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 06/05/2023

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

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F 000	INITIAL COMMENTS Complaint # NJ00151692, NJ00153388, NJ00157947, NJ00158216, NJ00157442, NJ00158017, and NJ00158731 Survey Date: 6/5/23 Census:186 Sample: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 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	F 550		6/21/23

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

Electronically Signed | 06/20/2023

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F 550	Continued From page 1 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. 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: Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to provide privacy and promote dignity during resident assessment. This deficient practice was identified for 1 of 1 resident (Resident #120) reviewed for dignity. This deficient practice was evidenced by the following: On 05/22/23 at 10:51 AM, the surveyor entered the [redacted] floor nurse's station and observed the Nurse Practitioner as he listened to Resident #120's [redacted] with a stethoscope as the resident stood outside of the day room in the	F 550	1.Resident #120 was evaluated by social services with no noted [redacted] from the assessment in the common area. The nurse practitioner received counseling on respect and dignity including providing a dignified environment during assessments. 2.All residents have the potential to be affected by this deficient practice. Social Work interviewed alert residents regarding privacy during physical	

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F 550	Continued From page 2 presence of other residents and staff. When interviewed at that time, the Nurse Practitioner stated that he usually assessed the resident in his/her room but the resident had a tendency to walk out of the room as he/she was a wanderer. According to the Admission Record Resident #120 was admitted to the facility with diagnosis which included but were not limited to: Ex Order 26. 4B1 [redacted]. Review of Resident #120's Quarterly Minimum Data Set (MDS), an assessment tool dated 04/28/23, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident was *Ex Order 26. 4B1* [redacted]. On 05/22/23 at 11:50 AM, the surveyor interviewed the Ex Order 26. 4B1 Floor C/D Unit Manager (UM) who stated that she observed the tail end of the Nurse Practitioner as he examined Resident #120 in front of the day room. The UM stated that resident privacy was required to be maintained at all times. The UM stated that the Nurse Practitioner should have taken the resident back to his/her room and pulled the curtain closed for privacy prior to examination. The UM stated that Resident #120 was easily redirected and pleasant. On 05/22/23 at 1:28 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the Nurse Practitioner should have taken Resident #120 back to his/her room to listen to his/her	F 550	assessments and no other resident was identified as affected by this deficient practice. 3. The facility policy was reviewed by the administrator and DON and determined to be in compliance with state and federal requirements. The staff educator will conduct education with all clinical staff on residents□ rights specifically focusing on providing a dignified environment when conducting physical assessments. 4.The director of nursing/ designee will conduct observations of assessments completed by medical professionals in the facilities specifically focusing on providing a dignified environment for physical assessments. 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. Findings of these audits will be presented at QAPI meetings monthly The administrator is responsible for execution and monitoring of this POC.	

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F 550	Continued From page 3 Ex Order 26. [redacted] because it was both a dignity and privacy issue. On 06/02/23 at 12:06 PM, the surveyor interviewed the Regional Director of Clinical Services (RDCS) in the presence of the Administrator. The RDCS stated that when the Nurse Practitioner performed an assessment on Resident #120 in the presence of other residents and staff it was a violation of both dignity and resident rights. Review of the facility policy titled, "Quality of Life/Dignity: (Revised 10/2021) revealed the following: 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 and respect at all times. NJAC 8:39 4.1(a) 12	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to provide	F 558	1. Residents #91□s room was reconfigured to allow ease of assess to her night stand by maintenance.	6/21/23

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F 558	Continued From page 4 reasonable space to allow the resident to move about the room without impairment. This deficient practice was identified for 1 of 3 residents (Resident #91) reviewed for position and mobility. This deficient practice was identified by the following: On 05/24/23 at 11:19 AM, the surveyor observed Resident #91 who self-propelled in the Ex Order 26. 4B1 with notable Ex Order 26. 4B1 . The resident reportedly was unable to access his/her night stand or get out of bed on the left side as Resident #160's bed was placed horizontally against the wall and was pushed snugly up against Resident #91's night stand. CNA #3 was present and stated that she realized that Resident #160's bed was too far over and blocked the Resident #91 access to his/her night stand but she had not reported it to maintenance. CNA #3 stated that Resident #160's bed and night stand should have pushed over so that Resident #91 had more room to get in and out of bed. On 05/25/23 at 11:32 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that Resident #91 previously mentioned to her that Resident #160's bed was placed up against the wall and impaired his/her ability to access their night stand and left side of the bed. LPN/UM #2 further stated that she believed that she let Maintenance know, but she did not log it in the Maintenance Book. LPN/UM #2 further stated that Resident #91 liked the keep their independence. On 05/25/24 at 9:40 AM, the surveyor interviewed the Maintenance Director (MD) who stated that if staff observed anything in need of repair they	F 558	C.N.A. #3 was educated to ensure that all residents have access their night stands and access to enter and exit their bed from either side. If the configuration of the room does not allow ease of access, maintenance is to be contacted to reconfigure furniture placement to accommodate both residents. 2. All residents have the potential to be affected by the deficient practice. The following actions were taken: An audit of all rooms was conducted by maintenance to ensure all rooms had furniture placement that accommodate both residents. 3. The administrator reviewed the policy on reasonable accommodations, needs/preferences and found it to be in compliance with state and federal guidelines. All staff was educated on reasonable accommodations, needs/preferences. The education will include placement of furniture to ensure residents have access to their night stand and bed and notifying maintenance if resident□s do not have access to their night stand or bed. 4. A accommodations audit sheet was developed and the maintenance director will conduct facility rounds by the to ensure compliance with resident□s access to their beds and night stands. The rounds will be performed weekly for	

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F 558	Continued From page 5 placed the request in the Log Book. The MD stated that some requests were verbal, and the work was completed and not documented. The MD did not recall receiving a request to move Resident #160's furniture to accommodate Resident #91's ability to move more freely about the room. On 05/26/23 at 11:38 AM, the surveyor observed Resident #91 lying in bed and the resident voiced that they were pleased that Resident #160's furniture were moved over so the resident was now able to access their night stand and bed more easily. On 06/02/23 at 10:38 AM, during an interview with Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS), the DON stated that staff should write concerns in the Maintenance Log in addition to calling the MD so that requests were documented for follow-up.	F 558	four weeks, followed by monthly, until full compliance is achieved. Any negative findings will be addressed immediately. Findings of the accommodation rounds will be presented at QAPI meetings monthly. Responsible Party: Maintenance Director	
F 584 SS=D	NJAC 8:39 31.1(b) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		6/21/23

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F 584	Continued From page 6 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to provide a safe, clean and homelike environment. This deficient practice was identified for 1 of 8 nursing units (Ex Order 26. 4B1) in 2 of 3 residents (Resident #45 and #160) observed for Ex Order 26. 4B1 This deficient practice was evidenced by the	F 584	1. The spackled wall behind the door in resident #160s room was sanded on 5/25/23 and painted on 5/29/2023 . A door stopper was installed to prevent further damage on 5/29/23. Resident #45s and resident #160s mattresses were replaced on 5/26/23.	

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F 584	Continued From page 7 following: 1. On 05/22/23 at 11:36 AM, the surveyor entered Resident #160's room and noted that there were two large holes in the wall behind the entry door of the room with exposed mesh. The area surrounding both holes had a thick, white coating around them which differed from the color the room was painted. The surveyor asked the resident how long the holes were there? The resident responded, "The holes have been there forever." On 05/24/23 at 9:44 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #3 who stated that the two holes behind Resident #160's door had been there for months. CNA #3 stated that she had not reported the holes herself, but maintenance already knew about it. CNA #3 stated that the holes were fixed once, though she was not sure when. CNA #3 further stated that they needed to put a door stopper on the door to prevent it from happening again. On 05/24/23 at 11:05 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that she never noticed the holes behind the entry door in Resident #160's room. LPN #1 stated that if she needed something repaired, she phoned maintenance. On 05/24/23 at 11:45 AM, the surveyor interviewed the Maintenance Director (MD) who stated that the holes in Resident #160's room were recently repaired. The MD stated that the residents always said that it has been like that for months, but he alleged that was not the case. The MD identified the thick white substance around the holes as spackle (compound used to	F 584	2. All residents have the potential to be affected by this deficient practice. The maintenance director completed an audit of all residents rooms and resident areas for walls with holes and/or spackle. Identified areas were spackled and painted. The housekeeping director completed an audit of all resident mattresses for rips and replaced any identified mattresses. 3. The Administrator, Maintenance Director, and housekeeping Director reviewed the policy on safe/ clean/ homelike environment determined the facility to be compliance with state and federal guidelines. The staff educator inserviced all staff including Maintenance staff on ensuring that residents have a safe, clean, and homelike environment specifically focusing on: ensuring all residents walls are free of holes and/or spackle marks, and all residents have a mattress that is free of rips and tears. Staff was educated to report any identified item to maintenance. A copy of the lesson plan and attendance will be filed for reference and validation. 4. The Maintenance Director developed an audit sheet for observations during environmental rounds. The audit sheet will monitor resident□s rooms for holes and	

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F 584	Continued From page 8 fill cracks). He further stated that the spackle indicated that the holes were repaired recently. The MD was unable to state when the holes were filled and spackled or when he planned to paint the area. On 05/24/23 at 12:39 PM, the surveyor interviewed the MD who stated that he completed walking rounds of the nursing units to ensure that every room in the facility was observed within the month. The MD stated that either staff completed a request in the maintenance log or maintenance noted items that needed repair during rounds. The MD stated that the spackling was done recently, though he was unable to provide the exact date and time. He stated that normally he let the spackle dry for a couple of days, then he sanded and painted. The MD stated that he did "random tackling" to get the work done and did not have an itinerary in place or documented evidence of completion. The surveyor asked the MD how he ensured that projects were completed? He acknowledged that he did not systematically track work orders and stated, "I am going to start doing that." The MD stated that he made notes for himself, but discarded them when finished. The MD provided the surveyor with work orders that were completed on the nursing unit for March and April 2023 which did not contain a request to repair the holes in the resident's wall. On 05/25/23 at 11:32 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that she was not aware that there were holes in the wall in Resident #160's room. LPN/UM #2 stated that she would have called maintenance to follow-up if she had known.	F 584	spackle marks. Identified areas will have a work order completed and a repair will be completed within 1 week of identification. Audits will be completed y by the Director of Maintenance/ designee x weekly x 4 weeks, and monthly until compliance is met. The Housekeeping Director developed an audit sheet for observations during environmental rounds. The audit sheet will monitor resident□s mattresses for rips and tears. Identified mattresses will have a replace mattress placed. The results of these audits will be presented at monthly QAPI. The Administrator is responsible for the execution and monitoring of this plan of correction.	

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F 584	Continued From page 9 On 05/25/23 at 12:34 PM, the surveyor interviewed the Administrator who stated that there were a number of special projects that were completed throughout the building such as spackling and painting. He stated that once an area was spackled it should have been painted within a week. 2. On 05/24/23 at 10:00 AM, the surveyor accompanied Certified Nursing Assistant (CNA) #3 as she provided *Ex Order 26. 4B1* to Resident #45 whose *Ex Order 26. 4B1* were saturated with *Ex Order 26.* [redacted]. When CNA #3 removed the sheets from the resident's bed the surveyor noted that there were holes and rips in the resident's mattress. CNA #3 proceeded to clean the mattress which glistened from *Ex Order 26. 4B1* [redacted]. When interviewed at that time CNA #3 stated, "They will place another resident in this same bed when the resident leaves." According to the Admission Record (an admission summary) Resident #45 was admitted to the facility with diagnosis which included, but were not limited to: *Ex Order 26. 4B1* [redacted]. On 05/24/23 at 11:26 AM, the surveyor accompanied CNA #3 to Resident #160's room to perform AM care. The resident's clothing and linens were saturated with *Ex Order 26.* [redacted]. CNA #3 removed the *Ex Order 26. 4B* [redacted] linens from the resident's bed and the surveyor noted both cracks and rips in the mattress. When the surveyor asked CNA #3 if	F 584		

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F 584	Continued From page 10 she reported the condition of the mattresses and she stated that she had not reported it to maintenance. According to the Admission Record, Resident #160 was admitted to the facility with diagnosis that included but were not limited to: Ex Order 26. 4B1 [redacted]. On 05/24/23 at 11:45 AM, the surveyor interviewed the MD and his assistant regarding the condition of Resident #45 and Resident #160's mattresses. The assistant stated that it was an "issue" if Ex Order 26. 4B1 seeped into the rips, tears, and holes in the mattress. The MD was unable to provide the surveyor with documented evidence that the mattresses were routinely inspected. Review of the Maintenance Log for the nursing unit failed to contain documented evidence that the nursing staff reported the condition of either resident's mattresses to maintenance or administration to be assessed for replacement. On 05/25/23 at 10:59 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that she had noted cracks and rips in the resident's mattresses and stated that if Ex Order 26. [redacted] seeped into the mattress it could cause both mold and infection. On 05/25/23 at 11:15 AM, the surveyor and Licensed Practical Nurse/Unit Manager (LPN/UM) #2 entered Resident #45's room to assess the condition of the resident's mattress and found the room unoccupied. LPN/UM #2 stated that it did not look like the resident had received	F 584		

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F 584	Continued From page 11 *Ex Order 26. 4B1* since last night as the linens were heavily *Ex Order 26. 4B* with a *Ex Order 26. 4B1*. LPN/UM #2 removed the resident's sheets from the bed to assess the mattress. LPN/UM #2 stated if the mattress was ripped and *Ex Order 26. 4B1* with *Ex Order 26.* it could cause mold and bacteria and that was an infection control issue. On 05/25/23 at 12:15 PM, the surveyor interviewed the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) regarding the outcome of the *Ex Order 26. 4B1* and the condition of both Resident #45 and Resident #160's mattress. The RDCS who stated that she served as a consultant to the facility for infection control related issues and was CIC *Ex Order 26. 4B1* certified, stated that if *Ex Order 26. 4B1* seeped into the cracks, rips, or tears in the mattress it would an infection control issue. NJAC 8:39 19.4, 31.4(a)(b)(e)(f), 4.1(a)	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Annual Minimum Data Set (MDS), an assessment tool for 3 of 4 residents (Resident #169, Resident #87, and Resident #45) reviewed for smoking.	F 641	1. Residents #169, #87 and #45 are not known to have been negatively affected by the deficient practice. The Minimum Data Set for each resident were modified to reflect the accurate smoking status. In addition, resident #87 s Minimum Data Set was also modified to reflect the	6/21/23

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	315209	A. BUILDING _____ B. WING _____	C 06/05/2023

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F 641	Continued From page 12 This deficient practice was evidenced by the following: 1. On 05/17/2023 at 11:01 AM, during the initial tour of the facility Resident #169 was observed ambulating in the hallway towards the room. The resident told the surveyor they were just on a "smoke break". Review of the Admission Record indicated that Resident #169 was admitted to the facility on Ex Order 26. 4B1. Medical diagnoses included, but not limited to *Ex Order 26. 4B1* [redacted]. Review of the Admission MDS, dated NJ Exec. Order 26:4.b.1 showed the resident had a Brief Interview of Mental Status of [redacted], meaning the resident had *Ex Order 26. 4B1* [redacted]. On 05/22/2023 at 11:00 AM, the surveyor reviewed Resident #169 Admission Assessment, dated 03/03/2023 which indicated the resident was a smoker and was assessed as a safe smoker, meaning a smoking apron was not needed during smoking. On 05/22/2023 at 11:30 AM, the surveyor reviewed Resident #169 care plan, initiated 03/06/2023. The care plan had a focus stating the resident was a smoker. Goals included remaining free from injury related to smoking, and interventions included education on benefits of smoking cessation and smoking rules and policies, and that the resident would be assessed regularly for smoking safety.	F 641	resident has a level II Preadmission Screening and Resident Review. 2. All residents have the potential to be affected by the deficient practice. The following actions were and will be taken: An audit was completed of all residents who are smokers to ensure the residents smoking status on the Minimum Data Set is accurately reflected. Identified discrepancies had the Minimum Data Set modified. 3. The Administrator and Minimum Data Set Coordinator reviewed the policy on MDS assessments and found it to be in compliance with state and federal guidelines. All nursing staff that complete Minimum Data Set will be educated by the staff educator on accuracy of all MDS assessments. 4. An audit tool was created to monitor the accuracy of the submitted Minimum Data Set. The administrator/ designee will complete audits of 10% of all resident Minimum Data Set will be completed weekly x 4 weeks and then monthly until compliance is met. Findings of these audits will be presented at QAPI meetings monthly The Administrator is responsible for the execution and monitoring of this plan of	

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F 641	Continued From page 13 On 05/22/2023 at 11:38 AM, the surveyor reviewed Resident #169 Admission Minimum Data Set (MDS), an assessment tool dated [redacted]. Under Section J titled Health Conditions, number J1300 for Current Tobacco Use was entered as zero, meaning no current tobacco use. On 05/25/2023 at 09:59 AM, the surveyor interviewed the Minimum Data Set Coordinator (MDSC). The surveyor asked the MDSC what sections of the MDS were completed by which facility staff and the MDSC said, "I do sections A and B, the social worker does C and D, Section F is completed by the Activities Department, GG is completed by me along with the Interdisciplinary Team and K was completed by the dietician". The surveyor asked who was responsible for section J, the Health conditions section of the MDS and she responded, "I do that section". The surveyor asked how she is made aware when the resident is a smoker and the MDSC said it was in the Admission Assessment that was completed by the nursing Supervisor, or she asks the activities department or social services. The surveyor then asked the MDSC to look at section J of the Admission MDS for Resident #169 and she responded, "Oh, that resident is a smoker". 2. The surveyor reviewed the Admission Record for Resident #87 which reflected that the resident was admitted on [redacted] with diagnoses that included *Ex Order 26. 4B1* [redacted]. On 05/24/2023 at 09:59 AM, the surveyor observed Resident #87 smoking in the	F 641	correction.	

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F 641	Continued From page 14 designated Ex Order 26. 4B1 floor smoking area. The surveyor reviewed Resident #87's Annual MDS dated 01/23/2023. The section J1300 for current tobacco use was coded as zero (0), indicating that Resident #87 does not currently use tobacco. The MDS Coordinator was interviewed on 06/02/2023 at 11:25 AM and confirmed that Resident #87's Annual MDS dated 01/23/2023 should have been coded as a 1 to indicate Resident #87 was a yes for tobacco use. Further review of the Annual MDS dated 01/23/2023 revealed that Section Ex Order 26. 4B1 under *Ex Order 26. 4B1* was coded as Ex Order 26. 4B1 but should have been coded as a [redacted] to indicate Ex Order that Resident #87 had been evaluated by *Ex Order 26. 4B1* and was determined to have a *Ex Order 26. 4B1* and/or *Ex Order 26. 4B1* or a related condition. The MDS Coordinator was interviewed on 06/02/2023 at 11:25 AM and confirmed that Resident #87's *Ex Order 26. 4B1* dated 01/23/2023 should have been coded as a [redacted] to indicate Resident #87 was evaluated and equated it to human error. On 06/06/23 at 11:20 AM, the surveyor reviewed the policy titled, "Smoking Program", dated 06/2022. Under the procedure section, number three it indicated that a smoking evaluation will be completed in the Electronic Health Record on admission/readmission, quarterly, annually, smoking contract violation and or change in smoking status or privileges. Section 3 (e) indicated that a dated current list of residents who	F 641		

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F 641	Continued From page 15 smoke will be maintained by Social Services and distributed to the Interdisciplinary Team. 3. On 05/25/23 at 10:00 AM, the surveyor reviewed Resident #45 smoking assessment which indicated that Resident #45 was safe to smoke at the facility. The surveyor then reviewed Resident #45 annual Minimum Data Set (MDS), dated 8/18/22. Under section J, titled tobacco use was marked as "zero", meaning the resident was not a smoker. On 05/25/23 at 10:09 AM, the surveyor interviewed the MDS Coordinator. The MDS coordinator reviewed the MDS, and she stated, "If I got it wrong, I know why, this was my first quarterly doing it, and I must have missed it". The MDS coordinator stated, "Next quarter, I would double check with activities".	F 641		
F 658 SS=D	NJAC 8:39-11.2 (e)1 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, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to implement a physician's order for an NJ Exec. Order 26:4.b.1 [redacted] The deficient practice was identified for 1 of 3	F 658	1. The physician for Resident #67 gave the order for the wearing of the Ex Order 26. 4B1 [redacted]. Resident #67 was evaluated by Ex Order 26. 4B1 [redacted] and did not suffer any ill affect from this omission of the physicians order.	6/21/23

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F 658	Continued From page 16 residents (Resident #67) reviewed for positioning and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." According to the Admission Record, Resident #67 was admitted with diagnosis that included, but were not limited to, *Ex Order 26. 4B1* [redacted]. A review of Resident #67's admission Minimum Data Set an assessment tool dated [redacted] revealed that he/she was *Ex Order 26. 4B1* and has range of *Ex Order 26. 4B1* of *Ex Order 26. 4B1* of the	F 658	Resident #67 has subsequently been discharged from the facility. 2. All residents with [redacted] have the potential to be affected by this deficient practice. Physical therapy completed an audit of all residents with [redacted] to ensure there are orders in place for the devices. Any identified residents had orders placed. 3. The facility policy on *Ex Order 26. 4B1* [redacted] was reviewed by the administrator and director of rehabilitation and determined to be in compliance with state and federal requirements. Licensed nurses and physical therapists will be educated on professional standards with emphasis on obtaining a physician□s order for *Ex Order 26. 4B1*. A lesson plan and attendance record will be kept on file for validation. 4. The Director of Rehabilitation/ designee will audit residents with [redacted] devices and a corresponding physician□s order is in place. 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.	

