STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/14/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

COMPLAINT#: NJ158446, NJ158513

CENSUS: 193

SAMPLE SIZE: 9

THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.

Based on observations, interviews, review of medical records, and other pertinent facility documents on 10/13/2022 and 10/14/2022, it was determined that the facility failed to follow and implement their Abuse Policy and Procedure for 1 of 9 residents (Resident #2), who has a known history of [redacted] after a staff and a Resident had a physical altercation that occurred on [redacted]. On [redacted] at 12:15 p.m., during a tour of the first floor, Resident #2 was observed with a [redacted] on the [redacted]. The Resident reported to the surveyor that a staff member [redacted] his/her [redacted]. The staff member was a nurse still working in the facility and was moved [redacted] to another floor.

According to the Certified Nursing Assistant

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

Electronically Signed | 11/18/2022

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F 000	Continued From page 1	F 000		

(CNA) on 10/1/2022, Resident #2 "had been having a rough day, vocal most of the day." LPN #1 came to the nursing station to her medication cart and asked Resident #2 to go to his/her room. Resident #2 became angry with LPN #1 and thought LPN #1 had a [redacted] in her hand, but it was her pen. When LPN #1 turned around, Resident #2 knocked the pen out of LPN #1's hand. When the LPN bent down to pick up her pen, Resident #2 was [redacted] and [redacted]. Resident #2 was in LPN #1's face, but the CNA could not clearly see the nurse holding onto Resident #2's [redacted]. The Registered Nurse (RN) came to the nursing station "to try and diffuse the situation." The CNA then called 911, and the Police arrived. According to the CNA, Resident #2 said to the Police, "[redacted] ...she [redacted]," referring to LPN #1.

According to the Nursing Supervisor/Licensed Practical Nurse (NS), she was upstairs on the [redacted] and received a call from the RN to come to the [redacted]. When the NS arrived on the [redacted], she observed Resident #2 on a stretcher; two Emergency Medical Technicians (EMTs) and the Police were present. LPN #1 informed the NS that Resident #2 was acting [redacted] and they were sending him/her out. The NS stated she heard Resident #2 say, [redacted]" and pointed to LPN #1. Resident #2 was holding his/her [redacted] out and said see, LPN #1 "has [redacted]." The NS assessed Resident #2's arm but did not see any [redacted], or [redacted] to the [redacted]. According to the NS, Resident #2 makes many allegations, so she was more concerned with getting the Resident out to the Hospital. The NS did not suspend LPN #1 or send her home she started the investigation and did interviews on

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F 000	Continued From page 2	F 000		

[redacted] The NS then called the DON and informed her there was an incident between Resident #2 and LPN #1.

According to the Assistant Director of Nursing (ADON), Resident #2 has behaviors and gets [redacted] at times. The ADON stated that approximately one week ago, on [redacted], Resident #2 was having a bad day, was [redacted] with staff, and threatened to [redacted] residents. Resident #2 also became [redacted] toward the Licensed Practical Nurse (LPN #1) and was [redacted] her. As the LPN moved and held her hands up, the Resident continued to [redacted] her, and the LPN held the Resident's [redacted] until 911 was called. The EMTs and the Police Officers arrived, and Resident #2 continued being combative with the EMTs. The Resident was then taken to the Hospital for [redacted] behaviors." On [redacted] the facility called the Hospital to get a report about Resident #2 and was notified the Resident had [redacted]. A reportable was at this time sent to the New Jersey Department of Health (NJDOH) for the staff-to-resident incident, howevever the reportable did not specify that Resident #2 accused LPN #1 of [redacted] his/her [redacted]. LPN #1 was at this time was taken off the schedule.

