that included and supported Resident #1's behavioral health care needs and develop individualized interventions related to the resident's diagnosis; - Review and revise Resident #1's behavioral health care plans that have not been effective; and	F 740	1. Resident #1 is no longer a resident. 2. This deficient practice has the potential to affect all residents with behavioral health disturbances. Residents with behavioral health disturbances were evaluated to ensure that patient centered interventions were implemented on the behavior care plan with care plans revised to indicate effective and ineffective interventions. 3. The facility policy on Behavioral Services was reviewed and the policy is in compliance with state and federal guidelines.	11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 76 - Provide meaningful activities and an environment and atmosphere that is conducive to Resident #1's [redacted] and [redacted] Findings included: 1. A review of Resident #1's Face Sheet revealed Resident #1 was admitted to the facility with diagnoses including [redacted]. A review of the quarterly Minimum Data Set (MDS) assessment, dated [redacted], indicated the facility was unable to do a Brief Interview of Mental Status (BIMS) assessment and the resident had [redacted], and other [redacted] symptoms directed towards others four to six days during the assessment period. The resident rejected care four to six days and wandered one to three days during the assessment period. A review of the comprehensive care plan, dated [redacted], indicated Resident #1 exhibited behavior symptoms such as being physically [redacted] with care, resistant to care, sitting self on the floor, pulling, breaking, and damaging furniture, electronics and walls related to [redacted], with a goal not to harm self or others through the review date. Interventions included the following: administer [redacted] medications as ordered, determine the cause of the behavior and assist as needed, distract with activities of interest, document all behaviors and attempt to identify a pattern to target interventions, have two staff to provide care as needed during combative episodes and when the	F 740	The staff educator will conduct education with all nursing staff, recreation, and social work staff on providing necessary services for the behavioral health needs of residents with [redacted] diagnosis; Developing and implementing a person-centered care plan that included and supported each resident's specific behavioral health care needs and develop individualized interventions related to the resident's diagnosis; review and revise each resident's behavioral health care plans that have not been effective; and provide meaningful activities and an environment and atmosphere that is conducive to each resident's mental and psychosocial well- being. Residents with newly identified behaviors will be discussed by the interdisciplinary team at weekly risk meeting. Patient centered interventions will be discussed and reevaluated for 4 weeks. 4. The DON/ designee will audit behavior notes on residents with psychosocial behavioral needs to ensure care plans and interventions have been initiated and reevaluated specific to the resident's individual psychosocial needs. The audits will evaluate if the necessary behavioral health services are provided that meet the resident's psychosocial needs. The audit will also include evaluation of the effectiveness of interventions, if meaningful activities are provided, and if the resident is provided an environment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 77 resident is resistive to care, and initiate [redacted] and [redacted] evaluations as needed. A further review of the care plan, dated [redacted], indicated Resident #1 used [redacted] medication related to [redacted] with the goal to have minimal side effects or adverse reactions related to the use of an [redacted] medication. Interventions included the following: give medications as ordered by the physician and monitor and document the side effects and the effectiveness; monitor and record occurrences of targeted behavior symptoms, such as [redacted], and [redacted], inappropriate responses to verbal communication, [redacted] and [redacted] towards staff and others and document per facility protocol; and monitor and record side effects and adverse reactions of [redacted] medication use. Observations on 10/03/2021 at 6:45 AM, at 11:32 AM, and at 3:14 PM revealed Resident #1 was sleeping in a [redacted] in an area around the nurse's station. An observation of the resident's room on 10/03/2021 at 11:33 AM revealed the resident's call bell light in the hallway was on. The resident's bed was up against the wall with the head of the bed against the air conditioner. The bed had a dirty sheet on it, with smudges of dirt and blood, and a pillow with no pillowcase. A ceiling tile in the corner of the room was missing. There were three large holes in the wall behind the door to the room. The door to the bathroom was hanging crooked and would not close completely. The bathroom had no faucet handles on the sink to	F 740	and atmosphere that is conductive to the residents mental and psychosocial well-being. Audits will be completed weekly X 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The administrator is responsible for execution and monitoring of this POC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 78	F 740		

turn the water on or off, and the shower hose in the bathtub was pulled down and lying in the bottom of the tub. The bathroom did not have a toilet paper dispenser and had no toilet paper. There were no personal items in the resident's room or bathroom. There was no other furniture in the room. There was no call bell cord in the room.

According to the computerized physician orders (CPO) for [redacted], orders for Resident #1 included the following:
- [redacted] milligrams (mg). Give one tablet by mouth at bedtime for [redacted]. This was ordered [redacted] and the dose was decreased to half a tablet [redacted] mg) by mouth at bedtime on [redacted]. It was then discontinued on [redacted].
- [redacted] mg. Give one capsule by mouth two times a day for s[redacted]. This was ordered [redacted] 1 and the dose was increased to two capsules [redacted] mg) two times a day on [redacted].
- [redacted] mg. Give one tablet by mouth in the morning and [redacted] mg one tablet by mouth at bedtime for [redacted]. This was ordered [redacted] and was decreased on [redacted] to give one tablet of [redacted] mg by mouth every 12 hours. It was then discontinued on [redacted].
- [redacted] mg. Give one tablet by mouth at bedtime for [redacted]. This was ordered [redacted] and the dose was increased to give two tablets of [redacted] mg by mouth at bedtime on [redacted].
- [redacted] mg. Give one tablet by mouth two times a day for [redacted] - a result of [redacted] use). This was ordered [redacted].
- [redacted] mg give one tablet by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 79	F 740		

mouth every eight hours as needed for [redacted]. This was ordered [redacted].
- [redacted] mg/[redacted] milliliters (ml). Give [redacted] mg) by mouth two times a day and [redacted] mg) at bedtime for [redacted]. This was ordered [redacted] and was increased to [redacted] mg) by mouth two times a day and [redacted] mg) at bedtime on [redacted].
- [redacted] mg. Give one tablet by mouth two times a day for [redacted]. This was ordered [redacted] and the dose was increased to two tablets [redacted] mg) by mouth two times a day on [redacted].

A review of the progress notes for [redacted], and [redacted] through [redacted] indicated Resident #1 frequently refused to allow the nurses to check the resident's [redacted] or administer [redacted] and other medications and on occasions became [redacted] and [redacted] with the staff when attempting. The notes indicated the staff attempted several times and the resident continued to refuse despite education. The notes indicated the physician was notified and was aware of the resident's refusals.

A review of a medication administration note, dated [redacted], indicated the resident exhibited [redacted] behaviors, standing on the bed, and banging and punching the wall. The notes indicated the resident grabbed the nurse and would not let them go. The only intervention documented as being attempted was redirection to sit down.

A further review of another medication administration note, dated [redacted], indicated the resident spent a portion of the night yelling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 80	F 740		

and walking without assistance, and at times Resident #1 also displayed [redacted] with the staff and refused medications. No interventions were documented as being attempted.

A review of a medication administration note, dated [redacted], indicated the resident was [redacted] and [redacted] banging on the walls of the resident's room. The note indicated the staff attempted to calm the resident, but the resident started [redacted] their [redacted] and [redacted] their [redacted] against the walls. The note indicated the resident was able to be calmed when offered and given a sandwich.

A review of a behavior note, dated [redacted] indicated the resident displayed an increase in verbal and physical outbursts, an increase in refusals of care or treatment, and an increase in behaviors of [redacted] requiring staff interventions. The note indicated multiple non-pharmacological interventions were attempted, including moving the resident to a less stimulating environment, redirection, approaching the resident in a calm manner, using short/simple phrases/sentences to ensure comprehension, and providing praise when the resident engaged in socially appropriate behaviors, but the resident's behavior was repetitive throughout the entire night shift, 11:00 PM until 7:00 AM. The note indicated the resident went into multiple residents' rooms and was [redacted] with the nurse, grabbing her and forcefully pushing her, yelling, and screaming profanities.