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F 658	Continued From page 17 [redacted].	F 658	Findings of these audits will be presented at QAPI meetings monthly The Director of Rehabilitation is responsible for the execution and monitoring of the plan of correction.	
	On 05/17/2023 at 12:09 PM, the surveyor observed Resident #67 in bed with his/her computer. Also observed [redacted] in his/her room. Resident #67 stated the staff assist him/her with putting [redacted] on daily. On 5/22/2023 at 1:43 PM, the surveyor observed Resident #67 wearing a [redacted] on his/her [redacted]. Upon review of Resident #67's Physician's Order (PO), the surveyor could not find a PO for the [redacted]. On 05/24/2023 at 12:17 PM, the surveyor interviewed the Director of Nursing (DON) and the Regional Director of Clinical Services. (RDCS) The DON stated there should be an order but not one that has to be signed out. The RDCS stated she cannot find a PO but further confirmed there should a physician's order. A review of the facility policy "Physician Orders" with a revised date of 02/20/2020 reveals physician orders will include a correlating medical diagnosis or reason.			
F 677 SS=F	NJAC:8:3927.1 (a) 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;	F 677		6/21/23

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F 677	Continued From page 18 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00157442, NJ00153388 Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility failed to ensure that Ex Order 26. 4B1 was provided to dependent residents in a timely manner. This deficient practice was identified for 4 of 9 residents (Resident #45, #160, #155 and #72) observed for Ex Order 26. 4B1 on 2 of 3 units ([redacted] Floor [redacted] and [redacted] Floor [redacted]) observed for incontinence [redacted] This deficient practice was evidenced by the following: Refer to F725 1. During the initial tour of the facility on 05/17/23 at 9:42 AM, the surveyors noted a strong smell of [redacted] that permeated the air on the [redacted] floor of the facility in the hallway beyond the main entrance to the facility that led to the [redacted] floor nursing units. On 05/24/23 at 9:02 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #3 who stated that she was assigned to 13 residents. CNA #3 stated that she had to pass breakfast trays before she performed AM care for several more residents who were all Ex Order 26. 4B1 and dependent on staff for care. At 09:44 AM, CNA #3 delivered a meal tray to the room of Resident #45 who was lying in bed and wore a [redacted]. The resident sat up on the side of	F 677	1. Resident #45, #160, #155 and #72 had Ex Order 26. 4B1 performed. NJ Exec. Order 26:4.b.1 were completed on Resident #45, #160, #155 and #72 and no new Ex Order 26. 4B1 were identified. 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 Ex Order 26. 4B1 . All residents had NJ Exec. Order 26:4.b.1 and there were no identified new [redacted] . Review of antibiotic administration did not reveal any new infections related to failing to provide Ex Order 26. 4B1 . . 3. The facility policy on ADL care was reviewed by the facility administrator and Director of nursing and the policy was determined to be in compliance with state and federal guidelines. The staff educator/ designee conducted an in-service with all nursing staff on ADL care provided for dependent residents specifically focusing on providing timely Ex Order 26. 4B1 .	

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F 677	Continued From page 19 the bed to eat breakfast and the surveyor noted that the resident's sheets were saturated with [redacted]. CNA #3 stated that the resident's sheets were always saturated when she did care in the AM. The surveyor interviewed the resident who stated that he/she was last changed at approximately 4:00 AM. The resident sat up and ate breakfast on the side of the bed in a [redacted] on top of wet sheets while CNA #3 began to collect meal trays on the nursing unit. At 10:00 AM, CNA #3 returned to Resident #45's room to do AM care with resident permission. The resident was assisted out of the bed and into a wheelchair. The resident's bed was saturated and the room smelled of [redacted]. The resident wore a photo identification that was attached to a lanyard around the resident's neck. CNA #3 asked the resident to remove the lanyard and informed the resident that the plastic identification holder and photo were *Ex Order 26. 4B1* [redacted]. The surveyor observed that the resident's identification was covered with a *Ex Order 26. 4B1* [redacted] and a *Ex Order 26. 4B1* [redacted] was present beneath the plastic cover that held the identification. CNA #3 stated that the resident's NJ Exec. Order 26:4.b.1 [redacted]. The surveyor asked the resident how he/she felt about delayed *Ex Order 26. 4B1* [redacted] and the resident stated, "There was nothing that they can do about it". CNA #3 proceeded to obtain disinfectant cleaner from Housekeeping and wiped down the resident's [redacted] soaked mattress which had rips and tears. According to the Admission Record (an admission summary) Resident #45 was admitted to the facility with diagnosis which included, but were not limited to: *Ex Order 26. 4B1* [redacted]	F 677	4. The Director of Nursing/ Designee will complete weekly audits of 100% of all NJ Exec. Order 26:4.b.1 [redacted] residents to ensure that NJ Exec. Order 26:4.b.1 [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 monthly QAPI. The Director of Nursing is responsible for the execution and monitoring of this plan of correction.	

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F 677	Continued From page 20	F 677		

and Ex Order 26. 4B1 [redacted].

Review of Resident #45's Quarterly Minimum Data Set (MDS), an assessment tool dated 05/07/23, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident was Ex Order 26. 4B1 [redacted] and had no documented instances of rejection of care. Further review of the MDS indicated that the resident required NJ Exec. Order 26:4.b.1 [redacted] nd was occasionally Ex Order 26. 4B1 [redacted].

At 10:51 AM, CNA #3 stated that she planned to take a 15 minute break and would resume AM care when she returned.

At 11:23 AM, CNA #3 entered the room of Resident #160 to do AM care with resident's permission. The resident was assisted to sit up on the side of the bed. The resident wore a white hoody and the back of the hoody was [redacted] and was stained with a Ex Order 26. 4B1 [redacted] to the level of the resident's Ex Order 26. 4B1 [redacted]. The resident's bed was Ex Order 26. 4B1 [redacted]. When interviewed at that time, Resident #160 was unable to state what time he/she was changed last. CNA #3 assisted the resident into the bathroom to get washed. CNA #3 then proceeded to strip Resident #160's bed and sprayed the mattress which had rips and tears with disinfectant cleaner.

According to the Admission Record Resident #160 was admitted to the facility with diagnosis that included but were not limited to: difficulty [redacted]

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F 677	Continued From page 21 Ex Order 26. 4B1 [redacted].	F 677		

Review of Resident #160's Ex Order 26. 4B1 dated 04/17/23, revealed that the resident had a BIMS score of [redacted] out of 15, which indicated that the resident was Ex Order 26. 4B1 and had no documented instances of rejection of care. Further review of the MDS indicated that the resident required NJ Exec. Order 26:4.b.1 [redacted] and was occasionally Ex Order 26. 4B1 [redacted].

At 11:59 AM, CNA #3 entered Resident #155's room to perform AM care with resident's permission. CNA #3 stated that there were no sheets on the bed and she did not know where they were. CNA #3 stated that the resident's [redacted] was [redacted] with [redacted] since this AM, but she had other resident's to care for. CNA #3 removed the resident's [redacted] and stated that his/her [redacted] was [redacted] CNA #3 stated that she found the resident lying under a fitted sheet this AM and the resident had no blankets. CNA #3 proceeded to open the night stand and found a fitted sheet that was soiled with Ex Order 26. 4B1 and was [redacted] according to CNA #3.

According to Resident #155's Admission Record, the resident was admitted to the facility with diagnosis that included, but were not limited to: Ex Order 26. 4B1 [redacted].

Review of Resident #155's Quarterly MDS dated 04/14/23, revealed that the resident had a BIMS

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F 677	Continued From page 22	F 677		

score of [redacted] out of 15, which indicated that the resident was *Ex Order 26. 4B1* and had no documented instances of refusal of care. Further review of the MDS indicated that the resident required NJ Exec. Order 26:4.b.1 and was frequently *Ex Order 26. 4B1* .

At 12:06 PM, CNA #3 stated that when she arrived to work this AM, the night shift CNA informed her that everyone was dry.

On 05/25/23 at 10:59 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that she noted that the residents on her assignment were *Ex Order 26. 4B1* and were not being changed as they should be. LPN #1 stated that the aides on day shift let her know that the residents were saturated about one week ago. LPN #1 stated that she informed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 of her concern that the residents on her assigned unit were overly saturated with [redacted].

On 05/25/23 at 11:10 AM, the surveyor interviewed LPN/UM #2 who stated that she had worked at the facility since January 2023. LPN/UM #2 stated that no one had brought it to her attention that there were concerns with *Ex Order 26. 4B1* care on her assigned nursing units ([redacted] and [redacted]).

On 05/25/23 at 11:15 AM, the surveyor requested that LPN/UM #2 come to Resident #45's room. Upon entry to the room, the resident was not in the room at the time and the resident's bed sheets were noted to be soaked and covered in a *Ex Order 26. 4B1* . LPN/UM #2 stated that it

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F 677	Continued From page 23 appeared the resident had not received Ex Order 26. 4B1 since last night. LPN/UM #3 then proceeded to open the resident's night stand where the resident's photo identification/lanyard was kept at the resident's request. LPN #2 stated that the plastic that covered the identification contained mold and was stained yellow from being wet with Ex Order 26.. LPN/UM #2 stated that the CNA #3 had 14 residents yesterday and was required to have eight on day shift according to staffing mandate. LPN/UM #2 stated that staffing was not as adequate as it should be. On 05/25/23 at 12:04 PM, the surveyor interviewed the Administrator in the presence of another surveyor regarding the heavy smell of Ex Order 26. that permeated the Ex Order floor of the facility. The Administrator attributed the odor to Resident #45 who often sat in his/her wheelchair at the entrance to the facility. The surveyor observed that the resident was not present when the odor was detected. The surveyor asked why the resident smelled so heavily of Ex Order 26. 4B1 The DON who was present at that time stated that it meant that the resident was Ex Order. The Regional Director of Clinical Services (RDCS) who was also present stated that if everyone was Ex Order during the Ex Order 26. 4B1 tour, there were not enough nurses and aides to help the residents in a way that was manageable. Both the Administrator and the DON stated that it was not acceptable for residents bed sheets to be permeated with Ex Order 26. 4B1. 2. On 5/24/23 at 8:55 AM, the surveyor accompanied by the Certified Nursing Assistant (CNA) completed an Ex Order 26. 4B1 tour on the Ex Order 26. Floor Ex O Unit. Three random residents who were identified by the CNA as being NJ Exec. Order 26:4.b.1	F 677		

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F 677	Continued From page 24 on staff for care, were observed for Ex Order 26. 4B1 . Resident #72 was observed in bed with a black shirt on that was not a pajama top. Resident #72 was asked by the CNA if she could check the Ex Order 26. 4B1 and the resident agreed. Resident #72 was wearing an Ex Order 26. 4B1 which was completely saturated with Ex Order 26. The draw sheet and fitted sheet positioned under the resident were visibly soiled and discolored. When interviewed at that time, the CNA stated that when she came into work the residents including Resident# 72 were saturated. The CNA stated that she then must give the resident full care which included changing the sheets and giving a complete shower or bed bath. According to the Admission Record, Resident #72 had diagnoses that included, but were not limited to: Ex Order 26. 4B1 . Review of Resident #72's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 04/18/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident was Ex Order 26. 4B1 . The MDS further revealed that Resident #72 was Ex Order 26. 4B1 and required NJ Exec. Order 26:4.b.1 . On 05/25/2023 at 12:13 PM, the surveyors interviewed the Director of Nursing (DON), the Licensed Nursing Home Administrator, and the Regional Director of Clinical Services. The DON stated it was not acceptable to have a resident's brief, clothes, and bedding Ex Order 26. soaked.	F 677		

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F 677	Continued From page 25 On 05/25/2023 at 1:20 PM, the surveyor interviewed the Ex Order 26. Floor C/D Unit Nurse Manager. When told about the Ex Order 26. 4B1 rounds completed on 05/24/2023, she stated that Resident # 72 must not have received care on the 11 to 7 shifts and rounds were not done. She furthered that was not acceptable for the residents to be like that. Review of the facility's "Quality of Life/Dignity Policy" (revised 10/21) indicated the following: ...Demeaning practices and standards of care the compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: ...Promptly responding to the resident's request for toileting assistance; and other needs. Review of the facility's "ADL-Personal Hygiene" policy revised 10/21 indicated Ex Order 26. 4B1 for a resident will be provided as needed for each idividual per care plan and kardex.	F 677		
F 686 SS=D	NJAC 8:39-27.1 (a), 27.2 (h) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Ex Order 26. 4B1. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent Ex Order 26. 4B1 and does not develop Ex Order 26. 4B1 unless the individual's clinical condition	F 686		6/21/23

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F 686	Continued From page 26 demonstrates that they were unavoidable; and (ii) A resident with NJ Exec. Order 26:4.b.1 receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new Ex Order 26. 4B from developing. This REQUIREMENT is not met as evidenced by: NJ#00158216, NJ#00157947, NJ#00158017, and NJ#00158731 Based on interview, and record review it was determined that the facility failed 1.) to clarify a physician's order for Ex Order 26. 4B1 consistent with professional standards of practice to promote Ex Order 26. 4B1 for Resident #284 and 2.) to follow an active physician's order for the daily Ex Order 26. 4B1 treatment for Resident #103. This deficient practice was identified for 2 of 3 residents reviewed for Ex Order 26. 4B1 (Resident #284 and Resident #103), and was evidenced by the following: 1. Resident #284 was admitted to the facility and had diagnoses which included, but was not limited to Ex Order 26. 4B1 A review of the order Summary Report with active orders as of 9/5/22 reflects a physician order (PO) dated 9/5/22 for Ex Order 26. 4B1 apply to per additional directions topically everyday shift for Ex Order 26. 4B1. There is no location specified. A review of the Ex Order 26. 4B1 reflects that the resident is receiving the Ex Order 26. 4B1	F 686	1. Resident #284 and resident #103 are currently discharged from the facility. 2. All residents with Ex Order 26. 4B1 have the potential to be affected by this deficient practice. All residents with NJ Exec. Order 26:4.b.1 had their treatment orders reviewed for specific location of the Ex Order 26. 4B1 noted in the physician's order. Identified deficient practice was immediately corrected. All residents with treatment orders had their treatment administration record reviewed for 30 days. No other resident was identified with any missing documentation on NJ Exec. Order 26:4.b.1. 3. The policy on NJ Exec. Ord Management, Physicians orders, and was evaluated by administration and determined to be in compliance with state and federal guidelines. The Staff Educator/ designee educated all nursing staff on treatment and services to prevent and/or heal Ex Order 26. 4B1 specifically focusing on placing an order with a specific site in the order and completing assigned treatments.	

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F 686	Continued From page 27 Ex Order 26 however there is no location specified. A review of the location of Ex Order 26. 4B1 reflects the location of administration for the Ex Order 26. 4B1 as "other". On 05/30/23 at 2:31 PM, the surveyor interviewed the 3 to 11 Registered Nurse Supervisor. She stated she did the admission evaluation dated NJ Exec. Order 26. It reflected that Resident #284 had a Ex Order 26. 4B1 to his/her Ex Order 26. 4B1 . She thinks the Ex Order 26. 4B was for the Ex Order 26. 4B1 but can't be certain. She stated the order for Ex Order 26. 4B should have a location on it. On 05/31/23at 02:56 PM, the surveyor reviewed the Comprehensive Care Path Assessment dated Ex Order 26. 4B which reflected that Resident #284 was admitted with Ex Order 26. 4B1 . It also reflected that Resident #284 was admitted with a Ex Order 26. 4B1 with Ex Order 26. 4 in progress to Ex Order 26. 4B1 . At that time the surveyor interviewed the 3 to 11 Registered Nurse who stated that the NJ Exec. Order 26:4.b.1 should specify a location. McCrayreid, Andrea 2. Resident #103 was admitted to the facility and had a diagnosis that included Ex Order 26. 4B1 [redacted]	F 686	A lesson plan and attendance record will be kept on file for validation. 4. The Director of Nursing/ designee will audit 20% of all NJ Exec. Order 26:4.b.1 to ensure the order has a specific NJ Exec. Order 26:4.b.1 noted. The audits will be conducted weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at monthly QAPI. The Director of Nursing/ designee will audit 20% of all NJ Exec. Order 26:4.b.1 to ensure the treatments have been completed. The audits will be conducted weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at monthly QAPI. The Director of Nursing is responsible for execution and monitoring of this POC.	

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Ex Order 26

On 5/23/2023 at 11:33 AM, the surveyor reviewed the physician-signed Physician's Order Form which included a physician's order to apply treatment daily to the Ex Order 26. 4B1 per Medical Doctor (MD) order to NJ Exec. Order 26:4.b.1 of Ex Order 26. 4B1 and document progress of the Ex Order 26. 4B1 on an ongoing basis.

Review of the Minimum Data Set (MDS), an assessment tool dated 05/06/2023 showed the resident had a Brief Interview of Mental Status (BIMS) of Ex Ord, meaning the resident was Ex Order 26. 4B1 and NJ Exec. Order 26:4.b.1 for Ex Order 26. 4B1 .

On 05/31/2023 at 10:15 AM, the surveyor observed Resident #103 sitting in the room listening to music. When interviewed at that time, the resident informed the surveyor that there was one staff member that consistently changed his/her Ex Order 26. 4B1, but there were times when that nurse was out and the other nurses did not complete the Ex Order 26. 4B1 . The resident could not recall specific dates but did refer to Ex Order 26. 4B1 .

At that same date and time, a review of the Ex Order 26. 4B1 reflected that the resident received the Ex Order 26. 4B1 for the month of Ex Order 26. 4B1 , however there were two dates on Ex Order 26. 4B1 , that were blank to confirm no treatment was completed on those 2 days.

A review of the Progress notes (PN) dated 09/12/2022, revealed the Social Worker (SW)

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F 686	Continued From page 29 saw the resident per resident's request. Resident had filed a grievance about his/her care. SW spoke with clinical team and wrote up two grievances. On 5/31/2023 at 02:01 PM, the surveyor interviewed the SW who stated it was not the SW who wrote the PN but was aware of Resident #103. The current SW stated they was not aware of any concerns regarding his/her care at this time and was not made aware of any outstanding grievances for Resident #103 when the SW started at the facility in [redacted], so SW could not speak to that and was unable to provide any grievances to reflect Resident's #103 concern of care during that time. A review of the facility policy titled "Physician Orders" revised on 2/2020 reflects that medication orders should be followed and will include name of drug, route, dosage, frequency, diagnosis, and stop date if appropriate.	F 686		
F 688 SS=D	NJAC 8:39 - 27.1 (a) Increase/Prevent Decrease in [redacted] CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without [redacted] does not experience reduction in [redacted] unless the resident's clinical condition demonstrates that a reduction in [redacted] is unavoidable; and §483.25(c)(2) A resident with limited [redacted]	F 688		6/21/23

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F 688	Continued From page 30 [redacted] receives appropriate treatment and services to increase [redacted] and/or to prevent further decrease in [redacted]. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interview, review of medical records and other facility documentation, it was determined that the facility failed to ensure that a resident with decreased [redacted] and mobility received prescribed treatments to prevent [redacted] and maintain current level of function for 1 of 3 residents reviewed for decreased ROM (Resident #91). This deficient practice was evidenced by the following: During the initial tour of the facility on 05/17/23 at 11:20 AM, Resident #91 was observed self-propelling in the wheelchair with notable [redacted]. The resident motioned the surveyor into his/her room and showed the surveyor a [redacted] that was on the window sill and was reportedly not offered to the resident for assistance with application. According to the Admission Record, Resident #91 was admitted to the facility with diagnosis which included, but were not limited to: [redacted]	F 688	1. Resident #91 had [redacted] placed. Rehab evaluated the resident with no decline in [redacted] noted. Resident #91 had the task updated to ensure the certified nursing aid receives the instruction to apply the [redacted] daily. Certified nursing aid #3 received education on ensuring the resident receives assistance with applying and removing the [redacted] daily. 2. All residents with [redacted] have the potential to be affect by this deficient practice. All residents with [redacted] orders were evaluated to ensure [redacted] were in place and instructions were on the CNA task for resident care. Negative findings were immediately corrected. 3.The facility policy on Appliances-appliances, [redacted] was reviewed by the Director of Nursing and	

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F 688	Continued From page 31 Ex Order 26. 4B1 [redacted]. Review of Resident #91's Admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out 15 which indicated that the resident was Ex Order 26. 4B1 [redacted]. Further review of the MDS indicated that the resident required NJ Exec. Order 26:4.b.1 [redacted] and had Ex Order 26. 4B1 on one side of the body in Ex Order 26. 4B1 [redacted]. Review of the Physician's Orders that were contained within Resident #91's electronic health record (EHR) revealed an order that was placed on 04/13/23 for Patient to wear a Ex Order 26. 4B1 [redacted] NJ Exec. Order 26:4.b.1 a day. The surveyor reviewed both the Treatment Administration Record (TAR) and the Medications Administration Record (MAR) and the order was not found in either document to indicate staff accountability for Ex Order 26. 4B1 application as ordered. Review of Resident #91's Care Plan revealed that there were no goals or interventions related to a Ex Order 26. 4B1 application. On 05/22/2023 at 11:36 AM, the Resident #91's Ex Order 26. 4B1 was observed on the window sill. On 05/24/2023 at 11:19 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #3	F 688	determined to be in compliance with state and federal guidelines. The Staff Educator/ designee educated all nursing staff and physical therapy staff on residents with NJ Exec. Order 26:4.b.1 should receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. The inservice included specific focus on application of [redacted] and ensuring the doctor□s order is transcribed to the C.N.A. task for rsident care. A lesson plan and attendance record will be kept on file for validation. 4. The Director of Nursing/ designee will audit 5 residents with Ex Order 26. 4B1 to ensure the MD order is transcribed to the task and the [redacted] are applied as per MD order and C.N.A. task. Audits will be completed on different residents weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be submitted at the facilities monthly QAPI meeting. The Director of Nursing is responsible for the execution and monitoring of this POC.	