The facility's failure to implement its "Abuse" and "Behavior Management" policies when the physical altercation occurred between Resident #2 and LPN #1 put all other residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10/13/2022 at 5:25 p.m. The Administrator was presented with the IJ template

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F 000	Continued From page 3 that included information about the issue on [redacted]. The IJ began on [redacted] and continued through [redacted] when the facility started in-services of their staff. The facility implemented the Removal Plan, which included a). Education on abuse, neglect, mistreatment, and misappropriation. b). Education on informing the administration immediately of an allegation of [redacted]. c). Education on the immediate removal of the accused staff member. d). Education on dealing with difficult behaviors, and e). Education on de-escalation techniques. So, the noncompliance remained on [redacted] as a level G for actual harm that is not an IJ based on the following: Resident #2 was [redacted] to LPN #1. The LPN held Resident 2's [redacted] to prevent the Resident from [redacted] her. The Resident complained of [redacted] before being sent to the Hospital, where an [redacted] was completed, which showed a [redacted]. Acccording to the ADON, the Police Department was notified on [redacted] of the [redacted]. This deficient practice was identified for 1 of 9 residents (Resident #2) and was evidenced by the following:	F 000		
F 558 SS=E	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: COMPLAINT #: NJ 158446, 158513	F 558	step 1	10/14/22

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F 558	Continued From page 4 Based on observation, interviews, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to keep the call bell system within reach for 3 of 9 residents who were dependent on staff for transfers and able to use the call bell. The facility also failed to follow its policy titled "Call Bells." This deficient practice was identified for 3 of 9 residents (Resident #7, Resident #8, and Resident #9) and was evidenced by the following: During a tour of the facility on 10/14/2022 at 11:45 a.m., the Surveyor entered a room with two residents, one by the door and one by the window. The Surveyor observed the first Resident closest to the window (Resident #8) lying in bed, watching television. The call bell was on the right side of the bed, touching the floor and not within the Resident's reach. The Surveyor asked Resident #8 to use the call bell, and the Resident attempted to reach the call bell but could not and stated: "I can't reach the call bell." The second Resident (Resident #9) was observed lying in bed, closest to the door. The Surveyor observed Resident #9's call bell on the floor out of the Resident's reach on the left side of the bed. The Surveyor asked Resident #9 about the call bell, but Resident #9 did not answer. On 10/14/2022 at 12:10 p.m., the Surveyor observed Resident #7 in his/her room in a wheelchair, approximately 5 feet from the bed. The Surveyor observed Resident #7's call bell under the Resident's bed. The Surveyor asked Resident #7 to use the call bell to call for staff assistance. Resident #7 stated, "I cannot reach it, the staff often forget to give me the call bell, and I	F 558	Residents #7, #8 and #9 are not known to have been negatively affected by the deficient practice. The call bells for these residents were immediately placed within their reach. The interdisciplinary team did a root cause analysis as to why the residents did not have the call bells in place and it was determined that either the resident dropped the call bell and could not retrieve or a staff member did not place the call bell in the residents reach. Education was given to the assigned C.N.A.s step 2 All residents have the potential to be affected by the deficient practice. The following actions were and will be taken: Rounds were made throughout the facility to ensure all call bells are within reach of the residents. step 3 The administrator and DON reviewed the policy on call bells and found it to be in compliance. All staff was educated on placement of call bells within reach of residents. Education will include monitoring the placement of residents call bells on hourly rounds. Staff will be educated that if a	

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F 558	Continued From page 5 cannot wheel myself." A review of the Electronic Medical Records was as follows: 1. According to the "Admission Record (AR)," Resident #8 was initially admitted to the facility on [redacted] and the most recent admission on [redacted] with diagnoses that included but were not limited to [redacted]. A review of Resident #8's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that Resident #8 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #8 has [redacted]. The Resident also required extensive assistance of two staff with bed mobility and transfers and depended on staff for personal hygiene. 2. According to the "AR," Resident #9 was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted]. A review of Resident #9's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that Resident #9 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the Resident has [redacted] and required extensive assistance with transfers and personal hygiene.	F 558	resident is unable to use a call bell, an alternate system or tap bell must be provided. step 4 A new call bell Compliance Log was developed and utilized for weekly rounds by the DON/Designee to ensure compliance with residents have access to their call bells. The rounds will be performed weekly using a sample of 10 residents per round, for four weeks, followed by monthly, until full compliance is achieved. Any negative findings will be addressed immediately. Findings of the call bell compliance rounds will be presented and discussed at the facility's QAPI meetings monthly, and further systematic changes will be implemented, if needed. Responsible Party: Director of Nursing	

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3. According to the "AR," Resident #7 was initially admitted to the facility on [redacted] and the most recent admission on [redacted] with diagnoses that included but were not limited to [redacted].