A review of a Hospital Transfer Form, dated [redacted] indicated the resident was sent to the emergency room for evaluation after the resident got violent with staff and showed both physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 81 and verbal aggression towards self and others. A review of the hospital discharge instructions, dated [redacted], revealed the resident was seen for [redacted] due to [redacted] and received discharge instructions and education for [redacted] and [redacted] The instructions indicated the resident received the following medications at the hospital: - [redacted] mg [redacted] - [redacted] mg - [redacted] m[redacted] - [redacted] mg [redacted] - [redacted] mg - [redacted] mg [redacted] - [redacted] mg - [redacted] mg According to the discharge instructions, medications the resident was to continue taking included: - [redacted] mg. Take four capsules [redacted] mg) orally three times a day - [redacted] mg. Take one tablet orally two times a day - [redacted] mg. Take one tablet orally three times a day - [redacted] mg. Take one tablet two times a day - [redacted] mg. Take one capsule orally two times a day - [redacted] mg. Take one capsule orally two times a day with meals A review of a behavior note, dated [redacted], indicated the resident had increased [redacted], [redacted], and behaviors such as attempting to punch and spit on the staff. The note indicated the resident was also damaging walls and trying	F 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 82	F 740		

to break windows. Multiple non-pharmacological interventions were attempted, including redirection, evaluating for hunger and thirst, checking for toileting needs, having staff approach the resident calmly and using short/simple phrases/sentences to ensure comprehension, providing praise and positive regard when the resident was engaging in socially appropriate behavior, and assisting the resident with problem solving. The note indicated after review of the discharge instructions from the crisis center, the physician was notified and an order for [redacted] mg three times a day was received and an order for a one-time dose of [redacted] mg was ordered to be given at that time. The note indicated afterwards the resident was still [redacted] but did not try to harm staff or objects.

A review of a Nursing Clinical Evaluation, dated [redacted], indicated the resident was found [redacted] on the floor in the hallway and became [redacted] trying to hit staff when they attempted to assist the resident off the floor. The evaluation indicated the resident threw a fit on the ground until the resident felt the wall and stood up and was then assisted into a wheelchair, continuing to swing at the staff.

A review of a SBAR (situation, background, assessment, recommendation) Summary, dated [redacted], revealed Resident #1's level of [redacted] resulted in [redacted] and all attempts at redirecting the resident failed. The resident was a danger to [redacted]. The recommendation was for the resident to be sent back out to the crisis center at the hospital. A review of the record revealed this did not occur.

A review of medication administration notes,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 83	F 740		

dated [redacted], revealed the resident was up all night, even after receiving an as-needed (PRN) dose of diphenhydramine and had bursts of [redacted] behavior and verbally assaulted the staff. The notes indicated interventions that were attempted included reorienting the resident to their room, asking the resident to sit down, and redirection.

A review of a Physician Assistant (PA) progress note, dated [redacted], revealed the resident's target behaviors included [redacted]. The note indicated the plan was to:
- Increase the [redacted] to 1[redacted] mg in the morning and afternoon and [redacted] mg at bedtime
- Taper the [redacted] mg at bedtime
- Start [redacted] mg at bedtime. This could be repeated one time if needed for[redacted]
- Start [redacted] mg twice a day
- Taper [redacted] mg to every 12 hours and this would likely be discontinued at next evaluation
- Continue [redacted] mg twice a day
- Continue [redacted] mg three times a day

No non-pharmacological or behavioral interventions were recommended.

A review of a social service documentation note, dated[redacted], revealed the interdisciplinary team (IDT) attempted to reach the resident's responsible party to discuss finding alternate placement for the resident due to continued behavioral episodes. The note indicated the resident was sent to the crisis center on [redacted] and was subsequently sent back.

A review of a progress note, dated [redacted], indicated at approximately 4:15 AM the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 84	F 740		

was standing on the air conditioner in the room screaming, with a piece of the ceiling lying on the bed. The note indicated the resident was reoriented and assisted off the air conditioner but became [redacted] and [redacted] throughout the rest of the shift.

A review of a medication administration note, dated [redacted], indicated the resident was up all night screaming and being [redacted] with the staff. The note indicated interventions included redirection and approaching the resident calmly, but effects of the interventions only lasted 10 to 20 minutes before the resident would start screaming and verbally attacking the staff.

A review of a PA progress note, dated [redacted] revealed the resident's target behaviors were impulsivity and intrusiveness with psychosis and aggression. The note indicated the plan was to:
- Continue the [redacted] at [redacted] mg in the morning and afternoon and [redacted] mg at bedtime
- Increase the [redacted] mg twice a day
- Stop the [redacted]
- Increase the [redacted] to [redacted] mg at bedtime
- Increase the [redacted] to [redacted] mg twice a day
- Stop the [redacted]
- Continue the [redacted] mg three times a day

No non-pharmacological or behavioral interventions were recommended.

A review of a physician progress note, dated [redacted], revealed the reason for the visit was a routine monthly visit. The note indicated the resident continued to have episodes of [redacted] and was recently sent to the crisis center but returned on the same day. The note indicated the resident was calmer after recent [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 85	F 740		

medication adjustment.

A review of a behavior note, dated [redacted] revealed the resident displayed an increase in verbal outbursts. Non-pharmacological interventions included redirecting to less stimulating environment; staff acknowledging the resident's feelings and offering emotional support; evaluating for pain, hunger, toileting needs, and thirst; approaching the resident calmly; using short/simple phrases/sentences to ensure comprehension; educating the resident on appropriate behaviors; and assisting the resident with problem solving. The note indicated the resident had a decrease in [redacted] and compliance with the new change in medication regime.

A review of the [redacted] Medication Monthly review, dated 0[redacted], indicated the resident's target behaviors included [redacted] and [redacted], and [redacted]. The note indicated the resident had over 50 episodes of behaviors being exhibited by yelling, [redacted] with staff, anxiety, refusing medications, [redacted], [redacted] and walking without assistance. No non-pharmacological or behavioral interventions were documented as being successful for the resident.

A review of a behavior note, dated [redacted], revealed the resident had an improvement with interventions and scheduled medications. The note indicated the resident was yelling and screaming but was easily redirected verbally back to their room. Non-pharmacological interventions included redirecting to less stimulating environment; staff acknowledging the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 86	F 740		

feelings and offering emotional support; evaluating for pain, hunger, toileting needs, and thirst; approaching the resident calmly; using short/simple phrases/sentences to ensure comprehension; educating the resident on appropriate behaviors; and assisting the resident with problem solving.

A review of an IDT meeting note, dated [redacted], indicated the resident was being followed by Risk Management due to an incident in which the resident hit a staff member. The note indicated the resident was sent out to the crisis center for worsening behavioral symptoms despite multiple attempts to redirect and calm the resident, and subsequently the resident was returned to the facility. The note indicated the social worker (SW) had made previous attempts to find appropriate placement without success.

A review of a medication administration note, dated [redacted], revealed the resident continued to display [redacted] and [redacted] behavior, screaming, and wandering the hallways and going into other residents' rooms throughout the night. The note indicated the resident was reoriented and redirected but continued to display [redacted] and [redacted] behavior when the resident needed [redacted] care or was asked to sit down.

A review of an IDT meeting note, dated [redacted], indicated the resident continued to be followed by Risk Management and the SW was continuing to attempt to find behavioral placement for the resident.

A review of the resident's Level II PASRR (Pre-Admission Screening and Resident Review),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 87	F 740		

dated [redacted], indicated the resident did not need specialized services, and the needs of the resident could be met in a nursing facility.

A review of the Consultant Pharmacist Review, dated [redacted] 1, revealed the [redacted] ordered for [redacted] would trigger an inappropriate use on the quality indicator report, and the diagnosis needed to be reviewed and the medication considered for a gradual dose reduction (GDR).

Licensed Practical Nurse (LPN) #5 was interviewed on 10/03/2021 at 1:10 PM and revealed Resident #1 had been at the facility for almost [redacted] years, and their behaviors were getting increasingly worse. She stated the resident was calm during the day shift but at night became [redacted] and would breaks things. She stated the resident was [redacted] and was able to walk and would [redacted] the hallways and try and go into other residents' rooms. She stated the resident was always stating they were hungry, so the resident was offered snacks and hydration frequently. LPN #5 stated if the resident was not combative, then the staff would walk with the resident. She stated the staff did not receive any training specifically to deal with this resident; they were just told to redirect the resident.

An observation on 10/04/2021 at 10:08 AM revealed the resident was sleeping in their bed covered with a sheet. The bed was placed in the center of the room with no other furniture in the room. The air condition on the wall with the window was pulled away from the wall with a diagonal crack in the sheet rock going from the air conditioner to the window. Pieces of sheet rock and white dust were on the floor under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 88	F 740		

window. A review of Resident #1's record revealed no documentation of how the air conditioner got pulled away from the wall.

Certified Nurse Aide (CNA) #6 was interviewed on 10/04/2021 at 11:26 AM. He stated Resident #1 was a very [redacted] and when the resident got angry, they could be very intimidating. He stated the resident did not have behaviors as much during the day and mostly slept. He stated when the resident became [redacted], the resident would punch holes in the walls and break whatever they could get their hands on. He stated he had not had any special training on how to deal with this resident. He stated since he was a male CNA, he did not have as much trouble with the resident as female CNAs would.