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who stated that Resident #91 was [redacted] with care and she only assisted the resdient to [redacted]

On 05/24/2023 at 11:05 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that the resident did not have any [redacted] ordered, only [redacted].

On 05/24/2023 at 11:14 AM, the surveyor observed Resident #91 self-propelling in the wheelchair in the hallway and the resident did not have his/her [redacted] on.

On 05/25/2023 at 11:32 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that she believed that Resident #91 had a [redacted], but would have to clarify. LPN/UM #2 looked in the computer and stated that it looked like an order was placed by [redacted] on 04/13/2023 for a [redacted] to be worn [redacted] a day as tolerated. LPN/UM #2 stated that the order should have been placed under scheduling details, but that was not completed so the order did not appear on the MAR/TAR for nursing to assist the resident with [redacted]. LPN/UM #2 stated that [redacted] also came to the unit and provided staff education on [redacted] usage.

On 05/26/2023 at 10:01 AM, the surveyor interviewed the [redacted] who stated that best practice was to make a recommendation via a triplicate form for the Unit Manager (UM). At that point, the UM wrote the order for the [redacted] and updated the care plan to include [redacted] usage. The [redacted] stated that the OT probably placed

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the order in the EHR incorrectly and did not enter scheduling details. She explained that either nursing or the aides could place the [redacted] on the resident. The [redacted] confirmed that on [redacted] a [redacted] was completed with the staff who were educated on [redacted] use and indicated that Resident #91 would tolerate [redacted] on [redacted] for a minimum of [redacted] daily with nursing encouragement. She stated that either nursing or the aides could apply the [redacted] and nursing did daily [redacted].

In a later interview with the DOR/SLP on 05/26/23 at 10:50 AM, she stated that the purpose of the [redacted] was to decrease the risk of [redacted] who was present at that time, explained that the [redacted] decreased [redacted] and maintained the resident's [redacted]. The [redacted] stated that [redacted] placed orders in the [redacted], but they did not schedule them and that was why management follow-up was needed. The [redacted] further explained that Resident #91 needed the [redacted] solely to [redacted] level of function as the resident was not at risk for [redacted].

On 05/26/23 at 11:38 AM, Resident #91 was observed lying in bed awake. The resident stated that he/she did not have their [redacted] on and stated that it was in the bottom drawer across the room. The surveyor confirmed that the [redacted] was in the drawer and out of the resident's reach.

On 05/26/23 at 11:54 AM, the surveyor interviewed CNA #1 who stated that the resident was only [redacted] and did not use a

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HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

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F 688	Continued From page 34	F 688		

Ex Order 26. 4B1 on their hand.

On 05/26/23 at 12:02 PM, the surveyor interviewed LPN #1 who stated that she was not aware that Resident #91 needed a Ex Order 26. 4B1 and it was not on the MAR/TAR, only lotion was ordered. LPN #1 further stated that she was not informed by the LPN/UM #2 or nursing in report that the resident required a Ex Order 26. 4B1.

On 05/26/2023 at 12:20 PM, the surveyor interviewed LPN/UM #1 who stated that Resident #91 used to wear a Ex Order 26. on the Ex Order 26. but some how it fell through the cracks. LPN/UM #1 recalled that Ex Order 26. 4B1 provided a staff in-service and educated the staff about Ex Order 26. usage. LPN/UM #1 stated that she saw the resident wear the Ex Order 26. at times but did not question it.

On 05/26/2023 at 1:41 PM, the surveyor interviewed CNA #1 who reviewed ADLs (activities of daily living) with the surveyor in the Kiosk. CNA #1 stated that Resident #91 now had an entry for a Ex Order 26. 4B1 to wear as tolerated with directions for used provided in the link to the resident's care plan. CNA #1 stated that she was unaware of that the resident needed a Ex Order 26. previously.

On 05/31/2023 at 12:41 PM, the surveyor observed Resident #91 lying in bed and the resident's Ex Order 26. was on the window sill. The resident stated that he/she had given up on staff putting it on. The resident stated that he/she could not move to get over to the window sill and could not put it on alone.

On 05/31/2023 at 12:43 PM, the surveyor interviewed CNA #3 who stated that Resident #91

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F 688	Continued From page 35 usually put the [redacted] on themselves. On 06/02/2023 at 10:26 AM, in the presence of the LPN/UM #2, Resident #91 stated that he/she could now apply the [redacted] themselves on their [redacted]. The resident stated that it was hard for them to do independently as the resident was [redacted]. The resident stated, "If I do not do it, nothing gets done." The resident demonstrated that he/she was able to to donn (put on) the [redacted] and did so with some difficulty. On 06/02/2023 at 12:06 PM, in an interview with the Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS) the RDCS stated that the CNAs were educated on offering the [redacted] to Resident #91 as the resident required assistance to donn the [redacted]. Review of the facility's policy, "Appliances-[redacted] [sic.}, [redacted] and [redacted]" (Revised 4/19) revealed the following: In order to protect the safety and well-being of residents, and to promote quality care, this facility uses appropriate techniques and devices for appliances, [redacted] and [redacted]. To assure all NJ Exec. Order 26:4.b.1 etc. are used appropriately and cared for properly and upper and lower extremities are maintained in a functional position. Nursing: Ensures proper schedule for donning and doffing (removal) appliance is known by CNA staff and provides appropriately sign off of task options. Ensures the staff is aware where device is to be stored and cared for	F 688		

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F 688	Continued From page 36 Release devices/appliances per physician order NJAC 8:39-27.2(m)	F 688		
F 689 SS=D	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: Based on observation, interviews, review of the medical record and other facility documentation, it was determined that that the facility failed to: a) properly assess and implement the facility's [redacted] management policy for a resident after a reported, unwitnessed [redacted] b) ensure [redacted] NJ Exec. Order 26:4.b.1 were followed by ensuring that a resident's bed was in the locked position This deficient practice was identified for 2 of 5 residents (Resident #99, Resident #284) reviewed for [redacted]. This deficient practice was evidenced by the following: 1. During the initial tour of the facility on 05/17/23 at 10:52 AM, the surveyor observed Resident #99 who was seated at the foot of an unsampled resident's bed visiting with friends. The Resident reported a [redacted] from bed a couple of nights ago and lifted their shirt and revealed a Ex Order 26. 4B1 [redacted] on the Ex Order 26. 4B1 of the [redacted]	F 689	1. Resident #99 was admitted to the [redacted] Call placed to [redacted] and received information that the resident did not have any [redacted] Ex Order 26. 4B1 and the [redacted] admission was not related to the [redacted]. The physician received individual education on reporting to nursing administration when a resident reports a [redacted] during an evaluation. Resident #284 is no longer a resident of the facility. Staff members involved was educated that the bed locks must be engaged 2. This had the potential to affect all residents. A review of physician notes was completed for 30 days and no other [redacted] was documented without nursing	6/21/23

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F 689	Continued From page 37 Ex Order 26. 4B1. The resident stated he/she also had a Ex Order 26. 4B1 and NJ Exec. Ord on the Ex Order 26. 4B1 which was covered beneath the resident's clothing. The resident stated he/she informed the nurse whose name the resident did not know. The resident stated that the nurse then proceeded to place a NJ Exec. Order 26:4.b.1 on their Ex Order 26. and NJ Exec. Order 26:4.b.1 was rendered. The resident stated that he/she requested to go to the hospital and the nurse stated, "We do not send people out to the hospital for Ex Order 26. 4B1." According to the Admission Record Resident #99 was admitted to the facility with diagnosis that included, but were not limited to: Ex Order 26. 4B1 [redacted]. Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated 03/05/23, revealed that the resident had a Brief Interview for Mental Status score of Ex Ord out of 15 which indicated that the resident was Ex Order 26. 4B1 [redacted]. Further review of the MDS revealed that the resident NJ Exec. Order 26:4.b.1 and set up for NJ Exec. Order 26:4.b.1 [redacted]. Further review of the MDS indicated that the resident had no documented NJ Exec. Order 26:4.b.1 documented during the quarterly review. 05/22/23 10:55 AM, the surveyor attempted to meet with Resident #99 and was informed by Licensed Practical Nurse (LPN) #2 that the	F 689	administration completing an incident report. An interview of all alert residents was completed with no other NJ Exec. O reported. An inspection of all beds was completed by maintenance and no other bed was identified as unlocked or with broken wheel locks. 3. The facility policy on accidents/ incidents and Ex Order 2 management was reviewed by the Director of Nursing and the Administrator and determined to be in compliance with state and federal guidelines. The staff educator/ designee completed to nursing staff on accident prevention and NJ Exec. Ord management. The in-service specifically focused on ensuring NJ Exec. Order 26:4.b.1 are reported to nursing administration to ensure a complete investigation is completed with a resident assessment, root cause analysis, and targeted interventions are initiated. In addition, the in-service included ensuring accidental hazards from the environment are addressed specifically focusing on ensuring beds are locked when not actively moving the bed. The lesson plan and attendance record will be kept on file for validation. 4. The Director of Nursing/ Designee will complete an audit of the medical record for notes pertaining to NJ Exec. Orde to ensure a	

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F 689	Continued From page 38 resident was [redacted] Review of the Progress Notes (PN) contained within the electronic health record of Resident #99 revealed an entry that was written by LPN #2 which indicated that the resident was sent out of the facility without incident accompanied by a Certified Nursing Assistant (CNA) to a [redacted] appointment. Further review of the PN revealed an entry written on 05/19/23 at 10:39 AM, by Licensed Practical Nurse/Unit Manager (LPN/UM) #2 which revealed that the CNA who accompanied Resident #99 to the [redacted] appointment phoned to report that the resident had a [redacted] and was currently with the [redacted]. The LPN/UM #2 phoned the [redacted] office and spoke with the Physician's Assistant who reported that the resident's [redacted] was around [redacted] and the resident was [redacted] and was sent to the [redacted]. Further review of the PN revealed an entry written by LPN #2 on 05/19/23 at 12:42 PM, which indicated that she phoned the [redacted] and confirmed that Resident #99 was admitted to the hospital with [redacted]. On 05/24/23 at 9:00 AM, the Regional Director of Clinical Services (RDCS) provided the surveyor with two [redacted] which indicated that Resident #99 had an unwitnessed [redacted] on 03/03/23 at 1:00 PM, after the resident tried to put a food tray on the food cart which resulted in an [redacted] to the [redacted]. The resident reported the [redacted] to a CNA and stated, [redacted]	F 689	resident assessment occurred, a complete investigation was initiated, and targeted interventions were initiated. Audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The Maintenance director will complete an audit of 25% of all beds for broken or unlocked beds. Identified beds will have immediate corrective action. Audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The Director of Nursing is responsible for the execution and monitoring of this plan of correction.	

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Further review of a Ex Order 26. 4B1 dated 05/10/23 at 2:18 PM, revealed that the resident had a witnessed Ex Ord in the activity room and was standing up while playing a card game and lost their balance and Ex Ord, landing on the Ex Order 26. 4B1. The resident did NJ Exec. Order 26:4.b.1 as a result.

On 05/25/23 at 2:55 PM, the surveyor reviewed a Weekly NJ Exec. Order 26:4.b.1 assessment which was completed on 05/18/23 at 2:55 PM, by an agency LPN which indicated that Resident #99's NJ Exec. Ord was intact and there were no new NJ Exec. Ord alterations and the NJ Exec. Ord was NJ Exec. Order 26:4.b.1.

On 05/25/23 at 11:26 AM, the surveyor interviewed LPN/UM #2 who stated that Resident #99's last reported Ex Ord occurred in the activity room when the resident Ex Ord and NJ Exec. Order 26:4.b.1 on 05/10/23.

At that time, the surveyor reviewed the 24 Hour Report binder which failed to contain documented evidence that Resident #99 had an unwitnessed Ex Ord from bed and sustained Ex Order 26. 4B1.

The surveyor reviewed a Physician's Progress Note contained within Resident #99's electronic health record effective 05/15/23 at 5:00 PM, which revealed:
History of Present Illness:
...Pt continues to c/o Ex Order 26. 4B1 . Ex Order 26. 4B1 consult is pending. Pt is NJ Exec. Order 26:4.b.1 and is c/o Ex Order 26. 4B1 from recent NJ Exec. O No other NJ Exec. Order 26:4.b.1 issue reported. Medications revived [sic.]. ...
Plan:

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F 689	Continued From page 40 [redacted]: recent [redacted] from bed. Likely related to recent bed rails issue. Continue NJ Exec. Order 26:4.b.1. *Ex Order 26. 4B1* [redacted]: 2/2 to [redacted]. Start pt on *Ex Order 26. 4B1* [redacted] 6 hr prn (as needed). On 05/26/23 at 11:04 AM, the surveyor interviewed Resident #99's Medical Doctor (MD) who stated that on 05/15/23, he saw the resident walking in the hall with [redacted] and the resident informed him that they sustained a [redacted] recently after he/she [redacted] from the bed. The MD explained that the facility discontinued all bed rails as they were perceived as a restraint. The MD stated that the resident used to have a bed rail to transfer and to help the resident from falling out of bed as the resident had a NJ Exec. Order 26:4.b.1 and could [redacted] out of the bed when they turned over in bed. He stated the resident's *Ex Order 26. 4B1* [redacted] was soft, as the *Ex Order 26. 4B1* [redacted] was resolving. The MD stated the resident did not tell me about any [redacted] only the [redacted] The MD stated that the resident's [redacted] was soft and it was not warranted to send the resident to the hospital. The MD stated he did not know why the resident's [redacted] decreased. The MD stated that resident's *Ex Order 26. 4B1* [redacted] was usually in the [redacted] and he was surprised why there was a low reading as the resident's [redacted] sounded okay. The MD stated he did not speak to the nurses about the *Ex Order 26. 4B1* [redacted] and [redacted] from bed because he assumed the resident was already assessed by the nurses. The MD stated that if a resident [redacted] was reported the nurses usually assessed the resident, documented the incident and texted him to inform him of the [redacted]. He stated that he was not informed of the resident [redacted] by the facility nursing staff.	F 689		

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F 689	Continued From page 41 On 05/26/23 at 12:07 PM, the surveyor confirmed that Resident #99's full-time CNA was not available for interview. At that time, the surveyor interviewed CNA #4 who stated that he last cared for Resident #99 a week and a half ago. He stated that the resident was set up for care and was able to NJ Exec. Order 26:4.b.1 . CNA #4 stated that he had not seen the resident's NJ Exec. Order and the resident had not reported a Ex Order to him. On 05/26/23 at 12:37 PM, the surveyor interviewed the Registered Nurse (RN) who stated that if a resident reported a Ex Order she would assess the resident, and notify the unit manager, doctor and family. The RN stated that she would document the Ex Order in a progress note, incident report and on the 24 Hour Report. On 05/26/23 at 1:53 PM, the surveyor interviewed the agency LPN who stated that she worked at the facility for two years. She stated that on 5/18/23, she was assigned to *Ex Order 26. 4B1* . She stated she performed a NJ Exec. Order 26:4.b.1 on Resident #99 and did a NJ Exec. Order 26:4.b.1 and noted NJ Exec. Order 26:4.b.1 on the Ex Order 26. 4B1 of the resident's Ex Order 26. 4B1 . She stated, *Ex Order 26. 4B1* She stated that she reviewed the resident's MD's PN and noted that he documented that he saw the Ex Order 26. 4B1 . She explained that if she documented the finding on her Weekly NJ Exec. Order 26:4.b.1 Documentation it would start a new UDA (User Defined Assessment). She stated that she did not look at the nurse's notes because it was not a new finding. She stated if it were a Ex Order 26. 4B1 , she would have measured it. She described the resident as NJ Exec. Order 26:4.b.1 and stated that the resident informed her of the Ex Order . She stated that she had not noted any NJ Exec. Order 26:4.b.1 on the resident's NJ Exec. Order She stated that the resident	F 689		

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was in bed and was a little sleepy at that time. The surveyor asked the agency LPN to describe the facility process for a resident with a reported [redacted] with sustained [redacted]. She stated she would call the doctor and ask for an order to send the resident out. She further stated that she would then document the resident's complaint of [redacted] She further stated that she did a competency for [redacted] today or yesterday and once a year.

On 05/26/23 the surveyor was provided with a Standard Pre-Survey Review Treatment Observation Dressing: [redacted] dated 01/10/23. The facility was unable to provide the surveyor with documented evidence that the agency LPN received training and competency related to Weekly [redacted] Documentation.

On 05/26/23 at 2:07 PM, the surveyor interviewed CNA #2 who was Resident #99's full-time CNA. CNA #2 stated that she worked on 05/18/23 and the resident had not reported a [redacted] to her. She stated that she did not see the resident's [redacted] as the resident dressed himself.

On 05/26/23 at 2:58 PM, the surveyor interviewed the Director of Nursing (DON) who stated that when Resident #99 reported the [redacted] from bed and requested to go to the hospital the nurse should have informed the doctor and sent the resident out as it was their right. The DON stated that a physician's order was required to perform [redacted] such as placing a [redacted] on the resident's [redacted]. The DON explained that the agency LPN who noted [redacted] on the resident's [redacted] should have reviewed the previous Weekly [redacted] ocumentation to see if the [redacted]

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F 689	Continued From page 43 Ex Order 26. 4B1 was documented, not the physician's PN. The DON stated that the agency LPN should have documented the Ex Order 26. 4B, described it and measured it to make sure that it did not spread. The DON stated that the agency LPN should have documented that the NJ Exec. Order 26:4.b.1, but there was an ongoing Ex Order 26. 4B. The DON stated that if a resident reported an unwitnessed Ex Orde a full body assessment should have been performed including neuro check,s and documented notification of administration, MD, family, complete the 24 Hour Report for a three day follow-up, and complete the event report. The DON confirmed that the resident's side rails were removed from the bed after it was determined that the resident lacked the ability to lower and raise the side rails independently in accordance with facility policy. On 05/31/23 at 12:08 PM, the surveyor interviewed LPN #2, Resident #99's full-time nurse, who stated that she last saw the resident prior to a scheduled appointment with the Ex Order 26. 4B1. LPN #2 stated that the resident had not reported a Ex Orde and was able to ambulate out of the facility to be transported to their appointment. LPN #2 stated that the resident's MD should have reported the resident's report of Ex Order 26. 4B1 and Ex Orde to nursing for follow-up. On 06/05/23 at 1:30 PM, the Regional Director of Clinical Services (RDCS) provided the surveyor with the requested "24 Hour Report and Change in Condition and Nursing Unit Activities" which indicated that on 05/19/23 Resident #99 was oof (out of facility) to a Ex Order 26. 4B1 Appointment. Admitted to NJ Exec. Order 26:4.b.1 with Dx: Ex Order 26. 4B1. Their was no further documentation that pertained to Resident #99 within the	F 689		

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F 689	Continued From page 44 documentation provided. On 06/02/23 at 12:06 PM, in the presence of the survey team, Administrator, and DON the RDCS stated that Resident #99's MD should not have assumed that the resident's [Ex Orde] was a reported [Ex Orde] and discussed it with nursing or the unit manager. Review the facility's policy, '[NJ Exec. Orde] Management and Prevention" (Revised 1/2020) revealed the following; The [Ex Order 2] may be witnessed, reported by the resident an observer or identified when a resident is found on the floor or ground. Post [NJ Exec. Orde] In the event a resident has [Ex Order 26.4] and/or is found on the ground, a complete heard-to-toe assessment must be performed... ...Obtain vital signs, obtain neurological checks per policy for any unwitnessed [Ex Orde] or any [Ex Orde] with evidence of injury to head. If no obvious injury move resident to a comfortable position. If injury, severe pain or abnormal assessments observed, call 9-1-1-transfer. ...Obtain finger-stick blood sugar if known diabetic. The nurse will complete an incident report. Contact physician and family and document in the medial record, including time and person spoken with.... Resident [NJ Exec] will be evaluated for 72 hours' post [NJ Exec. O], including full vital signs every shift. The Director of Nursing will be notified immediately for [Ex Order 2] resulting in injury an/or transfer. The DON will notify State agency per state specific requirements. Resident will be referred to therapy for a screen-for indiction of need for therapy	F 689		

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(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 interventions. Review of the facility's policy, "Accidents-Incidents" (Revised 8/2019) revealed the following: It is the policy of the Facility to monitor and evaluate all occurrences of accidents or incidents or adverse events occurring on the facility's premises which is not consistent with the routine operation of the facility or care of a particular resident. These occurrences must be evaluated and investigated. ...The occurrence may be a [redacted], skin tear, bruise, new pressure ulcer and may involve abuse, neglect, and mistreatment or an injury of unknown origin... Procedure: The following forms make up the Incident and Accident packet for investigating and reporting: Accident and Incident Report Form Incident/Accident Statement Form RN Supervisor/UnitManager Incident/Accident Statement Form Involved Party Statement-for all those involved CNA Statement form-for those on duty at the time of the incident Neuro Checklist-for unwitnessed accidents/incidents Rehab Referral form-if applicable Post-Accident/Incident Check List NJ#00158216 Review of the residents Admission Record revealed Resident #284 was admitted to the facility with diagnosis that included, but was not	F 689		

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	315209	A. BUILDING _____ B. WING _____	C 06/05/2023

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F 689	Continued From page 46 limited to *Ex Order 26. 4B1* [redacted].	F 689		

On 06/02/23 at 10:00 AM, the surveyor reviewed the facility provided Quality Assurance (QA) report regarding Resident #284. The report indicated the resident was found on the floor on [redacted] at 7:25 AM. The conclusion of the report indicated that Resident #284 lowered himself to the ground and was found on the floor next to his bed. The wheelchair was locked, floor was clean and dry, bed was in the low position, call bell was within reach and not engaged. No [redacted] was noted. There is no mention of the brakes on the bed being engaged.