A review of Resident #7's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that Resident #7 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the Resident was [redacted], required extensive assistance with bed mobility and transfers, and was totally dependent on staff for toilet use and personal hygiene.

During an interview on 10/14/2022 at 12:00 p.m., CNA #1, assigned to both Resident #8 and 9, stated, "the call bell was on the floor, but Resident #9 must have knocked it down. She further stated that Resident #8's call bell should have been clipped onto him/her #8 because the Resident cannot use his/her hand very well."

During an interview on 10/14/2022 at 12:21 p.m., CNA #2, assigned to Resident #7, stated she could not find the call bell, and it looked like the call bell was stuck under the bed frame. The call bell should be within his/her reach." The Surveyor observed CNA #2 lift Resident #7's mattress to locate the call bell.

During an interview on 10/14/2022 at 1:30 p.m., the Unit Manager (UM) stated that call bells should be functioning for everyone, even

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F 558	Continued From page 7 ambulatory patients. Any staff that gives care should put it within reach of the residents." A review of the facility document titled "Call Bells" with a "Creation Date: 7/2016" and "Last Date Revised: 8/2019" revealed under "Policy: Providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes." The document further revealed under "Procedure: [...] 5. When the Resident is in bed or confined to a chair be sure the call light is within easy reach of the Resident. [...] 8. Answer the Resident's call as soon as possible."	F 558		
F 600 SS=G	N.J.A.C.: 8:39-27.1 (a) Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: C#: NJ158446, NJ158513	F 600	step 1	10/14/22

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F 600	Continued From page 8 Based on interviews, medical record (MR) review, and review of other pertinent facility documents on [redacted] and [redacted], it was determined that the facility failed to protect and ensure that the residents were free from actual physical harm during an altercation between a resident (Resident #2) and a staff Licensed Practical Nurse (LPN), on [redacted] when Resident #2 and the LPN were in a physical altercation which resulted in Resident #2 sustaining [redacted] a [redacted], which required hospitalization. The facility also failed to follow its policy titled "Abuse." This deficient practice was identified for 1 of 9 residents and was evidenced by the following: During a tour on 10/13/2022 at 12:15 p.m., Resident #2 was observed with a cast in place on the left forearm and reported to the surveyor that a staff member [redacted] his/her [redacted], and the staff member was a nurse, and the nurse was still working in the facility. During an interview on 10/13/2022 at 12:21 p.m., the DON said they called the Hospital the next day and were told Resident #2 had a [redacted]. "The [redacted] happened while still in their care." The ADON added, at first, we thought it was just a behavior, but when they called us on [redacted] to say it was a [redacted], that's when we sent in the Reportable for the staff-to-resident incident, and LPN #1 was taken off the schedule on [redacted] This deficient practice was identified for 1 of 9 residents (Resident #2) and was evidenced by the following:	F 600	1. Resident #2 was sent to the ER and received treatment for [redacted] and [redacted] change in condition on [redacted] Resident #2 received orthopedic care with [redacted] for [redacted] and PRN [redacted] medications [redacted], [redacted] l) to treat [redacted]. 2. The nurse was suspended pending investigation on [redacted] and when she returned was assigned to a different unit. 3. A complete investigation was completed with staff and resident statements, unsubstantiating the LPN there fore this was not reported to the licensing board because abuse was UNSUBSTANTIATED. 4. LPN reinstated but assigned to a unit on another floor. 5. Resident seen by #2[redacted] on [redacted] in the hospital with PRN [redacted] medication adjustments made. 6. Resident behavior monitoring continues. step 2 1. All resident records for 3 months were reviewed on [redacted] for any [redacted] or [redacted] and potential for staff involvement without suspension and investigation. 2. All residents with [redacted] behaviors on [redacted] were reviewed for interventions on de-escalation strategies to avoid any injury to resident or staff.	