An observation on 10/05/2021 at 10:30 AM revealed Resident #1 was curled up in the fetal position on the bed wearing only an [redacted] and covered with a sheet. The bed was in the middle of the room. There was a large piece of the sheet rock missing on the wall above the air conditioner. A review of Resident #1's record revealed no documentation on what happened to the missing piece of sheet rock.

An observation on 10/05/2021 at 3:45 PM revealed Resident #1 was curled up in the same position that they were in at 10:30 AM. The resident was incoherent to their surroundings and difficult to arouse.

An observation on 10/06/2021 at 8:00 AM revealed Resident #1 was lying in their bed that was pushed against the wall, and the resident was covered with a sheet. At 11:20 AM, Resident #1 was dressed and sitting in their room in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 89	F 740		

wheelchair that did not have an armrest cover on the left side of the chair. The resident's head was bowed forward, and their eyes were closed. The resident was difficult to arouse and would mumble words.

LPN #7 was interviewed on 10/06/2021 at 8:20 AM. She stated she worked the night shift and Resident #1 was usually up all night, yelling, wandering, and at times would become combative. She stated the resident frequently refused their medications, finger sticks to check their [redacted], and any type of personal care. She stated the staff would try redirection and food and fluids and frequently had to provide [redacted] supervision for the resident to keep the resident and others safe.

LPN #8 was interviewed on 10/06/2021 at 9:58 AM. She stated she worked the night shift and spent most of her time dealing with Resident #1's behaviors. She stated the resident [redacted] the hallways and tried to go into other residents' rooms and would become [redacted] when the staff tried redirection. She stated the resident was violent and would hit the walls with their fist or their head and had assaulted the staff. She stated the facility had provided no education or training on how to deal with this resident's behaviors.

LPN #5 was interviewed on 10/06/2021 at 11:20 AM. She stated Resident #1 had their days and nights mixed up. She stated the resident usually slept during the day and evening and then was up all night. She stated the resident was violent and was not appropriate to be in the facility.

Resident #1's primary care physician was interviewed on 10/06/2021 at 2:34 PM. He stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 90	F 740		

he let the [redacted] evaluate and handle the resident's [redacted] medication, and he dealt with the resident's medical issues only. He stated with the shortage of staff the facility had, it was hard to manage the resident. He stated the resident needed more support from a facility that specialized in [redacted] issues, and he was told the facility was working on this placement. He stated the resident's baseline status was being [redacted].

The Social Service Director (SSD) was interviewed on 10/06/2021 at 2:58 PM. She stated Resident #1 was being seen by the [redacted] for medication adjustments. She stated she was trying to find a more suitable placement for the resident but was having issues with finding a facility that would accept the resident. The SSD stated she had not been in Resident #1's room recently and after observations were made of the resident's room with the surveyor, the SSD stated she was concerned about the condition of the resident's room and described the room as bleak and in disarray and disrepair. She stated she was not sure what type of training the staff had received to manage Resident #1's behaviors. The SSD stated she was going to resubmit for a Level II PASRR to be completed but said it would be denied because the resident had a diagnosis of [redacted]

The Nursing Home Administrator (NHA) was interviewed on 10/06/2021 at 4:54 PM. He stated he went into Resident #1's room almost every day and was aware of the condition the room was in. He stated the resident destroyed something in the room every day, and maintenance must go in and fix it. He stated Resident #1 was a big person and could get very [redacted] and punch holes in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 91	F 740		

walls. He stated the resident was sent to the crisis center, but it is not for long-term placement, and most times the crisis center says that the resident is stable and sends them back because they have [redacted], their behavior is not their fault, and they cannot commit them. The NHA stated they had done general education with all the staff on how to deal with behaviors but had not done any specific training on how to deal with Resident #1's behaviors.

The Director of Nursing (DON) was interviewed on 10/06/2021 at 5:25 PM. She stated Resident #1 was being managed by the [redacted] that came to the facility, and that they were making medication changes to try and address Resident #1's [redacted] behaviors. She stated she was not aware of any specific training the staff had received on how to deal with Resident #1's behaviors. She stated the facility was trying to find alternative placement for the resident, but in the meantime the staff would try different non-pharmacological interventions to calm the resident, including speaking to them in their [redacted], offering food and drink, and bringing them out of their room to the dining area to watch television.

An attempt was made to contact the [redacted] on 10/06/2021 at 4:30 PM and 6:00 PM with no response.

A review of the facility's policy, "Behavior Management," last revised 05/2020, indicated, "It is the policy of the facility to provide an interdisciplinary approach for the care of residents who exhibit problem behavioral symptoms which could lead to negative consequences for themselves or others.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 92 Residents demonstrating change/s in behavior shall be evaluated to ensure that appropriate interventions, as needed, are instituted in a timely manner. Residents need to be assessed for possible causes or triggers for the behavior including resident factors and environmental factors and situations. Behavioral symptoms and approaches should be placed in the resident-specific plan of care and communicated to the care staff and other departments, as appropriate." New Jersey Administrative Code § 8:39-5.1(d)	F 740		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 93 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, it was determined that the facility failed to ensure one (Resident #3) of three residents reviewed were free from unnecessary [redacted] medications. Specifically, the facility failed to ensure proper monitoring for the use of a [redacted] medication for Resident #3. The facility failed to monitor specific behaviors, monitor the effectiveness and monitor side effects of the [redacted] medication Resident #3 was taking. Findings included:	F 758	1. Resident#3 is no longer a resident of the facility. 2. All residents on [redacted] medications have the potential to be affected by this deficient practice. All residents on [redacted] medications were reviewed with appropriate monitoring of side effects initiated if not already in progress. In addition, resident records were updated to ensure there is monitoring for target behaviors and monitoring of the effectiveness of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 94 1. A review of the record revealed the facility admitted Resident #3 with diagnoses which included [redacted]. A review of the admission Minimum Data Set (MDS) assessment, dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], which indicated the resident had [redacted]. The resident had behaviors that consisted of [redacted] and [redacted], with an [redacted] that was continuously present. A further review of the MDS revealed the resident required extensive assistance of two people for activities of daily living (ADL), and the resident took an [redacted] medication seven of seven days during the assessment period. A review of the admission physician orders, dated [redacted], revealed orders for [redacted] - an [redacted] medication) at [redacted] milligrams (mg). The order indicated to give one tablet by mouth in the morning for behaviors. There was also an order for [redacted] at [redacted] mg. The order indicated to give one tablet by mouth at bedtime for behaviors. A review of the computerized physician orders (CPO) for [redacted] revealed the following: - [redacted] mg. Give one tablet by mouth in the morning for behavior. This was ordered on [redacted] - [redacted] mg. Give one tablet by mouth at bedtime for behavior. This was ordered on [redacted].	F 758	[redacted] medication. 3. The facility policy on psychotropic medications was reviewed and was considered to be in compliance with state and federal guidelines. The staff educator will educate nursing staff on ensuring residents are free unnecessary [redacted] medications. The in-service will focus specifically on ensuring proper monitoring for the use of [redacted] medication including behavior monitoring, effectiveness monitoring, and side effect monitoring. 4. The DON/ designee will audit a random sample of residents on psychotropic medications for monitoring of side effects, target behaviors, and effectiveness of interventions/ medications weekly x 4 weeks, then monthly until compliance is met. The results of these audits will be submitted at QAPI. The DON is responsible for execution and monitoring of this POC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 95	F 758		

There were no orders to monitor specific behaviors or for side effects of the [redacted] medication.

A further review of the [redacted] for [redacted] revealed the diagnoses for the [redacted] mg and [redacted] mg was changed to depression on [redacted].

A review of the Consultant Pharmacist Admission Review, dated [redacted], revealed the diagnosis for [redacted] needed to be clarified. No other recommendations were made for monitoring behaviors or side effects.

A review of Resident #3's record revealed there were no consents for the use of a [redacted] medication to review the risks and benefits of taking [redacted]

A review of the comprehensive care plan, dated [redacted] revealed the resident used [redacted] medications related to [redacted] with goals to show decreased episodes of signs and symptoms of [redacted] behaviors, and [redacted]. Interventions included the following: to give medications ordered by the physician, monitor and document side effects and effectiveness, educate resident on comfort measures, sleep promoting techniques and lifestyle changes that can contribute to optimal sleep, gradual dose reduction (GDR) as indicated, [redacted] and [redacted] consult as needed.