On 6/02/23 at 02:02 PM, the surveyor reviewed a Registered Nurse Assessment dated 9/10/2022 at 14:07 which reflected, 'NJ Exec. Order 26:4.b.1 [redacted]

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F 689	Continued From page 47 NJ Exec. Order 26:4.b.1 [redacted]." On 6/2/23 at 2:02 PM, the RDCS stated the breaks on the bed may not have been broken. She stated the staff may not have engaged the brakes. A review of the facility provided In-Service Attendance Record reflects that the facility in serviced the staff on 9/10/22, regarding ensuring that resident's beds and wheelchairs were secured (locked). Staff will ensure resident's bed or wheelchair is locked before and after care. A review of the facility policy titled "[redacted] Management and Prevention" revised 1/20/20 reflects The interdisciplinary team identifies and implements appropriate interventions to reduce the risk of [redacted] or injuries while maximizing dignity and independence.	F 689		
F 692 SS=D	NJAC 8:39-27.1 (a), 33.1 (d) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. *Ex Order 26. 4B1* [redacted]. Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and *Ex Order 26. 4B1* [redacted], unless the resident's clinical condition	F 692		6/21/23

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F 692	Continued From page 48 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a *Ex Order 26. 4B1* when there is a nutritional problem and the health care provider orders a *Ex Order 26. 4B1*. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to provide a resident with NJ Exec. Order 26:4.b.1 that were recommended for a resident with significant *Ex Order 26. 4B1*. This deficient practice was identified for 1 of 2 residents (Resident #102) reviewed for nutrition. This deficient practice was evidenced by the following: On 05/24/23 at 9:06 AM, the surveyor observed Resident #102 lying in bed with the head of the bed elevated eating breakfast. The Certified Nursing Assistant (CNA) #1 who assisted the resident stated that the resident always ate all of his/her food and asked for seconds. Review of the Admission Record revealed that Resident #102 was readmitted to the facility in *Ex Order 26. 4B1* with diagnoses which included but were not limited to: *Ex Order 26. 4B1* [redacted]	F 692	1. Resident #102 was evaluated by the dietician with no negative effect from deficient practice. The resident weight has been confirmed and current weight is within required *Ex Order 26. 4B1*. The residents NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 were removed from the resident plan of care and diet slip. 2. This had the potential to affect all residents. All residents diet slips, orders, and care plans were reviewed for NJ Exec. Order 26:4.b.1. The dietician validated that the residents were receiving NJ Exec. Order 26:4.b.1. In addition, all diet slips were reviewed by the Food Service Director and any residents with recommendations for *Ex Order 26. 4B1* was confirmed by the rehab director that the residents diet slips have the correct adaptive equipment recommended. 3. The facility policy on Nutrition was reviewed by the Dietician and the	

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F 692	Continued From page 49 Review of the Quarterly Minimum Data Set (MDS) dated [redacted] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident was [redacted]. Further review of the MDS revealed that the resident had a [redacted] while not on a physician-prescribed [redacted] and was [redacted] inches tall and weighed [redacted] lbs. Review of Resident #102's Care Plan revealed an entry which indicated that resident had a [redacted] or [redacted] with significant [redacted] that was initiated on 09/16/18. Further review of the Care Plan revealed an entry which indicated that the resident had interventions which included provide diet and consistency per MD order [redacted]. On 02/05/22, an entry was initiated to offer resident a snack every HS (hours of sleep). Review of the Order Summary Report dated 06/01/23 revealed that on 12/01/22, Resident #102 was ordered a [redacted], assist, set-up, and [redacted] supervision, [redacted]. On 12/08/22 an order was placed for [redacted] three times a day for [redacted] daily. On 02/05/22 an order was placed to [redacted] On 03/06/23 an order was placed for [redacted] give one tablet by mouth at bedtime for [redacted]. On 05/26/23 at 12:47 PM, the surveyor observed Resident #102 eating lunch in the dining room. The resident ate 100% of the meal which	F 692	Administrator and determined to be in compliance with state and federal guidelines. The staff educator/ designee completed in-service to all dietary staff and nursing staff on Nutrition/ Hydration Maintenance specifically focusing on providing a resident with nutritional interventions that were recommended for a resident with [redacted] including [redacted] and [redacted]. The lesson plan and attendance record will be kept on file for validation. 4. The Dietician/ Designee will complete an audit of 20% of all residents with orders and interventions for [redacted] to ensure the intervention is provided to the resident. Audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The Food Service Director will complete an audit of 25% of all resident diet slips with adaptive equipment to ensure the intervention is placed on the tray during meal service. Audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be	

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F 692	Continued From page 50 included macaroni and cheese, cauliflower, vegetable soup, an ice cream cup, milk and iced tea. The portion size of the macaroni and cheese and cauliflower appeared small. The Registered Dietician (RD) was present and assisted other residents who dined at the same dining table. On 05/26/23 at 2:20 PM, the surveyor interviewed the RD who stated that Resident #102 had experienced a significant Ex Order 26. 4B1 and the resident weighed NJ Exec. O lbs in Ex Order 26. 4B1 and on 12/04/22 the resident weighed NJ Exec. Order 2 lbs. The RD stated that a Ex Order 26. 4B1 of NJ Exec. Order was identified and a reweight was done on 12/7/22, and the resident weighed NJ Exec. Orc lbs. The RD stated that the rationale for the NJ Exec pound Ex Order 26. 4B1 was not known as the resident had a documented food intake of 75% at meals. The surveyor asked the RD if weekly weights were obtained in response to the identified Ex Order 26. 4B1. The RD stated that with the reweight we assumed that the weight was accurate. The RD stated that the resident's diet was upgraded and Ex Order 26. 4B1 were increased to three times per day. The Ex Order stated that the scale was checked for accuracy in Ex Order 26. 4B1 and it was replaced. Review of the resident's weights within the electronic health record revealed the following: on Ex Order 26. 4B1 NJ Exec. O lbs, on Ex Order 26. 4B1 NJ Exec. O lbs, on Ex Order 26. 4B1 NJ Exec. O lbs, on Ex Order 26. 4B1 NJ Exec. O lbs, and on Ex Order 26. 4B1 1 NJ Exec lbs. The RD stated that though it was not documented, the resident looked the same and did not appear to have NJ Exec. Order 26:4.b.1. The RD further explained that in February the resident's weight was NJ Exec. O lbs so we added NJ Exec. Order 26:4.b.1 in addition to the NJ Exec. Order 26:4.b.1. The RD stated that in March the resident weighed NJ Exec. O lbs and the Medical Doctor was informed of	F 692	presented at monthly QAPI. The Dietician is responsible for the execution and monitoring of this plan of correction.	

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F 692	Continued From page 51 the Ex Order 26. 4B1 and Ex Order 26. 4B1 [redacted] was prescribed. The RD stated that the resident's current nutrition plan was continued which also consisted of Ex Order 26. 4B1 of protein or starch. The RD explained that the resident's tray ticket should indicate "2 X" for things that should be served in Ex Order 26. 4B1. The surveyor asked if the macaroni and cheese that was served at lunch to the resident looked like it was a Ex Order 26. 4B1 size? The RD stated that she delivered the meal tray to the resident and had not actually looked at it. The RD further stated that the Food Services Director (FSD) was informed of the recommended scoop sizes to be used when Ex Order 26. 4B1 were served. On 05/31/23 at 12:48 PM, the surveyor observed Resident #102 seated in a chair eating lunch in the dining room. The resident ate 100% of the meal and only a small, single chicken drumstick bone remained on the plate. The surveyor reviewed the meal ticket which indicated the resident was served: Ex Order 26. 4B1 [redacted], 2 X 3 oz Oven Fried Chicken, 2 X 2 fl oz Country Gravy, mashed potatoes, wax beans, mandarin oranges, 4 fl oz juice, 8 fl oz 2% milk, 4 fl oz water, 4 fl oz iced tea, and a 4 fl oz Ex Order 26. 4B1. The surveyor observed that the resident had not received NJ Exec. Order 26:4.b.1 [redacted] utensils, Ex Order 26. 4B1 or a Ex Order 26. 4B1 [redacted] of chicken. On 05/31/23 at 12:54 PM, the surveyor interviewed the Dietary Aide (DA) #1 who confirmed that the Resident #102 had not	F 692		

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F 692	Continued From page 52 received a Ex Order 26. 4B1 as indicated on the tray ticket and stated that it must have been missed. The surveyor asked DA #1 why there was only one single small chicken bone on the resident's plate if the resident were served 2 X the serving of chicken? DA #1 stated that the resident may have gotten one big piece of chicken instead of two and he was unable to make that determination based on the chicken drumstick bone that remained on the resident's plate. On 05/31/23 at 12:56 PM, the surveyor interviewed CNA #1 who stated that Resident #102 had not received a Ex Order 26. 4B1 but did well with NJ Exec. Order 26:4.b.1. CNA #1 further stated that the resident normally received one large piece of chicken, not two as indicated on the meal ticket. On 05/31/23 at 1:49 PM, the surveyor interviewed the FSD who stated that he worked at the facility for nearly eight years. The FSD stated that today a chicken leg/thigh of oven fried chicken was served for lunch. The FSD stated that he probably had to cut the chicken in half for the resident as he may have run a little short. The FSD stated that he had not realized that the resident was ordered double portions until one week ago when a diet requisition slip was brought down to the kitchen. The FSD stated that he was not aware that the resident required a Ex Order 26. 4B1 as there were only three residents at the facility who required them as indicated by Ex Order 26. 4B1 recommendation. The FSD stated that the dietary staff were required to review the meal tickets while on the tray line to ensure that both Ex Order 26. 4B1 and Ex Order 26. 4B1 were provided as indicated on the meal ticket. The	F 692		

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F 692	Continued From page 53 surveyor asked the FSD why the resident had not receive the Ex Order 26. 4B1 ? The FSD stated that he ran out of the Ex Order 26. 4B1 yesterday. On 05/31/23 at 2:31 PM, the FSD provided the surveyor with a Diet Requisition slip dated 05/17/23, for Ex Order 26. 4B1 (i.e., Likes/Dislikes) Ex Order 26. 4B1 that was signed by the Assistant Director of Nursing (ADON). The FSD also provided the surveyor with a document titled, "Adaptive Feeding Audit" dated 04/06/23, that was provided by the Director of Ex Order 26. 4B1 which contained three resident names who required modified sippy cups. Resident #102 was not included on the list for Ex Order 26. 4B1 . The FSD explained that the RD informed him that the resident no longer required the Ex Order 26. 4B1 and it should not have been on the resident's meal ticket any longer. The FSD further explained that the Diet Requisition slip for large portions was provided by the ADON on 05/17/23. On 05/31/23 at 2:45 PM, the surveyor interviewed the ADON who stated that she was informed on 05/17/23 by the 3-11 CNA that the resdient had a large appetite and was supposed to get large portions. The ADON stated that she completed a dietary requisition form and took it down to the kitchen. The ADON stated that she was not informed by the RD that the resident needed Ex Order 26. 4B1 prior. On 05/31/23 at 03:02 PM, the surveyor interviewed the RD who stated that Ex Order 26. 4B1 should have been implemented for	F 692		

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F 692	Continued From page 54 Resident #102 in Ex Order 26. 4B1 and the FSD should have known and ensured that the resident received NJ Exec. Order 26:4.b.1. The RD stated that when the request for NJ Exec. Order 26:4.b.1 was placed in the diet system it was reflected on the diet ticket. On 06/01/23 at 2:32 PM, the surveyor interviewed the RD who stated that she reviewed her notes and in Ex Order 26. 4B1, she documented that the Resident #102 was getting Ex Order 26. 4B1 in her note. The RD explained that she thought that she messed up at some point thinking that the resident had Ex Order 26. 4B1 and they were not really there. The RD stated that the resident absolutely should have received Ex Order 26. 4B1 from Ex Order 26. 4B1 to present as indicated on the current meal ticket. The RD further stated that an order for Ex Order 26. 4B1 should have been placed in the electronic health record, in the Ex Order 26. and in the Ex Order system. The surveyor questioned why the resident's medical record failed to contain the documentation as described by the RD? The RD stated that she learned from her mistakes and she should have placed an order into the resident's Ex Order 26. 4B1 for Ex Order 26. 4B1 and into the Ex Order system. The RD stated that the ADON also should have placed an order into the Ex Order 26. 4B1 in addition to the Ex Order requisition form that she sent to the FSD. The RD further stated that Resident #102 weighed NJ Exec. Or lbs on Ex Order 26. 4B1 and when the resident was weighed on Ex Order 26. 4B1 in a wheelchair the resident weighed NJ Exec. O lbs. The RD stated that she wanted to "bang her head" when this happened as she was unable to explain the discrepancy. The RD stated that she wanted to	F 692		

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F 692	Continued From page 55 get another reweight. On 06/02/23 at 10:05 AM, the surveyor accompanied the RD, Licensed Practical Nurse/Unit Manager (LPN/UM) #2 of [redacted] Units, and CNA #2 to weigh Resident #102 in a wheel chair on a chair scale. The wheelchair was weighed first and weighed 36.8 lbs. The resident was then weighed and weighed [redacted] lbs in the wheel chair. The RD stated that the resident's weight was [redacted] lbs. The RD further stated that she did not know if there was an issue with scale accuracy. The RD stated that previously staff were not required to document whether the resident stood for their weight or if they were weighed in a wheelchair or [redacted] but they were required to do so now. On 06/02/23 at 10:38 AM, the surveyor interviewed LPN/UM #2 who stated that the RD was required to notify the resident's physician of [redacted] or the assigned doctor monitored the resident's weights. The surveyor reviewed Resident #102's [redacted] and observed a physician's progress note dated 12/23/22 at 4:45 PM, revealed that the resident's physician noted the resident's [redacted] and informed the resident's responsible party. On 06/02/23 at 12:06 PM, the surveyor interviewed the Administrator regarding Resident #102's [redacted], [redacted] and tray accuracy. The Administrator stated, "If it is on the ticket, it should go on the tray." The Administrator further explained that an order was required for the items listed on the meal ticket. The Director of Nursing (DON) who was present at that time stated that the Unit Manager along	F 692		

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F 692	Continued From page 56 with the RD were responsible to ensure that weekly weights were done when indicated. She stated that residents were weighed upon admission, and weekly x four, and after four weeks, they were weighed monthly thereafter. She further stated that if the resident had a Ex Order 26. 4B1 or Ex Order 26. of five lbs then weekly weights were required to be completed x four. The DON further stated that in early Ex Order 26. 4B1, Resident #102's order for Ex Order 26. 4B1 should have been discontinued from the meal ticket. Review of the facility policy titled, "Weight Assessment and Interventions" (Reviewed 02/23) revealed the following: Policy: The Multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight change for our residents. ...Weights will be recorded in the medical record (electronic health record where available) for each resident. a. Any weight change of 5 lb [sic.] in a month and 3 lbs in a week since their last weight assessment will be retaken within 48 hrs for confirmation and verified by nursing. b. Re weigh should be reviewed by the Licensed Nurse. c. Licensed Nurse will notify Dietician of identified weight change once reviewed. d. Dietician notification should be documented within Resident's medial record e. Dietician or diet technician will respond within 72 hours of receipt of notification ...The threshold for significant unplanned and undesired weight change will be based on the following criteria:	F 692		

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F 692	Continued From page 57 a. 1 month-5% weight change is significant; greater than 5% is severe. ...If the weight change is desirable, this will be documented and no change in the care plan will be necessary. ...Individual care plans shall address, to the extent possible: a. The identified cause of weight change; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment. NJAC 8:39 17.1(c), 17.2(d), 27.2(e)	F 692		
F 695 SS=D	*Ex Order 26. 4B1* and *Ex Order 26. 4B1* CFR(s): 483.25(i) § 483.25(i) *Ex Order 26. 4B1*, including *Ex Order 26. 4B1*. The facility must ensure that a resident who needs *Ex Order 26. 4B1*, including *Ex Order 26. 4B1*, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation review and clinical record review, it was determined that the facility failed to provide *Ex Order 26. 4B1* consistent with physician's order. This deficient practice was identified for 1 of 2 residents reviewed for *Ex Order 26. 4B1*, Resident #70 and was evidenced by the following: On 05/24/2023 at 11:00 AM, the surveyor	F 695	1. Resident #70 was evaluated with no negative effect noted. The *Ex Order 26. 4B1* was replaced with an unexpired *Ex Order 26. 4B1*. The resident□s physician order was updated to include a range of [redacted] due to residents preference and comfort level. The residents expired [redacted] was placed	6/21/23

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	315209	A. BUILDING _____ B. WING _____	C 06/05/2023

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F 695	Continued From page 58 observed Resident #70 sitting on the bed receiving Ex Order 26. 4B1 ([redacted]) Ex Order 26. 4B1 [redacted] by way of a Ex Order 26. 4B1 [redacted] The Ex Order 26. 4B1 was set to deliver Ex Order 26. 4B1 at a flow rate of Ex Order 26. 4B1 and there was separate Ex Order 26. 4B1 on the dresser across the room that was partially inside the top drawer. The Certified Nursing Assistant (CNA) was assisting Resident #70 with getting dressed and removed the Ex Order 26. 4B1 and laid it down on the residents' bed. The Ex Order 26. 4B1 was observed on the bed and was dated for 5/24/2023 with a piece of plastic tape. During an interview with the surveyor, CNA revealed that Resident #70 NJ Exec. Order 26:4.b.1 with care, NJ Exec. Order 26:4.b.1, and was also receiving Ex Order 26. 4B1 and the nurses were responsible for the Ex Order 26. 4B1 setting. The CNA indicated that she did not touch the Ex Order 26. 4B1 and could not speak to why the setting was incorrect, why the machine was dated for 05/10/2023, or why the Ex Order 26. 4B1 was on the dresser. The CNA added the nurses would be responsible for that. On 05/24/2023 at 11:05 AM, the surveyor reviewed Resident #70's current medical record which revealed that Resident #70 was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included, but not limited to Ex Order 26. 4B1 [redacted] Further review of the clinical record revealed a	F 695	in the garbage in the soiled utility room. The resident□s care plan for NJ Exec. Order 26:4.b.1 [redacted] was updated to include discarded Ex Order 26. 4B1 [redacted]. 2. All residents on Ex Order 26. 4B1 equipment have potential to be affected by this deficient practice. Residents on Ex Order 26. 4B1 were evaluated to ensure Ex Order 26. 4B1 not in use was placed in a plastic bag and dated within the current week. Resident□s Ex Order 26. 4B1 setting was audited to ensure the setting matches the physicians order. All Ex Order 26. 4B1 were checked by maintenance and expired Ex Order 26. 4B1 were replaced and/or inspected. No other resident was identified to be affected by this deficient practice. 3. The facilities policy on Ex Order 26. 4B1 was reviewed by administrator and Director of Nursing and determined to be in compliance with state and federal guidelines. The staff educator/ designee completed education to all nursing staffing on Ex Order 26. 4B1 specifically focusing on NJ Exec. Order 26:4.b.1 settings, Ex Order 26. 4B1 storage in a plastic bag while not in use are and using Ex Order 26. 4B1 that are within the indicated inspection cycle. The	

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F 695	Continued From page 59 Physician Order Sheet (POS) with a start date of 06/27/2022 that contained the following order: [redacted] every shift Check [redacted] sat every shift. Every night shift every Sunday for Equipment maintenance change and date [redacted] and storage bags once weekly." The most recent annual Minimum Data Set (MDS) an assessment tool with a date of 02/25/2023, indicated that Resident #70 had a [redacted] score of [redacted] indicating that Resident #70 had [redacted]. On 05/24/2023 at 11:08 AM, the surveyor interviewed the Registered Nurse (RN) assigned to Resident #70 regarding the [redacted] setting, the [redacted] expiration date on the [redacted] machine, and the [redacted] on the dresser. The RN verified that the physician's order was for Resident #70 to receive [redacted] at a flow rate of [redacted] via [redacted]. The surveyor entered Resident #70's room with the RN and both observed that the [redacted] setting was for [redacted] to be delivered at [redacted] and [redacted] was noted to be on the dresser and partially in the top drawer. Further review of the machine revealed there was a sticker with an expiration date for [redacted]. The RN confirmed that the physician's order for Resident #70 was for [redacted] of [redacted] not [redacted] as was set on the [redacted], that the [redacted] machine should have been changed out as of the [redacted] date, and the [redacted] should not have been left on the dresser. On 05/24/2023 at 11:10 AM, the surveyor	F 695	maintenance department received education on ensuring that medical equipment is inspection annually. The lesson plan and attendance record have been completed for validation. 4. The Director of Nursing/ designee will audit 20% of residents on [redacted] and [redacted] to evaluate that: the [redacted] is dated and bagged when not in use; [redacted] setting matches the physician order; and the [redacted] is within the noted inspection cycle. The audit reports will be completed weekly x 4 weeks; then monthly at a minimum of 6 months or until compliance is met. The results of these audits will be submitted at monthly QAPI. The Director of Nursing is responsible for the execution and monitoring of this plan of correction.	