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F 600	Continued From page 9 According to the Admission Record (AR), Resident #2 was initially admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted] and was readmitted on [redacted] with a diagnosis of [redacted], subsequent encounter for [redacted] with routine healing, dated [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #2 was [redacted] The MDS also showed Resident #2 required extensive assistance with Activities of Daily Living (ADLs). According to the MDS dated [redacted], Resident #2 had "Physical behavioral symptoms" directed towards others (e.g., [redacted] at others) 1 to 3 days and "Verbal behavioral symptoms" directed toward others (e.g., threatening others, screaming at others, cursing at others) 4 to 6 days, but less than daily, and had "Other behavioral symptoms not directed toward others" (e.g.., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds). 4 to 6 days but less than daily over the look-back period. A review of the Resident's Care Plan (CP) initiated on [redacted] revealed under "Focus" that Resident #2 exhibits behaviors and	F 600	3. All injuries of unknown origin were reviewed on [redacted] for 3 months prior to ensure accused staff was suspended pending investigation. 4. The facility policy on Abuse was reviewed by administration and considered to be in compliance with state and federal guidelines. 5. Alert residents on the LPN assignment were interviewed on [redacted] with no other resident reporting abusive behavior. step 3 The facility policy on abuse was reviewed by facility administration and determined to be in compliance with state and federal guidelines. Starting from 10/3/2022, the facility educated all staff (including physicians, administration, nursing, social work, dietary, recreation, maintenance, and housekeeping) on the abuse and neglect, injuries of unknown origin. The education will include: a) Education on abuse, neglect, mistreatment, and misappropriation. b) Education on the informing administration immediately of an allegation of abuse, fracture, or injury of unknown origin. c) Education on immediate removal of the accused staff member. d) Education on dealing with difficult behaviors. e) Education on de-escalation	

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F 600	Continued From page 10 symptoms such as: self-injurious behavior, history of violent behaviors, delusions, paranoia, resistance to care, noncompliance/refusals with medication plan; resident places self on the floor and pretends to have a loss of consciousness (LOC), calls the Police, refuses to maintain a clean environment, and is physically aggressive towards other residents. Accusatory towards staff and other residents. "Interventions/ Tasks" included but were not limited to: Redirect negative behavior as needed, ensure the Resident is safe, and give the Resident some time and reapproach. The CP also included under "Goals" Resident safety will be maintained through the review date. The CP also showed a "Focus" of Fracture/Joint replacement: Alteration in physical function related to the [redacted] dated [redacted] Under "Goal:" Resident will improve mobility, strength, and functioning through the next review date, dated [redacted]. Interventions included: Cast care as ordered, follow-up with [redacted] as ordered, medications as ordered, and monitor for decreased sensation and pulse in affected extremities, dated [redacted]. A review of the "Behavior Monitoring" sheet for Resident #2 dated [redacted] at 5:25 p.m. revealed the following documentation by the nurse: Resident had to be continuously redirected to room during the [redacted] shift for [redacted] toward staff and other residents. The Resident did not respond well to redirecting to the room. Resident continues to be [redacted] toward staff. Yelling, cursing, and name-calling. Resident then [redacted] and [redacted] the writer in front of the nursing station. The Resident was transferred to Hospital. The MD	F 600	techniques. Brightly colored signage was developed and posted to notify staff of importance and requirement of reporting abuse concerns and allegations and whom to report to. These signs were placed in the staff break room and staff bathrooms on 10/4/22 step 4 1. The administrator/ designee will interview 10 residents weekly x 4 weeks and then monthly thereafter for a minimum of 6 months or until compliance is met for any potential of an abusive act by a staff member. These interviews started on [redacted] The findings of these audits will be presented at monthly QAPI. 2. The Director of Nursing (DON)/Designee will audit the medical record weekly 4 weeks and then monthly for 6 months for any evidence of fracture or injury of unknown origin and compliance with reporting to ensure timely initiation of an investigation and suspension of any staff member that was potentially involved in the resident sustaining the injury. These audits were initiated on [redacted] The findings of these audits will be presented at monthly QAPI.	