A review of the medication administration record (MAR) for [redacted] revealed Resident #3 received one tablet of [redacted] mg by mouth in the morning at 9:00 AM and one tablet of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 96	F 758		

[redacted] mg by mouth at bedtime at 9:00 PM. There was no behavior monitoring or monitoring for side effects of the use of a [redacted] being documented on the MAR.

A review of the treatment administration record (TAR) for [redacted] revealed no behavior monitoring or monitoring side effects for the use of a [redacted] being documented.

A review of Resident #3's medical record on 10/04/2021 revealed very little documentation of behaviors by the nursing staff. Most of the documentation was done in physician progress notes, as to what was reported by nursing staff. A further review of the record revealed no documentation of non-pharmacological interventions being attempted.

A review of a physician progress note, dated [redacted], revealed the resident was [redacted] at the time of the visit. The resident was asking for their spouse and the nurse reported that this behavior had been occurring since admission. It indicated the plan was to offer supportive care and continue with the [redacted] regimen.

A review of a [redacted] progress note, dated [redacted], revealed the resident had an [redacted] reaction during admission to the facility with sufficient clinical significance to warrant a referral to the [redacted]. It indicated the resident did not appear to need or desire [redacted] while at the facility and was not likely to need it at discharge.

A review of a physician progress note, dated [redacted], revealed the resident was yelling out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 97	F 758		

for help and when asked why the resident was yelling, the resident stated they were not yelling. The note indicated the nursing staff reported the resident yelled out all night for their spouse, and the resident had had this behavior since admission. The plan was to increase the resident's [redacted] mg in the morning and [redacted] mg at bedtime for [redacted].

There was no documentation in the physician progress note that the resident's responsible party was notified of the increase in the medication. There was also no documentation that non-pharmacological interventions were attempted before increasing the resident's psychotropic medication

A review of the CPO for [redacted] revealed orders for Resident #3's [redacted] were increased to [redacted] mg in the morning and [redacted] mg at bedtime on [redacted] and a review of the MAR for [redacted] revealed Resident #3 was receiving the medication as per the physician orders.

A review of a progress note, dated [redacted] revealed the resident was [redacted] and [redacted]. It indicated the unit manager notified the Nurse Practitioner (NP) and an order was received to hold the bedtime dose of [redacted] for one day.

A review of a physician progress note, dated [redacted], revealed the resident was reported to be very lethargic and unable to stay awake during a visit with the spouse. It indicated that upon assessment the resident was sitting in a wheelchair with their eyes closed but did open them briefly when their name was called. However, the resident did go right back to sleep.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 98	F 758		

The plan was to hold the bedtime dose of [redacted] and monitor the resident.

A review of the MAR for [redacted] confirmed the bedtime dose of [redacted] mg was held on [redacted]

A review of a physician progress note, dated [redacted] revealed the resident was not able to participate in any therapy that day due to worsening [redacted]. It indicated a [redacted] and labs were pending, and a [redacted] was recommended.

A review of a team meeting note, dated [redacted], revealed the resident had multiple episodes of yelling out at night and the NP ordered an increase in the [redacted] to [redacted] mg daily with [redacted] mg at bedtime. It indicated the spouse was concerned the resident may be developing [redacted] due to [redacted], so the evening dose of [redacted] was held, and the [redacted] was negative. Documentation revealed the resident refused to have labs drawn.

A review of a physician progress note, dated [redacted], revealed the resident was [redacted] and the physician recommended starting the resident on [redacted] mg twice a day to [redacted].

A review of the CPO for [redacted] revealed an order was received on [redacted] for amantadine [redacted] mg per [redacted] milliliters (ml). The order indicated to give [redacted] ml by mouth two times a day for [redacted] According to the [redacted] MAR, the resident received this medication at 9:00 AM and 5:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 99	F 758		

A review of another physician progress note, dated [redacted], revealed nursing reported less screaming and yelling by the resident and the resident continued to take [redacted] twice daily and was being monitored for [redacted]

A review of a comprehensive care path note, dated [redacted], revealed the resident had a decreased [redacted], had verbal outbursts and was refusing assistance to groom.

According to the CPO for [redacted], the order for the evening [redacted] was changed on [redacted] to: [redacted] mg. Give one tablet by mouth at bedtime for [redacted]. Give with [redacted] mg tablet for a total dose of [redacted] mg. The order and diagnosis for the morning dose of [redacted] was not changed.

A review of a physician progress note, dated [redacted], revealed nursing reported less screaming and outbursts at nighttime and continued [redacted] mg in the morning and [redacted] mg in the evening.

A review of a progress note, dated [redacted] revealed the resident had no calling out or behaviors.

A review of a physician progress note, dated [redacted], revealed nursing reported the resident spent most of their time sleeping and when awake, sometimes yelling out at bedtime. It indicated the resident continued to be on [redacted] mg in the morning and [redacted] mg at bedtime.

A review of a progress note, dated [redacted] revealed the resident called out intermittently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 100 through the day. A review of a progress note, dated [redacted], revealed the resident was calling out and was given [redacted] with positive effects. It indicated the resident ceased calling out thereafter. A review of a Discharge Summary History, dated [redacted], revealed that during the resident's stay at the facility, the resident required placement on [redacted] due to screaming out at nighttime. During an interview on 10/06/2021 at 1:37 PM, Physician Assistant (PA) #1 stated she was the one who increased Resident #3's [redacted] based on reports she received from the nursing staff. She stated she would have expected those behaviors to be documented somewhere. She stated when she received a phone call about the resident being lethargic, she gave a verbal order over the phone to a nurse to decrease the dose of [redacted] back down to [redacted] mg in the morning and [redacted] mg at bedtime. She stated she did not remember what nurse she gave the order to, but she stated she did not follow up on it to ensure the order was put into the system. PA #1 stated she did not talk to the resident's family about increasing the medication. During an interview with on 10/06/2021 at 2:58 PM, the Social Service Director (SSD) stated she was not involved with the resident's [redacted] medications, and the facility did not currently have a [redacted] Committee or meeting. She stated if a concern arose with a resident, they were reviewed in the weekly at-risk meeting. During an interview on 10/06/2021 at 5:25 PM,	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 101	F 758		

the Director of Nursing (DON) stated that consents were needed for the use of any trial medications and [redacted] medications. The DON stated if the resident was admitted from the hospital with orders for a [redacted] medication, then consent was not required. Consents also did not need to be updated when the dose of a medication changed. She stated the nurse assigned to the resident would be responsible to obtain a consent when it was needed. She stated the resident's responsible party should be notified anytime there was a change in the resident's medications. She stated behavior monitoring should be specific to the medication being used by the resident, such as monitoring for anxiety with an anti-anxiety or psychosis with an [redacted]. She stated behavior monitoring should be documented on the MARs, otherwise the facility charted behaviors by exception (only when different than baseline). She stated side effects of [redacted] medications should be monitored and documented on the MARs.

The DON stated behaviors specific to the resident would be documented on the [redacted] Medication Evaluation with the start of a medication and every six months. The facility did not have a routine [redacted] Pharm meeting when she started working at the facility approximately 3 to 4 months ago. She stated they did the whole building once so far and the meeting needed to be done every three months or as needed but she stated they had not planned on how they were going to do it going forward.

The DON stated non-pharmacological interventions should be attempted with residents with behaviors and should be documented. Some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 102	F 758		

interventions could include redirection, offering food or fluids, or changing the resident's environment.

The DON stated Resident #3 had behaviors of calling out for the spouse during the night and resisting care. She stated the [redacted] was increased but when it caused the resident to have increased [redacted], she thought the medication was decreased back down to the original dose. She stated she was surprised to learn the resident was still on the increased dose.

A review of Resident #3's electronic medical record (EMR) revealed no [redacted] Medication Evaluation was completed for Resident #3.

A review of the facility's policy titled, "[redacted] Medication," last revised 07/2019, revealed, "The facility supports the appropriate use of psychopharmacologic medications that are therapeutic and enabling for resident suffering from mental illness. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of the individual resident."