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F 695	Continued From page 60	F 695		

interviewed the Unit Manager (UM) regarding the incorrect [redacted] setting, the outdated label on the machine, and the [redacted] that was left on the dresser. The UM confirmed that the [redacted] physician's order must be followed and acknowledged that the label on the machine meant that the machine should have been changed. The UM added that the [redacted] should not have been on the dresser. The UM turned off the [redacted] machine and removed the [redacted].

During the pre-exit conference on 06/01/2023 at 1:30 PM, the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Director of Clinical Services (RDCS) were informed of the findings. No further information was provided. The RDCS told the survey team that the RN on shift was an agency nurse and would be educated.

A review of the facility's policy titled, [redacted]" last revised September 2022, revealed the administration of *Ex Order 26. 4B1* is an essential element of appropriate management for a wide range of clinical conditions. However, [redacted] should be regarded as a drug and therefore requires prescribing in all but emergency situations. Failure to administer *Ex Order 26. 4B1* with appropriate monitoring is an integral component of Healthcare Professional's role. [redacted] is administered according to physician order. *Ex Order 26. 4B1* [redacted], without humidification, is changed weekly and prn, filters should be changed annually. Follow manufacturer's instructions for use to apply, adjust the flow settings, clean, and remove the device.

NJAC 8:39-11.2 (b) 27.1 (a)

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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: NJ #00151692, NJ #00153388, NJ#00157947, NJ#00158216, NJ00157442, NJ00158731, NJ00158017 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to: a.) provide nursing and related services to assure the residents safety	F 725	1. Resident #45, #160, #155 and #72 had *Ex Order 26. 4B1* performed. Facility schedules were evaluated Facility will attempt to ensure that the minimum requiremts for direct care staff to residents is met day shift 1 CNA per 8 residents, evening shift 1 CNA per 10 residents, night shift 1 CNA per 14	6/21/23

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F 725	Continued From page 62 and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care in accordance with the facility assessment and b.) provide sufficient staffing numbers to meet minimum staffing requirements. This deficient practice was observed on 2 of 3 nursing units and for 4 of 9 residents' reviewed, (Resident #45, #72, #155 and #160)) for care related to staffing. This deficient practice was evidenced by the following: Refer to F677 1. During the initial tour of the facility on 05/17/23 at 9:42 AM, the surveyors noted a strong smell of [redacted] that permeated the air on the [redacted] floor of the facility in the hallway beyond the main entrance to the facility that led to the [redacted] floor nursing units. On 05/24/23 at 9:02 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #3 who stated that she was assigned to 13 residents. CNA #3 stated that she had to pass breakfast trays before she performed AM care for several more residents who were all [redacted] and dependent on staff for care. At 09:44 AM, CNA #3 delivered a meal tray to the room of Resident #45 who was lying in bed and [redacted]. The resident sat up on the side of the bed to eat breakfast and the surveyor noted that the resident's sheets were saturated with [redacted]. CNA #3 stated that the resident's sheets were always saturated when she did care in the AM. The surveyor interviewed the resident who	F 725	residents. . [redacted] assessments were completed on Resident #45, #160, #155 and #72 and no new [redacted] were identified. 2. All residents have the potential to be affected by this deficient practice. Facility schedules were evaluated. Facility will attempt to ensure that the minimum requirements for direct care staff to residents is met- day shift 1 CNA per 8 residents, evening shift 1 CNA per 10 residents, night shift 1 CNA per 14 residents. Facility schedules were evaluated, Additional staff was hired, staffing agencies and recruiters were contracted to aid in the efforts to provide additional staff. The facility has initiated sign on bonuses to secure additional staff and bonuses for staff referrals. Additional ads were created on recruiting websites and recruiting flyers and signs placed in the community and facility to attract nursing staff. 3. The facility policy on staffing was reviewed by the Administrator and determined to be in compliance with federal guidelines. The staffing coordinator was educated on attempting to ensure that the minimum requirements for direct care staff to residents is met.	

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F 725	Continued From page 63 stated that he/she was last changed at approximately 4:00 AM. The resident sat up and ate breakfast on the side of the bed in a [redacted] brief on top of wet sheets while CNA #3 began to collect meal trays on the nursing unit. At 10:00 AM, CNA #3 returned to Resident #45's room to do AM care with resident permission. The resident was assisted out of the bed and into a wheelchair. The resident's bed was saturated and the room smelled of [redacted]. The resident wore a photo identification that was attached to a lanyard around the resident's neck. CNA #3 asked the resident to remove the lanyard and informed the resident that the plastic identification holder and photo were *Ex Order 26. 4B1* [redacted] The surveyor observed that the resident's identification was covered with a black and brown [redacted] and a *Ex Order 26. 4B1* [redacted] was present beneath the plastic cover that held the identification. CNA #3 stated that the resident's NJ Exec. Order 26:4.b.1. The surveyor asked the resident how he/she felt about delayed *Ex Order 26. 4B1* [redacted] and the resident stated, "There was nothing that they can do about it". CNA #3 proceeded to obtain disinfectant cleaner from Housekeeping and wiped down the resident's [redacted] soaked mattress which had rips and tears. According to the Admission Record (an admission summary) Resident #45 was admitted to the facility with diagnosis which included, but were not limited to: *Ex Order 26. 4B1* [redacted]. Review of Resident #45's Quarterly Minimum	F 725	The staff educator in- serviced nursing staff on ensuring that residents needs are met including *Ex Order 26. 4B1* [redacted] rendered to NJ Exec. Order 26:4.b.1 residents and *Ex Order 26. 4B1* [redacted] to NJ Exec. Order 26:4.b.1 [redacted] residents. Nursing supervisors were educated to notify administration and the Director of Nursing if there was not enough staff to render activities of daily living. 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 nursing staff is provided to meet the resident needs for activities of daily living Audits will be completed weekly x 4 weeks and monthly for a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The Director of Nursing/ Designee will complete weekly random audits of 20% of all *Ex Order 26. 4B1* [redacted] residents to ensure that incontinence 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 and no less than	

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F 725	Continued From page 64 Data Set (MDS, an assessment tool dated 05/07/23, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident was *Ex Order 26. 4B1* and had no documented instances of rejection of care. Further review of the MDS indicated that the resident required NJ Exec. Order 26:4.b.1 and was *Ex Order 26. 4B1* of both *Ex Order 26. 4B1*. At 10:51 AM, CNA #3 stated that she planned to take a 15 minute break and would resume AM care when she returned. At 11:23 AM, CNA #3 entered the room of Resident #160 to do AM care with resident permission. The resident was assisted to sit up on the side of the bed. The resident wore a white hoody and the back of the hoody was wet and was stained with a *Ex Order 26. 4B1* to the level of the resident's *Ex Order 26. 4B1*. The resident's bed was saturated. When interviewed at that time, Resident #160 was unable to state what time he/she was changed last. CNA #3 assisted the resident into the bathroom to get washed. CNA #3 then proceeded to strip Resident #160's bed and sprayed the mattress which had rips and tears with disinfectant cleaner. According to the Admission Record Resident #160 was admitted to the facility with diagnosis that included but were not limited to: *Ex Order 26. 4B1* [redacted]. Review of Resident #160's *Ex Order 26. 4B1* dated 04/17/23, revealed that the resident had a BIMS	F 725	6 months or until compliance is met. The results of these audits will be presented at the monthly QAPI. The Administrator is responsible for the execution and monitoring of this plan of correction.	

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F 725	Continued From page 65 score of [redacted] out of 15, which indicated that the resident was *Ex Order 26. 4B1* and had no documented instances of rejection of care. Further review of the [redacted] indicated that the resident required NJ Exec. Order 26:4.b.1 [redacted] and was *Ex Order 26. 4B1* of both [redacted]. At 11:59 AM CNA #3 entered Resident #155's room to perform AM care with resident permission. CNA #3 stated that there were no sheets on the bed and she did not know where they were. CNA #3 stated that the resident's brief was [redacted] with [redacted] since this AM, but she had other resident's to care for. CNA #3 removed the resident's brief and stated that his/her [redacted] CNA #3 stated that she found the resident lying under a fitted sheet this AM and the resident had no blankets. CNA #3 proceeded to open the night stand and found a fitted sheet that was [redacted] with *Ex Order 26. 4B1* and was wet according to CNA #3. According to Resident #155's *Ex Order 26. 4B1* the resident was admitted to the facility with diagnosis that included, but were not limited to: *Ex Order 26. 4B1* [redacted]. Review of Resident #155's *Ex Order 26. 4B1* dated 04/14/23, revealed that the resident had a BIMS score of [redacted] out of 15, which indicated that the resident was *Ex Order 26. 4B1* and had no documented instances of refusal of care. Further review of the MDS indicated that the resident required NJ Exec. Order 26:4.b.1 of [redacted]	F 725		

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F 725	Continued From page 66 NJ Exec. Order 26:4.b.1 and was *Ex Order 26. 4B1* of both *Ex Order 26. 4B1* . At 12:06 PM, CNA #3 stated that when she arrived to work this AM the night shift CNA informed her that everyone was dry. On 05/25/23 at 10:59 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that she noted that the residents on her assignment were *Ex Order 26. 4B1* and were not being changed as they should be. LPN #1 stated that the aides on day shift let her know that the residents were saturated about one week ago. LPN #1 stated that she informed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 of her concern that the residents on her assigned unit were overly saturated with *Ex Order 26.* . On 05/25/23 at 11:10 AM, the surveyor interviewed LPN/UM #2 who stated that she had worked at the facility since *Ex Order 26. 4B1* . LPN/UM #2 stated that no one had brought it to her attention that there were concerns with *Ex Order 26. 4B1* on her assigned nursing units (*Ex Order* and *Ex Order*). On 05/25/23 at 11:15 AM, the surveyor requested that LPN/UM #2 come to Resident #45's room. Upon entry to the room, the resident was not in the room at the time and the resident's bed sheets were noted to be soaked and covered in a *Ex Order 26. 4B1* . LPN/UM #2 stated that it had not looked like the resident had not received *Ex Order 26. 4B1* since last night. LPN/UM #3 then proceeded to open the resident's night stand where the resident's photo identification/lanyard was kept at the resident's request. LPN #2 stated	F 725		

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F 725	Continued From page 67	F 725		

that the plastic that covered the identification contained mold and was stained yellow from being wet with [redacted]. LPN/UM #2 stated that the CNA #3 had 14 residents yesterday and was required to have eight on day shift according to staffing mandate. LPN/UM #2 stated that staffing was not as adequate as it should be.

On 05/25/23 at 12:04 PM, the surveyor interviewed the Administrator in the presence of another surveyor regarding the heavy smell of [redacted] that permeated the [redacted] floor of the facility. The Administrator attributed the odor to Resident #45 who often sat in his/her wheelchair at the entrance to the facility. The surveyor observed that the resident was not present when the odor was detected. The surveyor asked why the resident smelled so heavily of [redacted] The DON who was present at that time stated that it meant that the resident was wet. The Regional Director of Clinical Services (RDCS) who was also present stated that if everyone was wet during the [redacted] tour, there were not enough nurses and aides to help the residents in a way that was manageable. Both the Administrator and the DON stated that it was not acceptable for residents bed sheets to be permeated with [redacted].

2. On 5/24/23 at 8:55 AM, the surveyor accompanied by the Certified Nursing Assistant (CNA) completed an [redacted] on the [redacted] Unit. Three random residents who were identified by the CNA as being [redacted] on staff for care, were observed for [redacted]. Resident #72 was observed in bed with a black shirt on that was not a pajama top. Resident #72 was asked by the CNA if she could check the [redacted] and the resident agreed. Resident #72 was wearing an

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	315209	A. BUILDING _____ B. WING _____	C 06/05/2023

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 Ex Order 26. 4B1 NJ Exec. Orde which was completely saturated with Ex Order 26. The draw sheet and fitted sheet positioned under the resident were visibly soiled and discolored. When interviewed at that time, the CNA stated that when she came into work the residents including Resident# 72 were saturated. The CNA stated that she then must give the resident full care which included changing the sheets and giving a complete shower or bed bath. According to the Admission Record, Resident #72 had diagnoses that included, but were not limited to: Ex Order 26. 4B1 . Review of Resident #72's Ex Order 26. 4B1 , an assessment tool used to facilitate the management of care, dated 4/18/23, revealed the resident had a Brief Interview for Mental Status (BIMS) score of Ex Or out of 15, which indicated that the resident was Ex Order 26. 4B1 . The MDS further revealed that Resident #72 was Ex Order 26. 4B1 and required NJ Exec. Order 26:4.b.1 On 5/25/23 at 12:13 PM, the surveyors interviewed the Director of Nursing (DON), the Licensed Nursing Home Administrator, and the Regional Director of Clinical Services. The DON stated it was not acceptable to have a resident's brief, clothes, and bedding Ex Order 26. soaked. On 5/25/23 at 1:20 PM, the surveyor interviewed the Ex Order 26. Floor C/D Unit Nurse Manager. When told about the Ex Order 26. 4B1 rounds completed on 5/24/23, she stated that Resident # 72 must not have received care on the 11 to 7 shifts and	F 725		

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F 725	Continued From page 69 rounds were not done. She furthered that was not acceptable for the residents to be like that. Review of the facility's "Quality of Life/Dignity Policy" (revised 10/21) indicated the following: ...Demeaning practices and standards of care the compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: ...Promptly responding to the resident's request for toileting assistance; and other needs. 1. For the week of complaint staffing from 01/23/2022 to 01/29/2022, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -01/23/22 had 16 CNAs for 194 residents on the day shift, required 24 CNAs. -01/24/22 had 17 CNAs for 194 residents on the day shift, required 24 CNAs. -01/25/22 had 17 CNAs for 194 residents on the day shift, required 24 CNAs. -01/26/22 had 15 CNAs for 194 residents on the day shift, required 24 CNAs. -01/27/22 had 20 CNAs for 196 residents on the day shift, required 24 CNAs. -01/28/22 had 18 CNAs for 196 residents on the day shift, required 24 CNAs. -01/28/22 had 13 total staff for 196 residents on the overnight shift, required 14 total staff. -01/29/22 had 8 CNAs for 196 residents on the day shift, required 24 CNAs. -01/29/22 had 16 total staff for 196 residents on the evening shift, required 20 total staff. -01/29/22 had 11 total staff for 196 residents on the overnight shift, required 14 total staff.	F 725		

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F 725	Continued From page 70 2. For the 2 weeks of complaint staffing from 03/13/2022 to 03/26/2022, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 4 of 14 evening shifts, and deficient in total staff for residents on 10 of 14 overnight shifts as follows: -03/13/22 had 12 CNAs for 197 residents on the day shift, required 25 CNAs. -03/13/22 had 17 total staff for 197 residents on the evening shift, required 20 total staff. -03/13/22 had 11 total staff for 197 residents on the overnight shift, required 14 total staff. -03/14/22 had 14 CNAs for 196 residents on the day shift, required 24 CNAs. -03/14/22 had 13 total staff for 196 residents on the overnight shift, required 14 total staff. -03/15/22 had 12 CNAs for 195 residents on the day shift, required 24 CNAs. -03/16/22 had 14 CNAs for 194 residents on the day shift, required 24 CNAs. -03/16/22 had 11 total staff for 194 residents on the overnight shift, required 14 total staff. -03/17/22 had 14 CNAs for 193 residents on the day shift, required 24 CNAs. -03/17/22 had 12 total staff for 193 residents on the overnight shift, required 14 total staff. -03/18/22 had 17 CNAs for 193 residents on the day shift, required 24 CNAs. -03/18/22 had 9 total staff for 193 residents on the overnight shift, required 14 total staff. -03/19/22 had 12 CNAs for 193 residents on the day shift, required 24 CNAs. -03/19/22 had 16 total staff for 193 residents on the evening shift, required 19 total staff. -03/19/22 had 9 total staff for 193 residents on the overnight shift, required 14 total staff.	F 725		

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F 725	Continued From page 71 -03/20/22 had 11 CNAs for 193 residents on the day shift, required 24 CNAs. -03/20/22 had 16 total staff for 193 residents on the evening shift, required 19 total staff. -03/20/22 had 12 total staff for 193 residents on the overnight shift, required 14 total staff. -03/21/22 had 16 CNAs for 192 residents on the day shift, required 24 CNAs. -03/21/22 had 18 total staff for 192 residents on the evening shift, required 19 total staff. -03/22/22 had 14 CNAs for 192 residents on the day shift, required 24 CNAs. -03/22/22 had 13 total staff for 192 residents on the overnight shift, required 14 total staff. -03/23/22 had 16 CNAs for 192 residents on the day shift, required 24 CNAs. -03/24/22 had 17 CNAs for 192 residents on the day shift, required 24 CNAs. -03/24/22 had 12 total staff for 192 residents on the overnight shift, required 14 total staff. -03/25/22 had 16 CNAs for 192 residents on the day shift, required 24 CNAs. -03/26/22 had 14 CNAs for 195 residents on the day shift, required 24 CNAs. -03/26/22 had 11 total staff for 195 residents on the overnight shift, required 14 total staff. 3. For the 2 weeks of complaint staffing from 07/03/2022 to 07/09/2022, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 2 of 14 evening shifts, and deficient in total staff for residents on 3 of 14 overnight shifts as follows: -07/03/22 had 7 CNAs for 194 residents on the day shift, required 24 CNAs. -07/03/22 had 17 total staff for 194 residents on the evening shift, required 19 total staff.	F 725		

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F 725	Continued From page 72 -07/04/22 had 13 CNAs for 193 residents on the day shift, required 24 CNAs. -07/05/22 had 14 CNAs for 192 residents on the day shift, required 24 CNAs. -07/05/22 had 18 total staff for 192 residents on the evening shift, required 19 total staff. -07/06/22 had 12 CNAs for 192 residents on the day shift, required 24 CNAs. -07/07/22 had 13 CNAs for 192 residents on the day shift, required 24 CNAs. -07/08/22 had 13 CNAs for 192 residents on the day shift, required 24 CNAs. -07/09/22 had 14 CNAs for 196 residents on the day shift, required 24 CNAs. -07/10/22 had 14 CNAs for 196 residents on the day shift, required 24 CNAs. -07/11/22 had 13 CNAs for 196 residents on the day shift, required 24 CNAs. -07/12/22 had 12 CNAs for 196 residents on the day shift, required 24 CNAs. -07/13/22 had 14 CNAs for 194 residents on the day shift, required 24 CNAs. -07/14/22 had 15 CNAs for 195 residents on the day shift, required 24 CNAs. -07/14/22 had 12 total staff for 195 residents on the overnight shift, required 14 total staff. -07/15/22 had 15 CNAs for 193 residents on the day shift, required 24 CNAs. -07/15/22 had 13 total staff for 193 residents on the overnight shift, required 14 total staff. -07/16/22 had 11 CNAs for 193 residents on the day shift, required 24 CNAs. -07/16/22 had 11 total staff for 193 residents on the overnight shift, required 14 total staff. 4. For the 2 weeks of complaint staffing from 09/04/2022 to 09/17/2022, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents	F 725		

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F 725	Continued From page 73 on 3 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 7 of 14 overnight shifts as follows: -09/04/22 had 14 CNAs for 191 residents on the day shift, required 24 CNAs. -09/04/22 had 11 total staff for 191 residents on the overnight shift, required 14 total staff. -09/05/22 had 15 CNAs for 191 residents on the day shift, required 24 CNAs. -09/05/22 had 16 total staff for 191 residents on the evening shift, required 19 total staff. -09/05/22 had 7 CNAs to 16 total staff on the evening shift, required 8 CNAs. -09/05/22 had 13 total staff for 191 residents on the overnight shift, required 14 total staff. -09/06/22 had 10 CNAs for 191 residents on the day shift, required 24 CNAs. -09/06/22 had 12 total staff for 191 residents on the overnight shift, required 14 total staff. -09/07/22 had 14 CNAs for 191 residents on the day shift, required 24 CNAs. -09/08/22 had 13 CNAs for 191 residents on the day shift, required 24 CNAs. -09/09/22 had 18 CNAs for 196 residents on the day shift, required 24 CNAs. -09/09/22 had 13 total staff for 196 residents on the overnight shift, required 14 total staff. -09/10/22 had 14 CNAs for 196 residents on the day shift, required 24 CNAs. -09/10/22 had 18 total staff for 196 residents on the evening shift, required 20 total staff. -09/11/22 had 13 CNAs for 197 residents on the day shift, required 25 CNAs. -09/11/22 had 18 total staff for 197 residents on the evening shift, required 20 total staff. -09/12/22 had 15 CNAs for 197 residents on the day shift, required 25 CNAs.	F 725		