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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 600	Continued From page 11 (Medical Doctor) and the guardian were called with a message left. According to the Accident/Incident Statement by Nursing Supervisor/LPN #2 (NS) on [redacted], LPN #1 reported to the NS that Resident #2 [redacted] and [redacted] her. The NS did a "visual assessment" of Resident #2's arm and wrote, "there was [redacted]" Resident #2 stated the nurse [redacted] his/her [redacted]. The Universal Transfer Form (UTF) dated [redacted] indicated that Resident #2 was transferred to the Hospital due to [redacted] and [redacted] behaviors." A review of the hospital records sent to the facility on discharge on [redacted] verified Resident #2 was treated in the Emergency Department (ED) on [redacted] and had an [redacted] on [redacted] at 10:53 p.m., after complaining of [redacted]. The [redacted] was of the [redacted] views. Under "History" was [redacted]. Under Findings:" [redacted]: There is a [redacted]... During an interview on 10/13/2022 at 12:19 p.m., in the presence of the DON, the ADON stated, Resident #2 has behaviors and gets [redacted] at times. One week ago, Resident #2 was having a bad day and was [redacted] with staff and threatening to hit residents. Resident #2 became [redacted] towards LPN #1, hit the nurse, and continued to hit the nurse. As the LPN moved and held [redacted] up, the Resident continued to [redacted] and [redacted] her. LPN #1 held the Residents [redacted] until the Registered Nurse (RN	F 600	3. Social Work (SW) will conduct interviews of 10 alert residents weekly x 4 weeks, then monthly for 6 months for any allegations of abuse or injury. These interviews were initiated on [redacted] The completion date for this tag was on [redacted] The results of these audits will be presented at QAPI. The Administrator is responsible for oversight of this POC.	

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#1) called 911. Resident #2 continued being [redacted] even with the EMTs.

During an interview on 10/13/2022 at 12:21 p.m., the DON stated they were told by the Hospital staff that Resident #2 had [redacted]."The [redacted] happened while still in their [the Hospital's] care." The ADON added, at first, we thought it was just a behavior, but when they called us on [redacted] to say it was a [redacted], we sent in the Reportable for the staff-to-resident incident, and LPN #1 was taken off the schedule on [redacted].

During an interview on 10/13/2022 at 1:35 p.m., LPN #1 stated, on [redacted], around 5:30 p.m., Resident #2 was observed cursing at other residents, not making any sense, [redacted]." LPN #1 said to Resident #2, "you can go to your room, relax and take a break." Resident #2 hit LPN #1 on the hand, causing LPN #1 to drop her pen. LPN #1 bent down to get the pen, and Resident #2 started "swinging and punching me." Resident #2 then grabbed LPN #1 by her shirt, and LPN #1 was able to hold both of Resident #2's [redacted]. LPN #1 demonstrated this to the surveyor by applying her [redacted] to her [redacted] LPN #1 said she did this in an attempt to defend herself. LPN #1 continued to say she was able to hold Resident #2 by both [redacted] and (demonstrated to the surveyor by holding her hand to her [redacted]) until staff stepped in. "I didn't want to be hit no more." LPN #1 stated Resident #2 did not twist or turn when she held the Resident's [redacted]. The LPN said [redacted] was [redacted] and pointed to [redacted] area after the incident, but LPN #1 did not go to the ED or have an [redacted] done and returned to work. LPN #1 further stated she did not return to work until

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[redacted], "they didn't tell me I was suspended; I just didn't return until they told me to come back, which was [redacted]"

During an interview on 10/13/2022 at 2:57 p.m., the CNA assigned to Resident #2 at the time of the [redacted] incident stated, Resident #2 "had been having a rough day, vocal most of the day." LPN #1 came to the nursing station to her medication cart and asked Resident #2 to go to [redacted] room. Resident #2 became angry with LPN #1. When LPN #1 turned around, Resident #2 knocked the pen out of LPN #1's hand. LPN #1 bent down to pick up her pen, and Resident #2 was [redacted] and [redacted]. Resident #2 went right into LPN #1's face. LPN #1 was holding onto Resident #2, but the CNA said she did not have a clear view. The Registered Nurse (RN) came to the nursing station "to try and diffuse the situation." The CNA called 911, and the Police arrived. The CNA stated, Resident #2 said to the Police, '[redacted] ...she [redacted] referring to LPN #1.

During an interview on 10/13/2022 at 3:32 p.m., the DON stated she received a call from the Nursing Supervisor on [redacted]. The NS reported that Resident #2 was [redacted] toward staff, so she would send [redacted] to the crisis center. The DON stated she was unaware of a staff to Resident incident at that time. The DON said, Resident #2 has a [redacted] and is sent out frequently to crisis for behaviors.