A review of the facility's policy titled, "Behavior Management," last revised 05/2020, revealed, "It is the policy of the facility to provide an interdisciplinary approach for the care of residents who exhibit problem behavioral symptoms which could lead to negative consequences for themselves or others. Residents demonstrating change/s in behavior shall be evaluated to ensure that appropriate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 103 interventions, as needed, are instituted in a timely manner. Behavioral symptoms and approaches shall be placed in the resident-specific plan of care and communicated to the care staff and other departments, as appropriate. Residents should be monitored for potential side effects of psychotropic meds." A policy related to consents was requested from the facility, but the facility did not provide a policy.	F 758		
F 812 SS=F	New Jersey Administrative Code § 8:39-29.3(1) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility policy review, and review of the New Jersey	F 812	1.	11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 104 Administrative Code (NJAC) 8:24 for food sanitation, it was determined that the facility failed to appropriately wear hair restraints when in the kitchen and consume food and store personal belongings away from food preparation and storage areas. This deficient practice could put the 179 residents who received meals from the facility's kitchen at risk for nausea, vomiting, and foodborne illness. Findings included: Reference: NJAC 8:24-2.4, Hygienic practices indicates, "(c) The following requirements shall apply to hair restraints: 1. Except as provided in (c)2 below, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens; and unwrapped single-service and single-use articles." 1. An observation on 10/02/2021 at 11:55 AM revealed Dietary Aide (DA) #1 entered the kitchen after delivering a meal cart to the hall with no hairnet on. His hair was approximately a half inch long. Further observation revealed DA #2, DA #3, DA #4 and DA #5 were on the tray line plating and setting up meal trays. They were not wearing any hair coverings. Each DA's hair was approximately a half inch to one inch long. During an interview on 10/02/2021 at 12:00 PM, DA #2 stated he had not been told to wear a hairnet in the kitchen. During an interview on 10/02/2021 at 12:02 PM, the Cook stated she was the only one wearing a	F 812	DA #1, DA #2, DA #3, DA #4, and DA #5 were issued hairnets. DA #1 was counseled to not eat or drink food in the kitchen. The food and drinks were immediately removed. The backpack was removed from the kitchen in a secure employee location. 2. All residents have the potential to be affected by this deficient practice. Based on resident record review, there was no signs or symptoms of food borne illness therefore there was no identified resident affected by this deficient practice. 3. The staff educator will give an in-service to all dietary staff on food procurement, prepare and serve sanitary food. The in-service will specifically focus on ensuring kitchen staff is wearing hairnets while in the kitchen. The in-service will include the requirement of not eating or drinking while in the kitchen and all personal items must be stored in a safe location outside of the kitchen. 4. The administrator/ Designee will complete weekly random audits of the kitchen to ensure hairnets are worn, no food items are consumed in the kitchen, and personal items are stored in a secure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 105	F 812		

hairnet because the rest of the staff were not following the rules. She further stated it was the Assistant Manager's responsibility to enforce the rules when the Food & Nutrition Services Director (FNSD) was not there.

During an interview on 10/02/2021 at 3:32 PM, the Assistant Manager stated his staff did not have hairnets on in the kitchen because they ran out. He stated the staff currently had hairnets on because he sent a staff member into storage to get more.

During an interview on 10/03/2021 at 9:21 AM, the FNSD stated he expected all kitchen staff to wear a hair covering at all times when in the kitchen. He further stated it was important to wear a hair covering in the kitchen, so no food was contaminated with someone's hair during food preparation and serving.

During an interview on 10/05/2021 at 10:13 AM, the Administrator stated he expected all kitchen staff to wear a hairnet when in the kitchen and in food preparation areas.

A review of the facility's policy titled, "General Infection Control in Food and Nutrition," revised 05/2019, revealed, "Staff shall wear hair restraints such as hats, hair coverings or nets that covers body hair to keep hair from contacting exposed food, clean equipment, utensils, or linens."

Reference: NJAC 8:24-2.4, Hygienic Practices, indicates, "(a) The following requirements shall apply to eating, drinking, or using tobacco: 1. Except as provided under (a)2 below, an employee shall only eat, drink, or use any form of tobacco, in compliance with the New Jersey

employee location outside of the kitchen. The audits will be completed weekly x 4 weeks and then monthly until compliance is met.

The results of these audits will be presented at QAPI.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 106	F 812		

Smoke-Free Air Act at N.J.S.A. 26:3D-55 through 3D-64 and the rules promulgated thereunder, in designated areas where the contamination of exposed food, clean equipment, utensils, linens, unwrapped single service and single-use articles, or other items needing protection cannot result."

2. An observation on 10/02/2021 at 3:35 PM revealed DA #1 picked up a slice of pizza from a box stored on top of the toaster in the kitchen and ate it while walking around the steam table and food preparation area. Further observation revealed a backpack on the preparation table next to the toaster.

An observation on 10/02/2021 at 3:40 PM revealed DA #1 drink from one of two personal drinks stored on top of the milk cooler next to the tray line.

During an interview on 10/02/2021 at 3:40 PM, DA #1 stated he was told not to consume any food or drinks in the kitchen. He further stated drinks should not be stored on the milk cooler. DA #1 then stated he forgot he should not eat or drink in the kitchen.

During an interview on 10/03/2021 at 9:21 AM, the FNSD stated staff should consume food and drinks in designated areas, not in the food preparation area. He then stated it was important to keep personal food and drinks away from the food preparation areas to minimize potential cross contamination of resident food from outside sources. The FNSD stated personal belongings such as backpacks or purses should be stored in the designated storage area outside of the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 107 During an interview on 10/05/2021 at 2:31 PM, the Administrator revealed staff should not eat in the food preparation areas or near the tray line. He further stated food, drinks, and personal belongings should not be stored where food was being prepared. A review of the facility's policy titled, "Staff Appearance and Hygiene Policy," revised 10/2019, revealed, "Personal belongings shall be stored in designated area for storage of these items. At no time are they to be in production, service, warewashing or food storage areas. Food will be consumed in designated areas only." New Jersey Administrative Code § 8:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		12/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 108	F 880		

arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 109 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ148720 Based on observations and interviews, it was determined that the facility failed to ensure the facility followed proper infection control procedures to prevent the spread of the COVID-19 virus throughout the facility. Specifically, the facility failed to ensure staff wore their masks correctly and ensured hand hygiene occurred during meal service. This deficient practice had the potential to affect all residents in the facility and occurred during the COVID-19 pandemic. Findings included: Multiple observations were made throughout the facility from 10/02/2021 through 10/06/2021 of facility staff not wearing their masks appropriately, touching their masks, and pulling down their masks to talk to each other or residents and not performing hand hygiene afterwards. Specific observations included the following: - On 10/02/2021 at 9:45 AM, Certified Nursing Assistant (CNA) #9 and CNA #10 were observed coming off the [redacted] floor [redacted] Hall with the bottom strap of their N95 masks hanging below their chins. This hallway (the [redacted] zone) was used as the isolation rooms for residents with unknown	F 880	1. Identified facility staff (C.N.A. #6, C.N.A. #9, C.N.A. #10, C.N.A. #11) not wearing their masks appropriately, touching their masks, and pulling down their masks to talk to each other or residents were counseled with immediate corrective action initiated. C.N.A. #11 was educated on performing hand hygiene during meal pass. NP#2 and the social work director were educated on performing hand hygiene after touching the front of their mask. 2. All residents have the potential to be affected by this deficient practice. 3. Corporate policies titles COVID 19 Outbreak Management and Infection Control policies were reviewed. The Regional Director of Clinical Operations held an Ad Hoc QAPI meeting in which a review of the deficiency occurred with a root cause analysis developed, and corrective actions developed including but not limited to audits. DIRECTED PLAN OF EDUCATION The Regional Consultant Board Certified in Infection Control educated all staff on deficiency, contributing factors, adherence to infection control practices specifically focusing on appropriate wearing of face masks, performing hand hygiene after	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 110 COVID-19 status. - On 10/02/2021 at 5:02 PM, CNA #11 was observed wearing her mask under her nose. - On 10/02/2021 at 5:04 PM until 5:16 PM, multiple staff were observed passing dinner trays on the [redacted] floor [redacted] Hall with no hand hygiene being performed by the staff in between passing the trays, and no hand hygiene was offered or provided to the residents prior to them receiving their meals. CNA #11 was observed to assist a resident in a room, walk out of the room and down the hallway to use a phone that was hanging in the hallway, then proceed to get another tray out of the cart and deliver it to another resident without performing hand hygiene. - On 10/02/2021 at 5:18 PM, a kitchen staff member was observed walking down the hallway delivering the food cart with his mask below his nose. Unit Manager (UM) #4 was interviewed on 10/03/2021 at 3:20 PM. She stated the last part of Hall B on the 1st floor was their red wing, where any COVID positive residents resided, and the first part of Hall [redacted] on the [redacted] floor was their [redacted] wing, where any suspected COVID residents, such as new admissions, resided. She stated this hall was kept separate from the residents of the facility by the double fire doors remaining shut. She stated they did not currently have any residents on the [redacted] Wing and had 10 residents on the [redacted] wing due to being new admissions or readmissions from the hospital. She stated the staff were to wear N95 masks and eye protection whenever on Hall [redacted], and then gown and gloves were to be put on before entering a resident's room.	F 880	touching the front of a face mask, and proper hand hygiene during meal pass. The facility shall provide in-service training to appropriate staff and validated competency by the DON, medical director, or Infection Preventionist, as follows: 1. Module 1 -Infection Prevention & Control Program https://www.train.org/main/course/108l350/ Provide the training to: Topline staff and infection preventionist 2. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff 3. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtu.be/xmYMUly7qiE Provide the training to: Frontline staff 4. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTATw9yav4 Provide the training to: Frontline staff 5. Nursing Home Infection Preventionist Training Course Module 5 -outbreaks https://www.train.org/cdctrain/course/10818.03/ Provide the training to: Topline staff and infection preventionist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 111 CNA #11 was interviewed on 10/03/2021 at 3:30 PM. The CNA was observed wearing her mask with the bottom strap hanging below her chin. She stated she was assigned to the [redacted] floor Hall [redacted] isolation rooms. She stated she wore an N95 mask whenever she worked because she was always on that hall. She stated she had been educated on the proper way to wear a mask but was in a hurry, so she did not put the bottom strap around her neck like she was supposed to. CNA #6 was interviewed on 10/04/2021 at 11:26 AM. The CNA was observed with the bottom strap of his mask hanging below his chin. He stated he had been trained on the appropriate way to wear the mask, but he had to pull it down often because he would get hot, and it was easier to breathe if the bottom strap was not on. The Director of Nursing (DON) was interviewed on 10/04/2021 at 2:05 PM. The DON stated the staff had been educated on the proper way to wear their masks and what PPE supplies should be used in the different parts of the building. She stated the staff should be using hand sanitizer in between passing each resident's meal trays and should be washing their hands after every third tray that they touched. She stated all residents should be offered and assisted with hand hygiene prior to being served their meals. Additional observations were made on 10/06/2021. At 1:37 PM, Nurse Practitioner #1 was observed touching the front of her mask frequently without performing hand hygiene afterwards. At 2:58 PM, the Social Service Director was observed touching the front of her mask frequently without performing hand hygiene afterwards.	F 880	6. Nursing Home Infection Preventionist Training Course Module 7 -Hand Hygiene https://www.train.org/main/course/1081806/ Provide the training to: All staff including topline staff and infection preventionist 7. Nursing Home Infection Preventionist Training Course Module 6A Principles of Infection Control Infection Control Training Provide training to: all staff including topline staff and infection preventionist. 8. Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https: / /www.train.org/main/cours.e/1081805/ Provide the training to: All staff including topline Staff and infection preventionist 4. Infection Preventionist /designee will perform Covid-19 infection control rounds, including observation of adherence to COVID 19 requirements for wearing masks and performing hand hygiene after touching the front of a face mask. Observation of meal pass and adhering to hand hygiene requirements will be observed daily x 4 weeks, and weekly x 4 weeks and then monthly until compliance is met. The results of these observations will be submitted at QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 112 The NHA was interviewed on 10/06/2021 at 5:10 PM. He stated the staff had been educated on the proper way to wear their masks, but they had started re-educating the staff on 10/05/2021.	F 880		
F 921 SS=E	New Jersey Administrative Code § 8:39-19.4 Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, it was determined that the facility failed to maintain a physical plant that was in good repair in both resident rooms and in common areas as evidenced by holes in the walls, water leak damages, ice machines in disrepair, missing and/or damaged base boards, and a black spotted substance growing in an ice machine area. This deficient practice had the potential to affect all residents. Findings included: [redacted] Floor, Activities/Dining Room: 1. On 10/05/2021 at 10:10 AM in the [redacted] floor dining/activities room, holes in the wall under the TV were observed, as well as missing baseboards (cove base), and missing molding on the wall located approximately 3 feet up from the floor. The edge of the molding appeared to be sharp and pointy. Located on the wall with the	F 921	1. The following repairs were made: [redacted] floor dining/activities room: the holes in the wall under the TV were repaired; the missing baseboards and missing moldings were replaced. Room [redacted] The wall behind the resident's bed was repaired. [redacted] Floor, Ice Machine Room: The ice machine was repaired and cleaned. The cove base around the edge of the wall was replaced, the wall where a cove base should have been was repaired. [redacted] shower room: The water was cleaned from the floor. The mirror over the vanity was replaced.	11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 113 windows, there was approximately 6 feet of baseboard (cove base) missing. On 10/05/2021 from 3:40 PM to 4:40 PM, a facility tour and corresponding interviews were conducted with the housekeeping director (HKD) and the assistant maintenance director (AMD). The tour started on the [redacted] floor at 3:40 PM in the activities/dining room. The first areas of concern that were identified were the missing molding, missing base board (cove bases), and holes in the wall. The HKD stated that he was also the acting maintenance director. It was just he and the AMD to do all the maintenance in the facility and it was too much. [redacted] Floor, [redacted] Wing: 2. On 10/05/2021 at 10:13 AM, Room [redacted] was observed. The wall behind the resident's bed was gouged through to the sheet rock. On 10/05/2021 at approximately 3:43PM, Room [redacted] was observed with the HKD and the AMD. The gouges in the wall behind the bed were identified. The HKD and the AMD were then interviewed. The AMD stated he needed to identify a better product to protect the wall. He also stated that if he had been made aware of it, it would have been fixed. Both the HKD and the AMD stated they made rounds of the facility weekly and that they tried to round on at least two hallways every day. They stated they also depended on an online work order system that can be initiated by any employee in the facility when an employee identified a maintenance issue. [redacted] Floor, Ice Machine Room:	F 921	The [redacted] Wing hallway linoleum floor outside the shower room was repaired. Room [redacted] The two large holes in the wall behind the door were repaired. The wall to the left of the window in the room was repaired; The exposed ventilation pipe was repaired. The packaged terminal air conditioner (PTAC) unit and the sheet rock was repaired. The furniture in the room was replaced. The toilet paper holder, toilet paper, mirror, faucets were replaced. The call light was repaired. Room [redacted] The call light was repaired Room [redacted]: the hand rail in the hallway was repaired The [redacted] ice machine room has been repaired and closed off for access. Room [redacted] the ceiling tiles were replaced; the wallpaper was replaced; the cove base was repaired; the transition piece was replaced. Room [redacted] the transition/threshold piece was repaired. Room [redacted] bed cubicle curtain was replaced. The water leak was repaired; The ceiling tiles were replaced. The upper portion of the window casing was repaired. The window was replaced. 2. All residents have potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 114 3. At 10:23 AM on 10/05/2021, the room for the ice machine/dispenser was observed. The ice machine was observed to be held together with black duct tape. The machine appeared to have a dust-like substance on it. The cove base around the edge of the wall was missing, and there were holes in the wall where a cove base should have been. At 3:45 PM on 10/05/2021, the [redacted] floor ice machine room was observed with the AMD and the HKD and they were interviewed at this time. The AMD stated the outside technician had duct-taped the machine together so that the covers would stay on tighter and make contacts connect. The AMD was not aware that ice was considered "food," and duct tape was porous. The AMD was not able to describe how the machine would be maintained in a clean manner. He also stated a vendor had been out to repair the machines recently. [redacted] Floor, [redacted]-Wing: 4. On 10/05/2021 at 10:25 AM, the [redacted] Wing shower room was observed. The floor was flooded around the commode with about a half inch of water with a circumference of approximately two feet around the commode. There was no mirror over the vanity. The [redacted]-Wing hallway linoleum floor outside the shower room was buckling. At 10:30 AM, Room [redacted] was observed to have two large holes in the wall behind the door. The first hole was in the shape and size of the door handle and the second hole was approximately 8" round. There was a large portion of the wall	F 921	Environmental rounds were completed by the administrator, AMD, and HKD and all identified in need of repairs were identified and addressed. Additional areas were reviewed for any evidence of: holes in the walls, water leak damages, ice machines in disrepair, missing and/or damaged base boards, and black spotted substances. 3. The facility's policy titled, "Operations - Maintenance Logbook" was reviewed and was in compliance with all state and federal guidelines. The staff educator will conduct education with all staff on a safe, functional, sanitary, and comfortable environment. The importance of ensuring that the facility remains in good repair and residents' rooms and common areas are free of: holes in the walls, water leak damages, ice machines in disrepair, missing and/or damaged base boards, and black spotted substances. 4. The administrator/ designee will conduct environmental rounds weekly x 4 weeks and monthly until compliance is met. The environmental rounds will evaluate and identify any areas with the following: holes in the walls, water leak damages, ice machines in disrepair, missing and/or damaged base boards, and black spotted substances. Work orders will be placed and repairs will be initiated for any identified area. The results of these audits will be reported at monthly QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 115	F 921		

missing to the left of the window in the room; this hole was about 12" wide and 16" high, exposing what appeared to be a ventilation pipe. Under the window, the packaged terminal air conditioner (PTAC) unit had been separated from the wall, and the sheet rock was exposed with holes in it. The only piece of furniture in the room was the resident's bed. In the resident's bathroom, the room was missing a toilet paper holder and toilet paper. There was no mirror, and no faucets were present on the sink leaving the resident no way to wash. The resident's call light had been removed from the wall socket. When the contact was broken, the call light remained on without a way to shut it off. At 10:32 AM, Certified Nursing Assistant (CNA) #2 came into Room [redacted] and stated the resident was destructive, and it was not safe to have items in the room.