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F 725	Continued From page 74 -09/13/22 had 14 CNAs for 197 residents on the day shift, required 25 CNAs. -09/14/22 had 13 CNAs for 198 residents on the day shift, required 25 CNAs. -09/15/22 had 16 CNAs for 198 residents on the day shift, required 25 CNAs. -09/15/22 had 10 total staff for 198 residents on the overnight shift, required 14 total staff. -09/16/22 had 15 CNAs for 198 residents on the day shift, required 25 CNAs. -09/16/22 had 13 total staff for 198 residents on the overnight shift, required 14 total staff. -09/17/22 had 13 CNAs for 199 residents on the day shift, required 25 CNAs. -09/17/22 had 9 total staff for 199 residents on the overnight shift, required 14 total staff. 5. For the 2 weeks of staffing prior to survey from 04/30/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 2 of 14 evening shifts, and deficient in total staff for residents on 14 of 14 overnight shifts as follows: -04/30/23 had 12 CNAs for 187 residents on the day shift, required 23 CNAs. -04/30/23 had 12 total staff for 187 residents on the overnight shift, required 13 total staff. -05/01/23 had 15 CNAs for 187 residents on the day shift, required 23 CNAs. -05/01/23 had 11 total staff for 187 residents on the overnight shift, required 13 total staff. -05/02/23 had 16 CNAs for 187 residents on the day shift, required 23 CNAs. -05/02/23 had 11 total staff for 187 residents on the overnight shift, required 13 total staff. -05/03/23 had 14 CNAs for 187 residents on the day shift, required 23 CNAs.	F 725		

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F 725	Continued From page 75 -05/03/23 had 11 total staff for 187 residents on the overnight shift, required 13 total staff. -05/04/23 had 12 CNAs for 191 residents on the day shift, required 24 CNAs. -05/04/23 had 9 total staff for 191 residents on the overnight shift, required 14 total staff. -05/05/23 had 16 CNAs for 183 residents on the day shift, required 23 CNAs. -05/05/23 had 9 total staff for 183 residents on the overnight shift, required 13 total staff. -05/06/23 had 12 CNAs for 181 residents on the day shift, required 23 CNAs. -05/06/23 had 9 total staff for 181 residents on the overnight shift, required 13 total staff. -05/07/23 had 12 CNAs for 181 residents on the day shift, required 23 CNAs. -05/07/23 had 15 total staff for 181 residents on the evening shift, required 18 total staff. -05/07/23 had 10 total staff for 181 residents on the overnight shift, required 13 total staff. -05/08/23 had 11 CNAs for 181 residents on the day shift, required 23 CNAs. -05/08/23 had 11 total staff for 181 residents on the overnight shift, required 13 total staff. -05/09/23 had 16 CNAs for 181 residents on the day shift, required 23 CNAs. -05/09/23 had 9 total staff for 181 residents on the overnight shift, required 13 total staff. -05/10/23 had 18 CNAs for 181 residents on the day shift, required 23 CNAs. -05/10/23 had 15 total staff for 181 residents on the evening shift, required 18 total staff. -05/10/23 had 11 total staff for 181 residents on the overnight shift, required 13 total staff. -05/11/23 had 12 CNAs for 184 residents on the day shift, required 23 CNAs. -05/11/23 had 9 total staff for 185 residents on the overnight shift, required 13 total staff. -05/12/23 had 14 CNAs for 184 residents on the	F 725		

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F 725	Continued From page 76 day shift, required 23 CNAs. -05/12/23 had 11 total staff for 184 residents on the overnight shift, required 13 total staff. -05/13/23 had 13 CNAs for 184 residents on the day shift, required 23 CNAs. -05/13/23 had 10 total staff for 184 residents on the overnight shift, required 13 total staff. On 05/26/23 11:47 AM, the surveyor interviewed the CNA who was assigned to [redacted] Unit, who stated that she was assigned to 12 residents. 05/31/23 12:27 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that often times there were only 2 aides for the whole floor and residents were saturated. She stated that residents complained that they were never changed. On 06/02/23 at 11:44 AM, the surveyor interviewed the staffing coordinator. She stated the CNA staffing ratios for the 7 to 3 shift was 8 to 10 residents per CNA, for the 3 to 11 shift 11 to 15 residents per CNA, for the 11-7 shift up to 20 residents per CNA. She stated she tried her hardest to have enough CNA's. She further stated "we could always work harder or more, but I don't think we are greatly understaffed." On 06/02/23 at 12:29 PM, during an interview with the Licensed Nursing Home Administrator (LNHA) regarding staffing, the surveyor asked if the facility had enough Certified Nursing Assistants (CNAs) on each shift, to meet the staffing requirements set forth by the State of New Jersey Regulations. The LNHA replied, "There are days when we don't meet them". On 06/06/23 at 09:19 AM, the surveyor reviewed	F 725		

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F 725	Continued From page 77 the policy titled, "Staffing Hours", with a revised date of 04/2019. The policy stated that the facility provides adequate staffing to meet needed care and services for our resident population. Under the procedure section, number two indicated that Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. NJAC 8:39-5.1 (a)	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		6/21/23

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F 755	Continued From page 78 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to A. establish a system of records for all controlled drugs in sufficient detail to enable an accurate reconciliation for the dispensing of controlled medications and B. ensure a controlled drug was dispensed in accordance with professional standards of practice. This deficient practice was observed for 2 of 4 medication carts inspected and during the medication pass and was evidenced by the following: A.On 5/24/23 at 10:43 AM, in the presence of the Licensed Practical Nurse (LPN), the surveyor inspected the medication cart on Ex Order 26. 4B1 Unit for storage and labeling of medications. During reconciliation of controlled medications, the surveyor observed the following: 1. 1 bottle of Methadone (a narcotic medication used to treat pain) in the narcotic box but the Controlled Drug Sheet (CDS) documented 2 bottles were left. 2. 41 Clonazepam (a narcotic medication used for anxiety) 0.5mg pills in the blister pack but the CDS documented there were 42 left. The LPN stated that she should have signed the CDS when she administered the medications. She stated she was told to pass breakfast trays out and she was in disarray.	F 755	1. The Controlled Drug Sheet for Ex Order floor was reconciled for the Ex Order 26. 4B1 and Ex Order 26. 4B1 was reconciled from the Ex Order 26. 4B1 to confirm the resident received the medication that shift. The assigned LPN received counseling on ensuring medications are signed out from the Ex Order 26. 4B1 at the time they are dispensed and administered. The Ex Order 26. 4B1 for Ex Order 26. 4B1 wing was reconciled for the Ex Order 26. 4B1 was reconciled from the Ex Order 26. 4B1 to confirm the resident received the medication that shift. The assigned LPN received counseling on ensuring medications are signed out from the Ex Order 26. 4B1 at the time they are dispensed and administered. Resident #116 received Ex Order 26. 4B1 within the ordered time and did not suffer any negative effect. The assigned LPN received counseling on ensuring that medication is signed out for the time it is removed from the Ex Order 26. 4B pack and administered at the time it is dispensed.	

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	315209	A. BUILDING _____ B. WING _____	C 06/05/2023

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

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F 755	Continued From page 79 On 5/24/23 at 10:52 AM, in the presence of the LPN the surveyor inspected the medication cart on Ex Order 26. 4B1 Unit for storage and labeling of medications. During reconciliation of controlled medications, the surveyor observed 16 Tramadol (a narcotic medication used to treat pain) 50mg in the blister pack but the CDS documented there were 17 left. The LPN stated that he should have signed the CDS and that he thought he had signed it out. Review of the facility's policy titled, "Control Substance Management," dated 08/2022, revealed that the medication nurse is responsible for recording any administered medications on the appropriate CDS including date, time, amount used and amount remaining signature. On 5/25/23 at 11:56 AM, the Regional Director of Clinical Services (RDCS) stated the nurses should sign the CDS out when they give the medication. B. On 5/22/23 at 8:45 AM, the surveyor observed the LPN preparing medication for Resident # 116. The surveyor observed Ex Order 26. 4B1 in the Ex Order 26. 4B pack. The declining inventory page for the Ex Order 26. 4B1 was signed out 5/22/23 at 9am (after the current time). The surveyor observed Ex in the Ex Order 26. 4B pack. The declining inventory sheet for Ex Order 26. 4B1 was signed out 5/22/23 at 9am (after the current time). The surveyor observed the Ex pills in a medication cup in the top drawer of the medication cart. The LPN stated that she poured the pills early because Resident #116 asked for her medication. She stated that she signed the medications out early and placed the pills in the	F 755	2. All residents on NJ Exec. Order 26:4.b.1 have the potential to be affected by this deficient practice. All Ex Order 26. 4B1 were audited and no other resident□s NJ Exec. Order 26:4.b.1 count was identified to be prematurely removed or removed without being signed out. 3. The facility policy on medication administration and NJ Exec. Order 26:4.b.1 as reviewed by the Director of Nursing and determined to be in compliance with state and federal guidelines. The staff educator/ designee educated license nursing on pharmacy services ensuring that the licensed staff follows the established system for removal of NJ Exec. Order 26:4.b.1 to ensure accurate reconciliation; and drug records are in order and account for al NJ Exec. Order 26:4.b.1 are maintained. The in-service will specifically focus on the following: A. NJ Exec. Order 26:4.b.1 substances must be signed out on the MAR and Ex Order 26. 4B1 at the time of removal. B. NJ Exec. Order 26:4.b.1 substances are to never be pre-poured and placed in the medication cart prior to administration. C. The MAR and the NJ Exec. Order 26:4.b.1 declining balance must reflect the same times. 4.	

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F 755	Continued From page 80 cart because she got sidetracked. She acknowledged that she should not have placed the medication in the top drawer. She stated she usually signs the CDS when she administers the medication. The surveyor observed the nurse administer Resident #116's scheduled medication with no concerns. On 5/22/23 at 9:06 AM, the [Ex Order 2] Floor [Ex Order] Unit Manager stated that the LPN should not have signed the CDS before administering medication. She furthered that the LPN should not have placed any medication in the top drawer of the medication cart. On 5/22/23 at 1:33 PM, the Director of Nursing stated the LPN should not have signed the CDS prior to administering the medication. A review of the facility's Medication Administration-Documentation Policy with a last date revised of 1-2019 indicated, administration of medication must be documented immediately after (never before) it is given, and medication must be poured/distributed at the time of administration.	F 755	The Director of Nursing/designee will audit 10 med passes on alternating hallways to ensure no [NJ Exec. Order 26:4.b.1] substances are removed and logged prior to administration or removed and not logged out at the time of removal. The audits will be completed weekly x 4 weeks then monthly for a minimum of 6 months or until compliance is met. All Audits will be presented at the facilities monthly QAPI meeting. The Director Of Nursing is responsible for the execution and monitoring of this POC. The Director of Nursing is responsible for the execution and monitoring of this plan of correction.	
F 812 SS=F	NJAC 8:39-29.2(d), 29.7(c) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		6/21/23

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F 812	Continued From page 81 §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 observation, interview and record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner in order to prevent food borne illness. This deficient practice was evidenced by the following: On 05/17/2023 at 9:33 AM, the surveyor accompanied by the Food service Director (FSD) observed the following in the kitchen: The surveyor observed a number of unlabeled items throughout the kitchen which included three bags of sugar on the table, on a shelf there were rolls and bagels, in the meat freezer there was a bag of chicken wings and one veggie burger in a box. In the ice cream freezer there were three boxes of Dixie ice cream cups. In the dry storage there was one can of Mashed potatoes and one	F 812	1. A. The following items were discarded: 1. The three bags of sugar on the table, 2. The rolls and bagels, 3. The bag of chicken wings 4. The one veggie burger in a box. 5. The three boxes of Dixie ice cream cups. 6. The one can of Mashed potatoes 7. The one box of Raisin Bran cereal. 8. The five bags of cake mix. 9. The block of margarine. 10. The container of Lyons thickener 11. The crate of milk 12. The log of bologna 13. The pizza box. B. The four metal pans that were stacked on top of each other were pulled apart and cleaned and dried separately.	

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F 812	Continued From page 82 box of Raisin Bran cereal. Over the sink on a shelf were five bags of cake mix. In the walk in refrigerator there was one block of margarine. On the counter there was a container of Lyons thickener that was unlabled. The FSD observed at the time of the tour that these items were not labeled and confirmed the items should have been labeled appropriately. The surveyor observed a crate of milk and the milk in the crate was outdated with an expiration date of 05/08/2023, there was a log of bologna with an expiration date of 05/06/2023, and a pizza box with an expiration date of 01/12/2023. The FSD confirmed that the dates were expired, the items were removed and discarded. On the middle shelf of the cleaned and sanitized rack, the surveyor observed four metal pans that were stacked on top of each other in an inverted position. The pans were pulled apart to separate them and the pans were wet with a clear liquid substance. The FSD stated the staff who was normally assigned to this task was out so the FSD had to use another staff and would re-educate the alternate staff on wet nesting. The FSD confirmed the items should have been completely dry and not wet. The FSD removed the pans from the shelf and advised the staff to rewash the four metal pans and showed the staff the appropriate way to stack the metal pans. During that same day of the kitchen tour at 10:14 AM, the surveyor observed a Licensed	F 812	C. The LPN that did not wear the hairnet no longer works at the facility. 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 facility policy on Food Procurement was reviewed by the Administrator and Food Service Director and determined to be compliant with state and federal regulations. The staff educator/ designee educated all dietary staff on food procurement, prepare and serve sanitary food. The in-service specifically focused on ensuring all items are dated when stored, expired food is discarded, ensuring staff is wearing hairnets while in the kitchen, and not nesting pots while drying. The staff educator/ designee educated all staff that hairnets must be worn while in the kitchen. 4. The Administrator/ Designee will complete audits of the kitchen to ensure hairnets are worn, food is dated when stored, expired food is discarded, and pots/ pans are not nested when drying. The audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met.	

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F 812	Continued From page 83 Professional Nurse (LPN) walk into the middle of the kitchen area without a hair net on and requested clear juice. The FSD provided the staff with the juice. The FSD confirmed that the staff was not wearing a hair net and should have worn a hair net before entering the kitchen. The surveyor interviewed the LPN who stated that they usually wore a hairnet and apologized for not having one on. The LPN then confirmed with the surveyor that a hairnet was important to be worn in the kitchen at all times. The surveyor reviewed the facility policy titled "Centers Health Care Food Storage", last date revised 03/09/2022. Which included that sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. The policy revealed the following under the Procedure heading: 7. (c.) "Food should be dated as it is placed on the shelves if required by state regulation." (d.) "Date marking to indicate the date or day by which a ready-to-eat, time/temperature control for safety food, (formerly known as PHF) should be consumed, sold, or discarded will be visible on all high-risk food." Refrigerated food storage: f. "All foods should be covered, labeled and dated. All foods will be checked to assure that	F 812	The results of these audits will be presented at monthly QAPI. The Administrator is responsible for the execution and monitoring of this plan of correction.	

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F 812	Continued From page 84 foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded." Frozen Foods: c. "All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be checked to assure that foods will be consumed by their safe use by dates or discarded." The surveyor reviewed the facility policy titled "Cleaning Dishes", last date reviewed 01/2023. The policy revealed the following under the Procedure heading: Sanitize 5. allow dishes to air dry. Invert dishes in a single layer to air dry. Check all dishes to be sure they are clean and dry prior to storing. Cleaning Standards 2. Pots and Pans free of grease, edge/lips clean with no build up of debris, air dried, dry before placed on pot rack, free of pits, smooth to touch. The surveyor reviewed the facility policy titled "Centers Health Care Employee Education", last date revised 06/01/2023. Under the hair net topic, the policy revealed the following: All staff must defer to the dietary staff when needing to order from the kitchen. If for any reason you need to enter the kitchen area you must put on a hair net and perform hand hygiene before entering.	F 812		

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F 812	Continued From page 85 NJAC 8:39-17.2(g)	F 812		

New Jersey Department of Health

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	060113	A. BUILDING: _____ B. WING _____	C 06/05/2023

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HAMMONTON CENTER FOR REHABILITATION	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: NJ #00151692, NJ #00153388, NJ00158216, NJ00157947, NJ00157442 Based on observation, interview, and record review it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to a.) provide *Ex Order 26. 4B1* in a timely manner and b.) maintain the required minimum direct care staff to shift ratios as mandated by the State of New Jersey, c.) to provide a full time designated Infection Prevention and Control Nurse to perform that sole role onsite at the facility. Refer to F677	S 560	1. No residents were noted to have been affected by this defficient practice. Facility schedules were evaluated to ensure that minimum staffing requirments of direct care staff to residents is provided to meet residents requirements for Activities of Daily living. 2. All residents have the potential to be affected by this deficient practice. Facility schedules were reviwed and staffing was added to meet the minimun requirements of direct care staff to resident.	6/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for 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 (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks listed, the staffing-to-resident ratio did not meet the minimum requirements and is documented below: A. For the week of complaint staffing from 01/23/2022 to 01/29/2022, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -01/23/22 had 16 CNAs for 194 residents on the	S 560	Additional staff was hired, staffing agencies and recruiters were contracted to aid in the efforts to provide additional staff. The facility has initiated sign on bonuses to secure additional staff and bonuses for staff referrals. Additional ads were created on recruiting websites and recruiting flyers and signs placed in the community and facility to attract nursing staff. 3. The facility policy on staffing was reviewed by the Administrator and determined to be in compliance with federal guidelines. The staffing coordinator was educated on ensuring that the minimum staffing requirements of direct care staff to residents are reached to provide activities of daily living to all residents. The staff educator in- serviced nursing staff on ensuring that residents needs are met including activities of daily living rendered to dependent residents and *Ex Order 26. 4B1* to dependent residents. Nursing supervisors were educated to notify administration and the Director of Nursing if there was not enough staff to render activities of daily living. 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	

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S 560	Continued From page 2 day shift, required 24 CNAs. -01/24/22 had 17 CNAs for 194 residents on the day shift, required 24 CNAs. -01/25/22 had 17 CNAs for 194 residents on the day shift, required 24 CNAs. -01/26/22 had 15 CNAs for 194 residents on the day shift, required 24 CNAs. -01/27/22 had 20 CNAs for 196 residents on the day shift, required 24 CNAs. -01/28/22 had 18 CNAs for 196 residents on the day shift, required 24 CNAs. -01/28/22 had 13 total staff for 196 residents on the overnight shift, required 14 total staff. -01/29/22 had 8 CNAs for 196 residents on the day shift, required 24 CNAs. -01/29/22 had 16 total staff for 196 residents on the evening shift, required 20 total staff. -01/29/22 had 11 total staff for 196 residents on the overnight shift, required 14 total staff. For the 2 weeks of complaint staffing from 03/13/2022 to 03/26/2022, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 4 of 14 evening shifts, and deficient in total staff for residents on 10 of 14 overnight shifts as follows: -03/13/22 had 12 CNAs for 197 residents on the day shift, required 25 CNAs. -03/13/22 had 17 total staff for 197 residents on the evening shift, required 20 total staff. -03/13/22 had 11 total staff for 197 residents on the overnight shift, required 14 total staff. -03/14/22 had 14 CNAs for 196 residents on the day shift, required 24 CNAs. -03/14/22 had 13 total staff for 196 residents on the overnight shift, required 14 total staff. -03/15/22 had 12 CNAs for 195 residents on the day shift, required 24 CNAs.	S 560	to actual payroll punches to ensure nursing staff is provided to meet the resident needs for activities of daily living Audits will be completed weekly x 4 weeks and monthly for a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The Director of Nursing/ Designee will complete weekly random audits of 20% of all NJ Exec. Order 26:4.b.1 residents to ensure that NJ Exec. Order 26:4.b.1 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 and no less than 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. The Administrator is responsible for the execution and monitoring of this plan of correction.	

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S 560	Continued From page 3 -03/16/22 had 14 CNAs for 194 residents on the day shift, required 24 CNAs. -03/16/22 had 11 total staff for 194 residents on the overnight shift, required 14 total staff. -03/17/22 had 14 CNAs for 193 residents on the day shift, required 24 CNAs. -03/17/22 had 12 total staff for 193 residents on the overnight shift, required 14 total staff. -03/18/22 had 17 CNAs for 193 residents on the day shift, required 24 CNAs. -03/18/22 had 9 total staff for 193 residents on the overnight shift, required 14 total staff. -03/19/22 had 12 CNAs for 193 residents on the day shift, required 24 CNAs. -03/19/22 had 16 total staff for 193 residents on the evening shift, required 19 total staff. -03/19/22 had 9 total staff for 193 residents on the overnight shift, required 14 total staff. -03/20/22 had 11 CNAs for 193 residents on the day shift, required 24 CNAs. -03/20/22 had 16 total staff for 193 residents on the evening shift, required 19 total staff. -03/20/22 had 12 total staff for 193 residents on the overnight shift, required 14 total staff. -03/21/22 had 16 CNAs for 192 residents on the day shift, required 24 CNAs. -03/21/22 had 18 total staff for 192 residents on the evening shift, required 19 total staff. -03/22/22 had 14 CNAs for 192 residents on the day shift, required 24 CNAs. -03/22/22 had 13 total staff for 192 residents on the overnight shift, required 14 total staff. -03/23/22 had 16 CNAs for 192 residents on the day shift, required 24 CNAs. -03/24/22 had 17 CNAs for 192 residents on the day shift, required 24 CNAs. -03/24/22 had 12 total staff for 192 residents on the overnight shift, required 14 total staff. -03/25/22 had 16 CNAs for 192 residents on the day shift, required 24 CNAs.	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 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

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S 560	Continued From page 4 -03/26/22 had 14 CNAs for 195 residents on the day shift, required 24 CNAs. -03/26/22 had 11 total staff for 195 residents on the overnight shift, required 14 total staff. For the 2 weeks of complaint staffing from 07/03/2022 to 07/09/2022, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 2 of 14 evening shifts, and deficient in total staff for residents on 3 of 14 overnight shifts as follows: -07/03/22 had 7 CNAs for 194 residents on the day shift, required 24 CNAs. -07/03/22 had 17 total staff for 194 residents on the evening shift, required 19 total staff. -07/04/22 had 13 CNAs for 193 residents on the day shift, required 24 CNAs. -07/05/22 had 14 CNAs for 192 residents on the day shift, required 24 CNAs. -07/05/22 had 18 total staff for 192 residents on the evening shift, required 19 total staff. -07/06/22 had 12 CNAs for 192 residents on the day shift, required 24 CNAs. -07/07/22 had 13 CNAs for 192 residents on the day shift, required 24 CNAs. -07/08/22 had 13 CNAs for 192 residents on the day shift, required 24 CNAs. -07/09/22 had 14 CNAs for 196 residents on the day shift, required 24 CNAs. -07/10/22 had 14 CNAs for 196 residents on the day shift, required 24 CNAs. -07/11/22 had 13 CNAs for 196 residents on the day shift, required 24 CNAs. -07/12/22 had 12 CNAs for 196 residents on the day shift, required 24 CNAs. -07/13/22 had 14 CNAs for 194 residents on the day shift, required 24 CNAs. -07/14/22 had 15 CNAs for 195 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 5	S 560		

day shift, required 24 CNAs.
-07/14/22 had 12 total staff for 195 residents on the overnight shift, required 14 total staff.
-07/15/22 had 15 CNAs for 193 residents on the day shift, required 24 CNAs.
-07/15/22 had 13 total staff for 193 residents on the overnight shift, required 14 total staff.
-07/16/22 had 11 CNAs for 193 residents on the day shift, required 24 CNAs.
-07/16/22 had 11 total staff for 193 residents on the overnight shift, required 14 total staff.

For the 2 weeks of complaint staffing from 09/04/2022 to 09/17/2022, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 3 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 7 of 14 overnight shifts as follows:

-09/04/22 had 14 CNAs for 191 residents on the day shift, required 24 CNAs.
-09/04/22 had 11 total staff for 191 residents on the overnight shift, required 14 total staff.
-09/05/22 had 15 CNAs for 191 residents on the day shift, required 24 CNAs.
-09/05/22 had 16 total staff for 191 residents on the evening shift, required 19 total staff.
-09/05/22 had 7 CNAs to 16 total staff on the evening shift, required 8 CNAs.
-09/05/22 had 13 total staff for 191 residents on the overnight shift, required 14 total staff.
-09/06/22 had 10 CNAs for 191 residents on the day shift, required 24 CNAs.
-09/06/22 had 12 total staff for 191 residents on the overnight shift, required 14 total staff.
-09/07/22 had 14 CNAs for 191 residents on the day shift, required 24 CNAs.
-09/08/22 had 13 CNAs for 191 residents on the

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S 560	Continued From page 6 day shift, required 24 CNAs. -09/09/22 had 18 CNAs for 196 residents on the day shift, required 24 CNAs. -09/09/22 had 13 total staff for 196 residents on the overnight shift, required 14 total staff. -09/10/22 had 14 CNAs for 196 residents on the day shift, required 24 CNAs. -09/10/22 had 18 total staff for 196 residents on the evening shift, required 20 total staff. -09/11/22 had 13 CNAs for 197 residents on the day shift, required 25 CNAs. -09/11/22 had 18 total staff for 197 residents on the evening shift, required 20 total staff. -09/12/22 had 15 CNAs for 197 residents on the day shift, required 25 CNAs. -09/13/22 had 14 CNAs for 197 residents on the day shift, required 25 CNAs. -09/14/22 had 13 CNAs for 198 residents on the day shift, required 25 CNAs. -09/15/22 had 16 CNAs for 198 residents on the day shift, required 25 CNAs. -09/15/22 had 10 total staff for 198 residents on the overnight shift, required 14 total staff. -09/16/22 had 15 CNAs for 198 residents on the day shift, required 25 CNAs. -09/16/22 had 13 total staff for 198 residents on the overnight shift, required 14 total staff. -09/17/22 had 13 CNAs for 199 residents on the day shift, required 25 CNAs. -09/17/22 had 9 total staff for 199 residents on the overnight shift, required 14 total staff. For the 2 weeks of staffing prior to survey from 04/30/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 2 of 14 evening shifts, and deficient in total staff for residents on 14 of 14 overnight shifts as follows:	S 560		

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S 560	Continued From page 7 -04/30/23 had 12 CNAs for 187 residents on the day shift, required 23 CNAs. -04/30/23 had 12 total staff for 187 residents on the overnight shift, required 13 total staff. -05/01/23 had 15 CNAs for 187 residents on the day shift, required 23 CNAs. -05/01/23 had 11 total staff for 187 residents on the overnight shift, required 13 total staff. -05/02/23 had 16 CNAs for 187 residents on the day shift, required 23 CNAs. -05/02/23 had 11 total staff for 187 residents on the overnight shift, required 13 total staff. -05/03/23 had 14 CNAs for 187 residents on the day shift, required 23 CNAs. -05/03/23 had 11 total staff for 187 residents on the overnight shift, required 13 total staff. -05/04/23 had 12 CNAs for 191 residents on the day shift, required 24 CNAs. -05/04/23 had 9 total staff for 191 residents on the overnight shift, required 14 total staff. -05/05/23 had 16 CNAs for 183 residents on the day shift, required 23 CNAs. -05/05/23 had 9 total staff for 183 residents on the overnight shift, required 13 total staff. -05/06/23 had 12 CNAs for 181 residents on the day shift, required 23 CNAs. -05/06/23 had 9 total staff for 181 residents on the overnight shift, required 13 total staff. -05/07/23 had 12 CNAs for 181 residents on the day shift, required 23 CNAs. -05/07/23 had 15 total staff for 181 residents on the evening shift, required 18 total staff. -05/07/23 had 10 total staff for 181 residents on the overnight shift, required 13 total staff. -05/08/23 had 11 CNAs for 181 residents on the day shift, required 23 CNAs. -05/08/23 had 11 total staff for 181 residents on the overnight shift, required 13 total staff. -05/09/23 had 16 CNAs for 181 residents on the day shift, required 23 CNAs.	S 560		

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S 560	Continued From page 8 -05/09/23 had 9 total staff for 181 residents on the overnight shift, required 13 total staff. -05/10/23 had 18 CNAs for 181 residents on the day shift, required 23 CNAs. -05/10/23 had 15 total staff for 181 residents on the evening shift, required 18 total staff. -05/10/23 had 11 total staff for 181 residents on the overnight shift, required 13 total staff. -05/11/23 had 12 CNAs for 184 residents on the day shift, required 23 CNAs. -05/11/23 had 9 total staff for 185 residents on the overnight shift, required 13 total staff. -05/12/23 had 14 CNAs for 184 residents on the day shift, required 23 CNAs. -05/12/23 had 11 total staff for 184 residents on the overnight shift, required 13 total staff. -05/13/23 had 13 CNAs for 184 residents on the day shift, required 23 CNAs. -05/13/23 had 10 total staff for 184 residents on the overnight shift, required 13 total staff. On 06/02/23 at 12:29 PM, during an interview with the survey team and the Licensed Nursing Home Administrator (LNHA) regarding staffing, a surveyor asked if the facility had enough Certified Nursing Assistants (CNAs) on each shift, based on the State of New Jersey Regulations. The LNHA replied, "There are days when we don't meet them". On 06/02/23 at 11:44 AM, the surveyor interviewed the staffing coordinator. She stated the CNA staffing ratios for the 7 to3 shift was 8 to 10 residents per CNA, for the 3 to 11 shift 11 to 15 residents per CNA,for the 11-7 shift up to 20 residents per CNA. She stated she tries her hardest to have enough CNA's. She furthered "we could always work harder or more but I don't think we are greatly understaffed."	S 560		

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S 560	Continued From page 9 On 06/06/23 at 09:19 AM, the surveyor reviewed the policy titled, "Staffing Hours", with a revised date of 04/2019. The policy stated that the facility provides adequate staffing to meet needed care and services for our resident population. Under the procedure section, number two indicated that Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. B. Refer to F677 c.) During an interview on 06/02/2023 at 12:37 PM, the Director of Nursing (DON) stated that she served in the role simultaneously as the Infection Prevention and Control (IPC) Nurse and the DON for approximately a year and a half until a full time IPC was hired two months ago in April 2023. The DON stated she has the trainings and was able to do both positions full time as the IPC and the DON. During an interview on 06/02/2023 at 01:35 PM, the Regional Director of Clinical Service (RDCS) stated she had the IP trainings and was working as the consultant to the DON during that time. The RDCS confirms that she did not work onsite at the facility on a daily basis. Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following: ii. Required Core Practices for Infection Prevention and Control: Facilities are required to have one or more individuals with training in infection prevention	S 560		

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S 560	Continued From page 10 and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; or b. A Physician who has completed an infectious Disease fellowship; or c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of Infection Control experience. iv. Facilities with 100 or more beds or on-site *Ex Order 26. 4B1* services must: 1. Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021.	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation it was determined that the facility did not offer residents evening activities two	S 720	1. No residents have been negatively affected as a result of this deficient practice. Facility hired an employee who	6/21/23

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S 720	Continued From page 11 nights per week and was evidenced by the following: On 05/24/23 at 10:34 AM, the surveyor held a group meeting with seven residents in attendance (Residents #15, 38, 63, 64, 123, 146, and Resident #169). During the resident meeting, all the residents in attendance voiced concerns of no evening activities being offered. Seven of the seven residents told the surveyor that there had never been any evening activities. Resident #123 told the surveyor that there had never been any activities staff in the building in the evenings for as "long as I can remember". On 05/24/23 at 12:30 PM, the surveyor reviewed three months of activities calendars, March, April and May 2023. There were no evening activities offered on the three months reviewed by the surveyor. On all of the three months the last activity time for each day was 3:00 PM. On 05/31/23 at 12:35 PM, the surveyor interviewed the facility Activities Director (AD). The surveyor asked the AD who was responsible to create the activities calendar and the AD said it was her responsibility. The surveyor then asked the AD about evening activities and the AD told the surveyor, "We have nothing right now, I just hired someone, and someone retired, so it's been rough". The surveyor asked the AD when the last evening activities and the AD said, "Have not had evening activities for approximately a year or two, something like that". The AD told the surveyor that the activities staff worked from 8:30 to 4:30 PM, seven days/week. On 06/06/23 at 12:16 PM, the surveyor reviewed	S 720	will start on 6/21/23. This employee has been hired to provide evening activities for the Residents. 2. All residents have the potential to be affected by this deficient practice. Activities Dir. has been in serviced on the NJ state regulation related to ensuring facilities are providing evening activities for residents 3. Administrator will audit activities staffing schedules weekly x 4 weeks and then monthly x 3 months or until compliance is met to ensure evening activities are being provided for residents. 4. All audits will be presented and reviewed during the facilities monthly QAPI meeting. All concerns presented during the meeting will be addressed and corrected. The Administrator is responsible for this plan of correction.	

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S 720	Continued From page 12 the policy titled, "Recreation Services", dated 05/2019. Under the procedure section, number four (b), indicated that activities are offered at hours convenient to the residents, including evenings, holidays and weekends.	S 720		

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	315209	A. BUILDING _____ B. WING _____	R-C 08/01/2023

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

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 8/01/2023 to verify the facility's POC for the Recertification survey of 6/05/2023. The facility was found not in compliance with F677. CENSUS: 157 SAMPLE SIZE: 12	{F 000}		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out [redacted] receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure a resident received the appropriate [redacted] specifically by applying two [redacted] on a resident. The deficient practice was identified for 1 of 13 residents (Resident #12) observed during the tour of the facility. On 08/01/2023 at 8:13 AM, during the initial tour of the facility and in the presence of Licensed Practical Nurse (LPN) #1, the surveyor observed Resident #12 in his/her room. At that time, Resident #12 informed the surveyor that his/her [redacted]. Upon receiving Resident #12's consent, LPN #1 exposed Resident #12's	{F 677}	1. [redacted] was provided immediately to Resident #12. A [redacted] was completed with no noted [redacted]. Assigned CNA was immediately counseled and suspended pending investigation. 2. All [redacted] residents have the potential to be affected by this deficient practice. All other [redacted] residents were assessed for [redacted]. No new [redacted] were noted as a result of this Audit. All other [redacted] residents were audited to ensure that no residents were [redacted] nor were any residents identified with a [redacted] 3. Staff educator educated all nursing staff on facilities policy and procedure for	8/14/23

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

Electronically Signed | 08/14/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 1 Ex Order 26. 4B1 NJ Exec. Ord that appeared saturated with Ex Order 26. . At that time, when LPN #1 opened the Ex Order 26. 4B1 NJ Exec. Ord, it was exposed another Ex Order 26. 4B1 NJ Exec. Ord that also appeared saturated with NJ Exec. Order 2 A review of Resident #12's Diagnoses located in the Electronic Medical Record (EMR) revealed he/she was diagnosed with Ex Order 26. 4B1 [redacted]. A review of Resident #12's Annual Minimum Data Set (MDS) an assessment tool dated NJ Exec. Order 26:4.b.1, revealed under section "C" that he/she had a Brief Interview for Mental Status score of Ex Or /15 indicating that he/she had Ex Order 26. 4B1 [redacted]. The MDS also revealed under section, "H" that he/she was occasionally Ex Order 26. 4B1 [redacted]. A review of Resident #12's 06/10/2020 Care Plan located in the EMR revealed a focus that he/she has Ex Order 26. 4B1 [redacted] related to Ex Order 26. 4B1 [redacted] and Ex Order 26. 4B1 [redacted]. On 08/01/2023 at 9:28 AM, during an interview with the surveyor, Certified Nursing Assistant (CNA #1) replied, "No. Absolutely not." when the surveyor asked if two Ex Order 26. 4B1 NJ Exec. Order 2 can be applied to a resident at one time. On the same date at 9:35 AM, during an interview with the surveyor, CNA #2 confirmed Resident	{F 677}	proper Ex Order 26. 4B1 with specificity on prohibiting NJ Exec. Order 26:4.b.1 on residents. 4. Director of Nursing / Designee will audit all Ex Order 26. 4B1 residents per shift to ensure residents are being changed timely and are not being NJ Exec. Order 26:4.b.1. The audit will be conducted every shift x 4 weeks and then daily x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all NJ Exec. Order 26:4.b.1 residents are changed timely and are not NJ Exec. Order 26:4.b.1. In addition, Director/ Designee will conduct random weekly night shift audits x 4 weeks and then monthly x 3 months or until compliance is met. All audit results will be reviewed monthly by the quality assurance and performance improvement committee. Audits will be reviewed for 3 months or until compliance is met.	

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 _____	R-C 08/01/2023

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 2 #12 is Ex Order 26. 4B1 . Further, she replied, "No" when the surveyor asked if two Ex Order 26. 4B1 NJ Exec. Order can be applied to Resident #12. On the same date at 12:04 PM, during an interview with the surveyor, the Director of Nursing (DON) confirmed Resident #12 is Ex Order 26. 4B1 . Secondly, she stated, "It is not facility policy" when the surveyor asked if two Ex Order 26. 4B1 NJ Exec. Order can be applied to Resident #12. Lastly, the DON replied, "No." when the surveyor asked if CNAs are supposed to be applying two Ex Order 26. 4B1 NJ Exec. Order to residents. A review of the facility policy titled, Ex Order 26. 4B1 - Assessment and Management" revised 5/2019 revealed under, "Policy" that, "2. Management of Ex Order 26. 4B1 will follow relevant clinical guidelines." A review of the facility policy titled, Ex Order 26 - Personal Hygiene" revised 10/2021 revealed under, "Policy" that, "Ex Order 26. 4B1 for a Resident will be provided as needed for each individual Resident per care plan and Kardex." § 8:39-27.1 (a) § 8:39-27.2 (h)	{F 677}		

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	8/1/2023 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 F0558	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	06/21/2023	LSC	06/21/2023	LSC	06/21/2023
ID Prefix F0641	Correction	ID Prefix F0658	Correction	ID Prefix F0686	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	06/21/2023	LSC	06/21/2023	LSC	06/21/2023
ID Prefix F0688	Correction	ID Prefix F0689	Correction	ID Prefix F0692	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	06/21/2023	LSC	06/21/2023	LSC	06/21/2023
ID Prefix F0695	Correction	ID Prefix F0725	Correction	ID Prefix F0755	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	06/21/2023	LSC	06/21/2023	LSC	06/21/2023
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/21/2023	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 6/5/2023

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060113	A. BUILDING: _____ B. WING _____	R-C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 Repeat Deficiency Survey Dates: 8/1/2023 Survey Census: 157 Sample Size: 12 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	{S 000}		
{S 560}	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident	{S 560}	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. All Nurse managers and Manager on Duty for the weekends were educated on CNA staffing minimum ratios as required	8/14/23

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

Electronically Signed | 08/14/23

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 _____	R-C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 ratios as mandated by the state of New Jersey for 8 of 14 day shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into 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 CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 07/16/2023 to 07/29/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one direct care staff member to every 10 residents for the evening shift as documented below: The facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows:	{S 560}	by New Jersey Department of Health. In addition, they have been educated to notify the Director of Nursing and/or the Administrator if CNA staffing ratios have not been met. Facility will review staffing daily for each day, evening, and night shift to ensure the minimum CNA staffing ratios are met. The facility will continue to focus on recruitment and retention including but not limited to, use of web-based recruitment advertising, contract utilization, sign on bonuses and referral bonuses, shift differentials and employee moral incentives. The facility will continue to assess and evaluate the staffing outcomes based on offered rates, job fairs, recruitment packages and staff retention weekly, making necessary adjustments based on analysis and findings. 4. The Administrator and/or designee will create an audit tool to utilize for Recruitment to track and trend recruitment efforts weekly x4, then monthly for 3 months or until compliance is met. All audit results will be reviewed monthly by the quality assurance and performance improvement committee. Audits will be reviewed for 3 months or until compliance is met.	