During the tour with the AMD and HKD on 10/05/2021 at 3:47 PM, the call light in Room [redacted] on the [redacted]-Wing was still on. Both the AMD and the HKD stated they had not been notified that it was not working properly and was not shutting off. The holes in the walls and the PTAC unit being away from the wall were discussed. The AMD stated they tried to keep the resident safe and monitor the room, but "this was not how any resident should live."

In the [redacted]-Wing shower room at 3:52 PM, the HKD stated the toilet must have overflowed, but no one had reported the pooling water on the floor. When asked why there was no mirror over the vanity, the AMD stated he had never noticed that before.

[redacted] Floor, [redacted] Wing:

5. On 10/05/2021 at 10:35 AM, the call light in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 116 Room [redacted] was observed to not be able to be turned off. This was observed by the Director of Nursing (DON) at this time. The DON stated she would have to inform the maintenance department. At 3:55PM, during the tour with the HKD and the AMD, the call light in Room [redacted] on the [redacted]-Wing was still on. Both the AMD and the HKD stated they had not been notified that it was not working properly and not shutting off. Second Floor, A-Wing: 6. On 10/05/2021 at 10:37 AM, the hand railing outside of Room [redacted] was observed to be broken. The remaining piece of the railing had sharp and jagged edges. It appeared as though fabric had been stuffed inside the handrail. The corner piece that was broken off was not in sight. Housekeeper (HKS) #1 was interviewed about the broken handrail. She stated she did not know how long it had been missing, but that maintenance would need to be notified and a new piece ordered. At 3:57 PM, the hand railing outside of Room [redacted] was observed. Part of the handrail had been repaired since the morning tour. The AMD stated the housekeeper informed him of the broken handrail, but he only had some of the pieces to fix it. He was still missing the corner piece that would make the edge smooth. The AMD stated the corner piece would need to be ordered and he would have to find something to protect the sharp edge. [redacted] Floor, Ice Machine Room:	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 117 7. At 10:45 AM on 10/05/2021, the room on the [redacted] floor with the ice machine was observed. The ice machine was not functional and was disassembled. The room was missing about four ceiling tiles, and about five ceiling tiles were observed to have dark ring stains on them. A few of the tiles were hanging down as if they were sagging. A black spotted substance was growing on the tiles and down the pipe in the rear right corner of the room. The black spotted substance also appeared to be growing on the same pipe in the middle and at the base. At 4:07 PM, the [redacted] floor ice machine room was observed with the AMD and the HKD and they were interviewed at this time. The HKD stated the facility was getting bids to replace the broken ice machine. When asked what the black substance was growing on the ceiling tiles and down the pipe, the AMD stated it was mold. The HKD would not commit to what the substance may have been. [redacted] Floor, [redacted]-Wing: 8. On 10/05/2021 at 10:48 AM, Room [redacted] was observed. The room was directly behind the ice machine room. The bathroom in Room [redacted] was observed to have several ceiling tiles missing and several ceiling tiles with dark ring stains. The wallpaper had been taped back up to the wall. The wallpaper was sagging down the wall as if it was falling off. In the room, a corner of the wall near the floor, just outside of the bathroom, had loose cove base/base board, and the wall was missing from behind the loose base. At 10:52 AM, rooms [redacted] and [redacted] were both observed to be missing a transition/threshold	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 118	F 921		

piece of flooring from the room to the hallway. The missing piece exposed the cement floor.

At 4:10 PM, Room [redacted] was observed with the AMD and the HKD and they were interviewed at this time. The AMD and HKD stated they had not been in that room's bathroom in "quite some time." When asked if the room was on their weekly rounds, the HKD stated they did the best they could. The AMD stated there was evidence that there had been a water leak, and that was probably contributing to the wallpaper sliding down off the wall and why part of it was being held up by black duct tape.

At 4:12 PM, both the AMD and the HKD agreed the threshold/transition piece from the room to the hallway was missing for Rooms [redacted] and [redacted]. They stated it should have been identified and replaced.

First Floor, D-Wing:

9. On 10/05/2021 at 11:12 AM, two alert and oriented residents from Room [redacted] brought the damages in their room to the attention of this surveyor. The room was observed. There was a hole in the mesh of the [redacted]-bed cubicle curtain. There had been a water leak in the room that entered over the window in the room. There were stained and missing ceiling tiles closest to the window. The upper portion of the window casing was stained and peeling. The window on the left had a large crack going diagonally through the center of the window. The residents stated they had been in that room for months and maintenance had not addressed their concerns.

At 4:13 PM, Room [redacted] was observed with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 119	F 921		

AMD and the HKD and they were interviewed at this time. Both the AMD and the HKD confirmed there had been a leak in that room above the window. It stained the ceiling tiles and all around the window, with most of the damage around the upper window frame. The alert and oriented resident in the [redacted] bed spoke up and stated the window was broken before the resident moved into that room, and that was at least four months prior to the tour. The HKD stated he would need to have corporate approve having a window repair person come out to fix it.

[redacted] Floor, [redacted]-Wing:

10. On 10/05/2021 at 11:30 AM at the entrance to the [redacted]-Wing hallway, a trashcan was observed to have been placed there to catch a water leak in the ceiling. A slow water drip was observed.

At 11:31 AM, the right fire door to the [redacted]-Wing hallway was unable to be kept open by the magnet because the magnet was hanging down by its wires. The wall surrounding the door magnet had been pushed in and was unable to support the magnet. The sheet rock was in disrepair.

At 11:32 AM, Room [redacted] was observed. An overbed light was hanging down by the wires from above the bed. There was what appeared to be water damage, as evidenced by the discoloration of the top frame above the window. The discoloration spanned across the entire window. The light fixture above the sink in the bathroom had three lights; two of the three lights were burned out.

At 11:36AM, Room [redacted] was observed. The PTAC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 120	F 921		

unit was pulled away from the wall, leaving a gaping hole behind the unit. The baseboard was missing, and there was an extension cord for a window air conditioning unit. The extension cord did not have a surge protector.

At approximately 11:45 AM, Room [redacted] was observed. There was what appeared to be water damage, as evidenced by the discoloration of the top frame above the window. The discoloration spanned across the entire window. The light fixture above the sink in the bathroom had three lights; two of the three lights were burned out.

At approximately 11:50 AM, Room [redacted] was observed. There was what appeared to be water damage, as evidenced by the discoloration of the top frame above the window. The discoloration spanned across the entire window. The light fixture above the sink in the bathroom had three lights; two of the three lights were burned out.

At approximately 11:55 AM, Room [redacted] was observed. There was what appeared to be water damage, as evidenced by the discoloration of the top frame above the window. The discoloration spanned across the entire window. The light fixture above the sink in the bathroom had three lights; two of the three lights were burned out.

At 4:18 PM, during the continued tour with the HKD and AMD, the beginning of [redacted]-Wing was observed. The HKD stated there was a leak in a main valve and that the corporate office had been notified to approve having a contractor come out to repair the leak. The AMD stated it had been leaking for at least a week.

While walking onto the [redacted]-Wing, at 4:20 PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 121	F 921		

AMD and the HKD stated they were aware of the fire door magnet that was hanging down and that the wall needed repaired. They stated they had to purchase a stronger sheet rock that would hold up to the weight of the magnet.

At 4:23 PM, in Room [redacted] the AMD tried to get the dangling overbed light to snap back into the fixture but stated he would need more tools to fix it. The HKD stated a few weeks ago there had been a water leak into the room causing the damage in the top portion of the window frame. The AMD was not aware of the burned-out lights in the bathroom light fixture. Two of three lights were burned out.