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 _____	R-C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

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{S 560}	Continued From page 2 -07/16/23 had 16 CNAs for 157 residents on the day shift, required 20 CNAs. -07/17/23 had 18 CNAs for 156 residents on the day shift, required 19 CNAs. -07/18/23 had 17 CNAs for 154 residents on the day shift, required 19 CNAs. -07/20/23 had 18 CNAs for 154 residents on the day shift, required 19 CNAs. -07/21/23 had 14 CNAs for 154 residents on the day shift, required 19 CNAs. -07/22/23 had 17 CNAs for 154 residents on the day shift, required 19 CNAs. -07/23/23 had 16 CNAs for 157 residents on the day shift, required 20 CNAs. -07/24/23 had 18 CNAs for 155 residents on the day shift, required 19 CNAs.	{S 560}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060113 Y1	A. Building B. Wing Y2	8/1/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0720 Reg. # 8:39-7.3(d) LSC	Correction Completed 06/21/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 6/5/2023	☐ 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)	8/15/2023 (Y3)

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 08/14/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/5/2023	☐ 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	8/15/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 08/14/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**06/05/2023**

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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/18/2023 and 05/19/2023 and Hammonton Center For Rehabilitation and Healthcare was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Hammonton Center For Rehabilitation and Healthcare is a Two-story, Type I Fire Resistant building that was built in January 1984. The facility is divided into 13 smoke zones. The facility has one Diesel emergency generator.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K 222		6/22/23

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

Electronically Signed | 06/22/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**06/05/2023**

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**

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K 222	Continued From page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**06/05/2023**

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
K 222	Continued From page 2 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 05/18/2023 and 05/19/2023, it was determined that the facility failed to provide 1 of 11 designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building with eleven designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility AMM a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor inspected eleven (11) designated exit discharge doors with the following	K 222	1. Facility removed the knob latches from the front entrance doors. All other Egress Doors of the facility have been audited. No Additional knob latches have been discovered as a result of this audit. 2. All resident can be affected by this deficient practice. Dir. of Maintenance and all Maintenance personal have been in serviced on NFPA 101 related to egress with specificity on the requirement that knob latches cannot be install on any doors used for means of Egress. 3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that no latches have been installed on any doors used for means of Egress . 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**06/05/2023**

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K 222	Continued From page 3 results: 1) On 05/19/2023 at approximately 11:48 AM, the surveyor observed the main entrance two sets of automatic sliding exit discharge doors (internal set of doors and external set of doors) revealed thumb turn locks on the egress side of both sets of doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The doors had a sign that read, Push here in the event of an emergency. Thumb turn locks and fastening device on the door could restrict emergency use of the exit. The AMM confirmed the findings at the times of observations. On 05/19/2023 during the survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e)	K 222		
K 311 SS=D	NFPA 101 2012 - 7.2.1.6.1 (4). Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with	K 311		6/22/23

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K 311	Continued From page 4 construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 05/18/2023 and 05/19/2023, in the presence of facility Management it was determined that the facility failed to ensure that 1 of 14 exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building and a basement with fourteen (14) designated exit access doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility AMM a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor inspected and conducted closure test of fourteen (14) exit access doors leading into exit stairways with the following results:	K 311	1. On 5/18/2023 Maintenance Department immediately addressed and fixed the existing door knob to positively latch upon closure of the door. All other doors used for means of Egress that have doorknobs installed on them, have been audited to ensure that they positively latch upon closure of the door. No additional issues have been discovered as a result of this audit. 2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to vertical openings with specificity on doors positively latching for all exit access doors. 3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all exit doors positively latch upon closure. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

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K 311	Continued From page 5 On 05/19/2023, 1. At approximately 11:33 AM, during a closure test of the [redacted] floor stairway (next to Social Services) corridor exit access door, when the door was opened to a 90 degree opening to the door frame and allowed to self-close, the door did not positive latch into its frame. This test was performed two additional times with the same results. The surveyor observed the door had no means to positive latch into its frame. The stairwell doors would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The AMM confirmed the finding at the time of observations. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard.	K 311		
K 321 SS=E	NJAC 8:39- 31.2(e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321		6/22/23

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K 321	Continued From page 6 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7.	K 321	1. The Maintenance department adjusted the Dietary dry storage door and the Medical Records storage room door to ensure that these doors self-close into their frame upon closure. 2. All residents can be affected by this deficient practice. Dir. of Maintenance and all Maintenance personal have been in serviced on NFPA 101 related to Hazardous areas □ enclosures to ensure that all self-closing doors self-close into	

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K 321	Continued From page 7 This deficient practiced was evidenced by the following: On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building and a basement. Starting at approximately 9:22 AM on 05/18/2023 in the presence of the facility AMM a tour of the building was conducted. Along the tour of the facility the surveyor observed the following hazardous area that failed to have smoke resisting doors. On 05/18/2023: 1) At approximately 9:39 AM, an inspection of the Medical records storage room in the basement was performed. During a closure test of the corridor door leading into the Medical records storage room, the door did not self-close into its frame. The surveyor observed 22 combustible boxes of medical records in the room. This test was repeated two additional times with the same results. The room was larger than 50 square feet. With this corridor door not self-closing this would	K 321	their frames upon closure. 3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all doors fit into their frames upon closure. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately	

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K 321	Continued From page 8 allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 10:03 AM, an inspection of the Dietary storage room in the basement was performed. During a closure test of the corridor door leading into the Dietary storage room the door did not self-close into its frame. The surveyor observed combustible boxes and other combustible products in the room. This closure test was repeated two additional times with the same results. The surveyor observed and recorded measurements of the opening of the door to the frame was a 1/2 inch gap between the door and frame. The surveyor measured and recorded the room which is 14 feet by 21 feet (294 square feet) which is larger than 50 square feet. With this corridor door not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted on the corridor wall in the area identified that you would need to pass these rooms as the primary and or secondary egress route out of the area in the event of a fire. The AMM confirmed the findings at the time. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the	K 321		

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K 321	Continued From page 9 surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e)	K 321		
K 341 SS=E	Life Safety Code 101 Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 05/18/2023 and 05/19/2023, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 3 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section	K 341	1. Facility has engaged the services of facilities fire alarm vendor to install a audio and visual alarm in the second floor smoke patio area to ensure that residents and staff who are outside on the patio are notified of emergencies. All other areas of the facility have been audited to ensure that areas requiring the audible and visual alarm have them installed and are in	6/22/23

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K 341	Continued From page 10 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided layout identified the facility as a two-story building with a basement. Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM, a tour of the building was conducted. Along the two day tour of the facility, the surveyor inspected three (3) outside enclosed Resident courtyards with the following: On 05/18/2023 at approximately 12:08 PM, the surveyor observed in the *Ex Order 26. 4B1* floor Residents' outside enclosed smoking area that the facility failed to have an audio and visual alarm to notify Resident, Staff, and Visitors of an activation of the building's fire alarm system. At this time the surveyor asked the AMM, "Do you have an audio and visual alarm tied into the buildings fire alarm system." The AMM looked around and told the surveyor, no. The AMM confirmed the findings at the time. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the	K 341	working order. 2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to fire alarm system installation of audio and visual alarms with specificity on requirement of installations of Audio and visual alarms. 3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all areas of the facility/ patios requiring the installation of audio/ visual alarms will have them installed. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

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K 341	Continued From page 11 surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 05/18/2023 and 05/19/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical	K 351	1. All damaged or missing ceiling tiles for [redacted] janitors closet were replaced on 5/19, ceiling tiles for the Activities Dir office, [redacted] server room, [redacted] scale room, [redacted] janitors closet have been replaced on 5/22 with new ceiling tiles. All	6/22/23

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K 351	Continued From page 12 environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following: On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility layout which identifies the various rooms. A review of the facility provided layout identified the facility as a two-story building with a basement. Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility AMM, a tour of the building was conducted. Along the two (2) day tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 05/18/2023, 1) At approximately 11:17 AM, inside the [redacted]. floor janitors closet, the drop ceiling had an approximately 6 inch by 6 inch hole through the room's ceiling tile. 2) At approximately 11:34 AM, inside the [redacted]. floor Activity Director's office, the drop ceiling was	K 351	other ceiling tiles of the facility have been audited to ensure that no other ceiling tiles are damaged or missing. All ceiling tiles that were damaged or missing noted on the audit, have been replaced with new ceiling tiles. 2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to Sprinkler system installations with specificity on the requirement that all areas of the facility that require ceiling tiles have them installed and are not damaged. 3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all areas of the facility which require ceiling tiles have them installed with no damage to them. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

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K 351	Continued From page 13 missing one (1) 2' by 4' and two (2) 2' by 2' ceiling tiles from the grid. On 05/19/2023, 3) At approximately 10:34 AM, inside the Ex Order 26. 4B1 server room, there were several wires running through the ceiling tiles leaving openings in the ceiling grid. 4) At approximately 10:40 AM, inside the Ex Order 26. 4B1 scale room basement level Electrical room, the drop ceiling was missing two (2) 2' by 4' ceiling tile from the grid. 5) At approximately 11:17 AM, inside the Ex Order 26. 4B1 Janitor's closet, the drop ceiling was missing Two (2) ceiling tiles from the grid. With the opening in the ceilings, in the event of a fire, the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. The AMM confirmed the findings at the time. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e)	K 351		
K 355 SS=E	NFPA 13 Portable Fire Extinguishers CFR(s): NFPA 101	K 355		6/22/23

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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
K 355	Continued From page 14 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform Hydrostatic testing for 16 of 28 fire extinguishers, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4- 3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 4- 4.3 Six Year Maintenance, Every 6 years,	K 355	1. The Fire extinguishers located in the basement near the medical supply room, in the commercial laundry room, in the basement elevator mechanical room, near the [redacted] floor nursing station, [redacted] floor to the [redacted] of resident room [redacted], [redacted] floor to the [redacted] of resident room [redacted], [redacted] floor at the [redacted] Unit Nursing station, near the [redacted] floor nourishment station, [redacted] floor near the Resident salon, [redacted] floor to the [redacted] of Resident room [redacted], [redacted] floor to the [redacted] of resident room [redacted], [redacted] floor corridor near stairwell, [redacted] floor in the corridor near the main lobby area and the class K type fire extinguisher in the kitchen have all been hydrotested on 5/19/2023. All extinguishers in need of replacement have been replaced on 5/19/2023 and will be hydrotested at the proper time in accordance with NFPA 101 and as per the requirement to hydrotest all Fire Extinguishers in the facility. All other fire extinguishers in the facility have been hydrotested on 5/19/2023 to ensure they are in accordance with the NFPA 101 hydrotesting regulation. Any fire extinguishers needing replacement as a result of this audit have been replaced. 2. All residents can be affected by this deficient practice. Dir of Maintenance and	

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K 355	Continued From page 15 stored-pressure fire extinguishers shall require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon recovery systems. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall be from that date. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following: On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility layout which identifies the various rooms. A review of the facility provided layout identified the facility as a two-story building with a basement. Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM, a tour of the building was conducted. During the two (2) day building tour the of the facility, the surveyor observed and inspected twenty eight (28) portable fire extinguishers in various locations that were last annually inspected July 2022 with the following results:	K 355	all Maintenance personnel have been in serviced on NFPA 101 related to Hydrotesting requirement and the need to replace extinguishers that are not in compliance with the regulation. 3. Dir of Maintenance will audit all areas of facility monthly x 3 months or until compliance is reached to ensure that all extinguishers that are not in compliance with hydrotesting requirement are replaced with new extinguishers. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

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K 355	Continued From page 16 On 05/18/2023, 1) At approximately 9:38 AM, the surveyor observed in the basement near the Medical supplies room, One "ABC" Type fire extinguisher near the Medical supplies room last Hydrostatic tested 2016. 2) At approximately 9:41 AM, the surveyor observed in the basement commercial laundry room, One "ABC" Type fire extinguisher last Hydrostatic tested 2015. 3) At approximately 10:16 AM, the surveyor observed in the basement Elevator mechanical room One "BC" Type fire extinguisher last Hydrostatic tested 2008. 4) At approximately 10:40 AM, the surveyor observed on the Ex Order 26. 4B1 floor to the right of Resident room Ex Order 26. 4B1, One "ABC" Type fire extinguisher last Hydrostatic tested 2016. 5) At approximately 10:56 AM, the surveyor observed on the Ex Order 26. 4B1 floor at the Nursing station, One "ABC" Type fire extinguisher last Hydrostatic tested 2015. 6) At approximately 11:29 AM, the surveyor observed on the Ex Order 26. 4B1 floor to the left of Resident room Ex Order 26. 4B1 One "ABC" Type fire extinguisher last Hydrostatic tested 2016. 7) At approximately 11:50 AM, the surveyor observed on the Ex Order 26. 4B1 floor to the left of Resident room Ex Order 26. 4B1 One "ABC" Type fire extinguisher last Hydrostatic tested 2016.	K 355		

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K 355	Continued From page 17 8) At approximately 10:56 AM, the surveyor observed on the Ex Order 26. 4B1 floor at the [redacted] unit Nursing station, One "ABC" Type fire extinguisher last Hydrostatic tested 2014. 9) At approximately 12:01 PM, the surveyor observed on the Ex Order 26. 4B1 floor at the Nourishment station, One "ABC" Type fire extinguisher last Hydrostatic tested 2014. 10) At approximately 12:04 PM, the surveyor observed on the Ex Order 26. 4B1 floor near the Residents Salon, One "ABC" Type fire extinguisher last Hydrostatic tested 2015. On 05/19/2023: 11) At approximately 10:48 AM, the surveyor observed on the Ex Order 26. 4B1 floor to the left of Resident room [redacted], One "ABC" Type fire extinguisher last Hydrostatic tested 2016. 12) At approximately 10:55 AM, the surveyor observed on the Ex Order 26. 4B1 floor to the right of Resident room [redacted], One "ABC" Type fire extinguisher last Hydrostatic tested 2016. 13) At approximately 11:09 AM, the surveyor observed on the Ex Order 26. 4B1 floor in the corridor near the Main lobby area, One "ABC" Type fire extinguisher last Hydrostatic tested 2016. 14) At approximately 11:33 AM, the surveyor observed on the Ex Order 26. 4B1 floor in the corridor near stairwell, One "ABC" Type fire extinguisher last Hydrostatic tested 2015. 15) At approximately 12:01 PM, the surveyor observed inside the Kitchen one Class K-Type fire extinguisher last Hydrostatic tested 2011.	K 355		

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K 355	Continued From page 18 This fire extinguishers metal cylinder was damaged. 16) At approximately 12:10 PM, the surveyor observed on the [redacted] floor Dietary corridor, One "ABC" Type fire extinguisher last Hydrostatic tested 2015. The AMM confirmed the finding at the time of observations. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. NFPA -10. NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 364 SS=E	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of	K 364		6/22/23

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K 364	Continued From page 19 glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 05/18/2023, in the presence of facility management, it was determined that the facility failed to prohibit transfer grills in corridor walls on resident sleeping units. This deficient practice was evidenced by the following: On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility layout which identifies the various rooms. A review of the facility provided layout identified the facility is a two-story building and a basement. The facility has 60 resident sleeping rooms on the [redacted] floor, 60 resident sleeping rooms on the [redacted] floor and various common areas on both floors. Starting at approximately 9:22 AM on 05/18/2023 in the presence of the AMM a tour of the building was conducted. At 12:12 PM, the surveyor observed a 19 inch by 19 inch open transfer grill installed in the corridor wall. Further inspection identified the open transfer grill lead into an Activities storage room which housed a Heating, Ventilation and Air Conditioning (HVAC) unit inside an open closet with-in the	K 364	1. Facility ordered a new motorized smoke/fire damper to be installed on the [redacted] floor HVAC activities closet near the elevator. All other areas of the facility have been checked and audited to ensure no other areas need a smoke/fire damper. There were no other areas identified in need of smoke/fire damper as a result of this audit. 2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to the requirement on that all Transfer grills installed in walls need to be equipped with a smoke/fire damper. 3. Dir of Maintenance will audit all areas of facility monthly x 3 months or until compliance is reached to ensure that all areas of the facility that have a transfer grill installed in the wall have a smoke/fire damper installed as well to prevent the spread of smoke/fire. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

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K 364	Continued From page 20 storage room. The surveyor observed inside the storage room multiple combustible items. The AMM confirmed the findings during the two day tour of the facility at the time of the inspections. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 - 31.2 (e).	K 364		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for two (2) of ten (10) smoke barrier	K 372	1. On 5/22 the Maintenance Department sealed the penatration noted in the wall on [redacted] floor [redacted] wing above double doors. On 5/23 the penatration in the wall on [redacted] wing above the corridor double doors was sealed with fire rated sealer in accordance	6/22/23

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K 372	Continued From page 21 walls as evidenced by the following: On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility's layout which identifies the various rooms. A review of the facility provided layout identified the facility is a two-story building and a basement. There are five (5) smoke barrier walls on the [redacted] floor and six (6) smoke barrier walls on the [redacted] floor. Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM, a tour of the building was conducted. Along the two day tour, the surveyor observed the following smoke barrier walls that failed to maintain the 1/2 hour fire rated construction as required by code in the following location. On 05/18/2023, 1) At approximately 10:35 AM, the surveyor observed above the corridor double smoke doors ceiling tiles going into the [redacted] floor [redacted]-Wing", one approximately 1" penetration with a electrical cable running through the smoke barrier wall. 2) At approximately 11:35 AM, the surveyor observed above the corridor double smoke doors ceiling tiles going into the [redacted] floor [redacted]-Wing", one approximately 1-1/2" penetration with a white electrical cable and one black pipe running through the smoke barrier wall.	K 372	with NFPA 101. All other areas in the facility have been audited to ensure that there are no gaps in need of fire-resistant material. There have been no other areas in need of fire-resistant seal as a result of this audit. 2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to smoke barrier construction with specificity to openings and penetrations that require NFPA approved fire rated seal. 3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all areas of the facility that require NFPA approved fire resistance seal have been corrected. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately	

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K 372	Continued From page 22 These penetrations was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The AMM confirmed the finding at the time. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility	K 374	1. On 5/24, Maintenance department	6/22/23

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K 374	Continued From page 23 provided documentation on 05/18/2023 and 05/19/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 4 of 10 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility layout which identifies the various rooms. A review of the facility provided layout identified the facility is a two-story building with ten (10) sets of double corridor smoke doors on the [redacted] floors. Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM a tour of the building was conducted. Along the two (2) day tour the surveyor performed a closure test of ten (10) sets of double smoke doors in the corridors with the following results: On 05/18/2023,	K 374	corrected this deficient practice by adding a metal plate door sweep to the [redacted] floor [redacted] wing double doors, [redacted] wing double doors, [redacted] floor [redacted] wing double doors and [redacted] floor [redacted] wing double doors. All mentioned doors are now at 3/4 inch off the floor level. All other smoke barrier doors have been checked and audited to ensure that there are no gaps measuring more than 3/4 of an inch high off the floor level. 2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to smoke barrier doors and the requirement to ensure that there are no gaps measuring more than 3/4 of an inch high off the floor level in accordance with NFPA 101. 3. Dir of Maintenance will audit all smoke barrier doors of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all smoke barrier doors have no gaps measuring more than 3/4 of an inch from the floor to the bottom of the door. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

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K 374	Continued From page 24 1) At approximately 10:35 AM, during a closure test of the [redacted]. floor "[redacted]- Wing" double smoke doors in the corridor next to Resident room [redacted], when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 1-1/8 inch wide by 8 inch high gap along the bottom meeting edge of the doors. This test was repeated two additional times with the same results. 2) At approximately 11:22 AM, during a closure test of the [redacted]. floor "[redacted]- Wing" double smoke doors in the corridor next to Resident room [redacted], when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 1-1/8 inch undercut gap along the bottom edge of the doors. This test was repeated two additional times with the same results. 3) At approximately 11:44 AM, during a closure test of the [redacted]. floor "[redacted]- Wing" double smoke doors in the corridor next to Resident room [redacted], when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 1/4 inch wide by 7 inch high gap along the bottom meeting edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire, and poisonous gasses to pass from one smoke	K 374		

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K 374	Continued From page 25 compartment to another in the event of a fire. On 05/19/2023, 4) At approximately 10:59 AM, during a closure test of the [redacted] floor "[redacted]- Wing" double smoke doors in the corridor near Resident room [redacted] when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 1-1/8 inch undercut gap along the bottom edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire, and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The AMM confirmed the findings during the two day tour of the facility at the time of the inspections. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. N.B. 8:39-31.1(c), 31.2(e)	K 374		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.	K 521		6/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**06/05/2023**

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**

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K 521	Continued From page 26 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 5 of 14 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility layout which identifies the various rooms and smoke compartments in the facility. A review of the facility provided layout identified the facility as a two-story building with 120 Resident sleeping rooms and various common areas. Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM a tour of the facility was conducted. Along the two (2) day tour the surveyor inspected and tested ten (10) Resident sleeping room bathrooms and four (4) shower room bathroom exhaust systems.	K 521	1. Exhaust fans in rooms [redacted] and [redacted]-bathroom, resident bathroom [redacted] were corrected on 5/22/23. Exhaust vents in resident bathroom [redacted] and resident bathroom in [redacted] have all been corrected on 5/23/23 and are now in good working condition. All other exhaust fans in resident rooms and bathrooms have been checked and audited to ensure that they are in good working order. No other concerns were noted with any other exhaust fans as a result of this audit 2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to HVAC ventilation and the requirement for all exhaust fans to be in good working condition. 3. Dir of Maintenance will audit all exhaust fans of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all exhaust fans are in good working condition and are providing the various areas of the facility with proper ventilation. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**06/05/2023**

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K 521	Continued From page 27 This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 14 resident bathrooms in the following locations: On 05/19/2023, 1. At approximately 10:40 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the AMM that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:45 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 10:47 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4. At approximately 11:21 AM, inside Resident	K 521		

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	315209	A. BUILDING 01 B. WING	06/05/2023

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K 521	Continued From page 28 room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 11:23 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The AMM confirmed the findings at the time of observations. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		6/22/23

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	315209	A. BUILDING **01** B. WING _____	**06/05/2023**

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HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	**43 N WHITE HORSE PIKE** **HAMMONTON, NJ 08037**

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K 918	Continued From page 29 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/18/2023 and 05/19/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following:	K 918	1. The facility contacted its generator service vendor for them to install a remote emergency stop button. Generator vendor and facility will schedule a date for service to install the required Emergency stop button. Facility has only one generator. 2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to the requirement of facility generators to have an Emergency stop Button installed and in	

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	315209	A. BUILDING **01** B. WING _____	**06/05/2023**

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K 918	Continued From page 30 On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) if the facility had an Emergency Generator. The AMM told the surveyor, yes we have one Diesel Emergency Generator. On 05/18/2023 (day one of survey) at approximately 10:06 AM, in the presence of the AMM, an inspection inside the boiler room where the Emergency Generator is located, the surveyor observed that the emergency stop button was located on the front control panel of the generator. At this time the surveyor asked the AMM, "Do you have a remote emergency stop button for the generator." The AMM said, no. The AMM confirmed the finding at the time of observation. On 05/19/2023 during the survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	good working condition. 3. Dir of Maintenance will audit the generator weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that the Emergency stop button is in good working condition. 4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately.	

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 01 - MAIN BUILDING 01 B. Wing Y2	8/1/2023 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	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0222		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0311		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0321		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0341		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0351		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0355		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0364		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0372		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0374		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0521		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0918		06/22/2023
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #		Completed	
LSC			
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #		Completed	
LSC			
ITEM Y4	ID Prefix	Correction	DATE Y5
Reg. #		Completed	
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?
6/5/2023	☐ YES ☐ NO