At 4:25 PM, in Room [redacted] on the [redacted]-Wing, the AMD and the HKD stated they were not aware of the PTAC being pulled away from the wall. The AMD stated it had not been reported through the online maintenance system. The AMD also removed the non-surge-protected extension cord from the window unit air conditioner. The HKD stated it never shouldn't have been allowed in the room.

At 4:27 PM, in Room [redacted] the light fixture in the bathroom had two of three lights burned out. The AMD stated he needed to round on all bathrooms to see how many lightbulbs needed to be replaced. The AMD indicated the upper window frame needed to be scraped, plastered, and painted to fix the water damage.

At 4:29 PM, in Room [redacted], the light fixture in the bathroom had one of three lights burned out. The AMD stated he needed to round on all bathrooms to see how many lightbulbs needed to be replaced. The AMD indicated the upper window

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 122	F 921		

frame needed to be scraped, plastered, and painted to fix the water damage. There was also a broken toilet paper holder, and the roll of toilet paper was on the floor in the bathroom.

At 4:30 PM, in Room [redacted], the light fixture in the bathroom had one of three lights burned out. The AMD stated he needed to round on all bathrooms to see how many lightbulbs needed to be replaced. The AMD indicated the upper window frame needed to be scraped, plastered, and painted to fix the water damage. The HKD identified the blinds were stained and needed to be replaced. He stated the water stains most likely happened when the water leaked around the upper window frame.

On 10/06/2021 at 5:10 PM, the Nursing Home Administrator (NHA) was interviewed. He stated he was aware that the facility needed some repairs, but with the two employees (the AMD and the HKD), they were not going to be able to get everything done, so he was now trying to bring in some outside contractors to assist. This surveyor asked if he was aware of the black substance growing in the [redacted] floor ice machine room, and he stated he knew about stains on the ceiling tiles, but not the black substance. He reviewed an invoice from the recent ice machine vendor that indicated "found water drip from ceiling, informed on-site maintenance about mold growth due to water drip." The invoice was dated [redacted]. The NHA stated that all invoices went straight to the corporate office, and he was not aware of the statement on the invoice, nor did maintenance inform him of the comment from the repairman. Then he added, "When did the ice machine repairman become an expert on mold? I'll have to have my own study done."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 123 The facility's policy titled, "Operations - Maintenance Logbook," dated [redacted], revealed, "The maintenance technicians are trained and required to check this kiosk at least once a day in the morning as part of their morning building rounds. Staff members are encouraged to write a request in this electronic kiosk when they see or notice something in the building that needs to be repaired or addressed by the maintenance department." New Jersey Administrative Code § 8:39-32.1(a)	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060113	A. BUILDING: _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ148720, NJ148438, NJ148225, NJ147973, NJ147766, NJ146520, and NJ145242 Census: 181 Sample Size: 40 TYPE OF SURVEY: Complaint Survey The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint Intakes #NJ146520, #NJ148438, and #NJ147973 Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined the facility failed to maintain direct care staff-to-resident ratios as mandated by New Jersey State Law. This was evident for 34 of 84	S 560	1. The facility schedules were reviewed and staffing was added to meet the minimum requirement of direct care staff to resident requirement. 2. All residents have potential to be affected by this deficient practice.	12/29/21

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

Electronically Signed | 11/02/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060113	A. BUILDING: _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 shifts reviewed. This had the potential to affect all residents. Findings included: Reference: NJDOH memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aid to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 06/20/2021 through 06/26/2021, 09/12/2021 through 09/18/2021, and 09/26/2021 through 10/09/2021, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below: 06/20/2021 - 21 CNAs for 187 residents on the	S 560	The facility schedules were reviewed and additional staff was added to meet the requirements for direct care staff to resident ratio. 3. The staff educator was educated on ensuring that adequate staffing levels are reached to comply with the NJ state requirement for direct care staff to resident ratio. 4. The administrator will audit schedules to ensure direct care staff to resident ratio requirement is met. Audits will be completed weekly x 4 weeks and monthly until compliance is met. The results of these audits will be presented at monthly QAPI. The Administrator is responsible for execution and monitoring of this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060113	A. BUILDING: _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 day shift 06/21/2021 - 16 CNAs for 187 residents on the day shift 06/22/2021 - 18 CNAs for 187 residents on the day shift 06/23/2021 - 20 CNAs for 187 residents on the day shift 06/24/2021 - 17 CNAs for 187 residents on the day shift 06/25/2021 - 19 CNAs for 190 residents on the day shift 06/26/2021 - 15 CNAs for 190 residents on the day shift 09/12/2021 - 18 CNAs for 180 residents on the day shift 09/13/2021 - 19 CNAs for 180 residents on the day shift 09/14/2021 - 17 CNAs for 180 residents on the day shift 09/15/2021 - 18 CNAs for 178 residents on the day shift 09/16/2021 - 22 CNAs for 178 residents on the day shift 09/17/2021 - 17 CNAs for 178 residents on the day shift 09/18/2021 - 17 CNAs for 178 resident son the day shift 09/26/2021 - 13 CNAs for 184 residents on the day shift 09/26/2021 - 10 direct care staff for 184 residents on the night shift 09/27/2021 - 16 CNAs for 181 residents on the day shift 09/28/2021 - 12 CNAs for 181 residents on the day shift 09/28/2021 - 11 direct care staff for 181 residents on the night shift 09/29/2021 - 14 CNAs for 181 residents on the day shift 09/29/2021 - 11 direct care staff for 181 residents	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060113	A. BUILDING: _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3	S 560		

on the night shift
09/30/2021 - 14 CNAs for 181 residents on the day shift
10/01/2021 - 17 CNAs for 180 residents on the day shift
10/01/2021 - 8 direct care staff for 180 residents on the night shift
10/02/2021 - 13 CNAs for 178 residents on the day shift
10/02/2021 - 8 direct care staff for 178 residents on the night shift
10/03/2021 - 12 CNAs for 178 residents on the day shift
10/04/2021 - 15 CNAs for 177 residents on the day shift
10/04/2021 - 12 direct care staff for 177 residents on the night shift
10/05/2021 - 14 CNAs for 177 residents on the day shift
10/06/2021 - 20 CNAs for 177 residents on the day shift
10/07/2021 - 15 CNAs for 177 residents on the day shift
10/08/2021 - 18 CNAs for 181 residents on the day shift
10/09/2021 - 17 CNAs for 181 residents on the day shift

During an interview on 10/05/2021 at 1:58 PM, the Director of Nursing (DON) stated the facility scheduled eight nurses for the 7:00 PM to 3:00 PM shift, eight nurses for the 3:00 PM to 11:00 shift, and four nurses for the 11:00 PM - 7:00 AM shift. They scheduled 21 CNAs for the 7:00 AM - 3:00 PM shift, 16 CNAs for the 3:00 PM - 11:00 PM shift and 16 CNAs for the 11:00 PM to 7:00 AM shift. Their census ranged from 175 - 182 residents, and they are accepting new admissions. On average they got 15-30 admissions each month. The DON further stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060113	A. BUILDING: _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 their census was about 180, and 60 residents to a nurse was a standard in long-term care. During an interview on 10/05/2021 at 2:31 PM, the Administrator revealed he expected 16 CNAs, eight nurses, and one supervisor for the 3:00 PM to 11:00 PM shift. He further stated they were meeting the new regulations for staffing ratios, and staff in the building could adequately cover the care. The Administrator then stated it was his responsibility if staff were not able to meet the needs of the residents.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060113 Y1	A. Building B. Wing Y2	12/13/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	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 report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/29/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON
10/6/2021

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315209 Y1	A. Building B. Wing Y2	12/13/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0580	Correction	ID Prefix F0656	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.21(b)(1)	Completed
LSC	11/05/2021	LSC	11/05/2021	LSC	11/05/2021
ID Prefix F0658	Correction	ID Prefix F0677	Correction	ID Prefix F0689	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	11/05/2021	LSC	11/05/2021	LSC	11/05/2021
ID Prefix F0725	Correction	ID Prefix F0740	Correction	ID Prefix F0758	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.40	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed
LSC	11/05/2021	LSC	11/05/2021	LSC	11/05/2021
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix F0921	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)	Completed
LSC	11/05/2021	LSC	12/29/2021	LSC	11/05/2021
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 COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/6/2021	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060113 Y1	A. Building B. Wing Y2	12/29/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	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 report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/29/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/6/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315209 Y1	A. Building B. Wing Y2	12/29/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 12/29/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/6/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			