During an interview on 10/13/2022 at 4:21 p.m., the NS stated she was [redacted] on the [redacted] floor and received a call from the RN to come to the [redacted]. When the NS arrived on the [redacted]

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floor, she observed Resident #2 on a stretcher; two EMTs and the Police were present. LPN #1 informed the NS that Resident #2 was acting [redacted], and they were sending him/her out. The NS stated she heard Resident #2 say, [redacted]," and pointed to LPN #1. "He/she was holding his/her [redacted] out and said see (name), she ([redacted]." The NS stated she did not see any redness, swelling, or bruising to the [redacted]. The NS further said LPN #1 "told me she held him/her (Resident #2) by his/her arms." but she did not suspend LPN #1 or send her home on [redacted]. The NS started the investigation and did interviews on [redacted] with residents and staff. NS then called the DON and informed her there was an incident between Resident #2 and LPN #1. The NS said she also told the DON that Resident #2 accused LPN #1 of [redacted] his/her [redacted] On 10/2/2022, the NS received a call from the hospital physician informing her that Resident #2's [redacted]. The NS stated she was aware of the facility's policy for Reportable events for injuries, and staff should be suspended while an abuse investigation is conducted.

During an interview on 10/13/2022 at 5:20 p.m., the DON and the ADON verified that the facility Abuse policy states that if an abuse allegation is made against a staff member, the accused staff member should be sent home immediately. The investigation started, and the NS should know the rules and regulations related to abuse and could have implemented them.

According to the facility's policy titled "Abuse," under "Policy:" The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of

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F 600	Continued From page 15 resident/patient property by anyone including staff, family, friends, etc. The facility prohibits any exploitation of the mentally and physically disabled resident in the facility. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Under Protocol "The Shift Supervisor is identified as responsible for immediate initiation of the reporting process." The policy also showed under "Protection:" "Immediate suspension of the suspected employee (S), pending outcome of the investigation." Under "Employee Suspension from Duty:" Anytime an allegation is made involving abuse, neglect, or mistreatment of a resident/patient, which names a specific employee, the employee is suspended until the completion of the investigation. The employee is not to remain on duty and is not to be assigned to any other area of the facility.	F 600		
F 607 SS=J	N.J.A.C: 8:39-4.1(a)5 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		10/14/22

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F 607	Continued From page 16 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ158446, NJ158513 Based on observations, interviews, review of medical records, and other pertinent facility documents on 10/13/2022 and [redacted], it was determined that the facility failed to follow and implement their Abuse Policy and Procedure for 1 of 9 residents (Resident #2), who has a known history of [redacted] Type after a staff and a Resident had a physical altercation that occurred on [redacted] On 10/13/2002 at 12:15 p.m., during a tour of the first floor, Resident #2 was observed with [redacted] in place on the [redacted]. The Resident reported to the surveyor that a staff member [redacted] his/her [redacted]. The staff member was a nurse still working in the facility and was moved [redacted] to another floor. According to the Certified Nursing Assistant (CNA) on [redacted] Resident #2 "had been having a rough day, vocal most of the day." LPN #1 came to the nursing station to her medication cart and asked Resident #2 to go to his/her room. Resident #2 became angry with LPN #1 and thought LPN #1 had a needle in her hand, but it was her pen. When LPN #1 turned around, Resident #2 knocked the pen out of LPN #1's hand. When the LPN bent down to pick up her pen, Resident #2 was [redacted] and [redacted]. Resident #2 was in LPN #1's face,	F 607	step 1 1. Resident #2 was sent to the ER and received treatment for [redacted] and [redacted] change in condition on [redacted] 2. The nurse was suspended pending investigation on [redacted] and when she returned was assigned to a different unit. 3. A complete investigation was completed with staff and resident statements, unsubstantiating the LPN on [redacted] 4. LPN reinstated on 10/4 but assigned to a unit on another floor. 5. Resident seen by [redacted] in the hospital on [redacted] with medication adjustments made. 6. Resident behavior monitoring continues. 7. This incident was reported to the police on [redacted] 8. This incident was not reported to the NJ licensing board due to the unsubstantiated findings. step 2 1. On 10/4/22, All resident records for 3 months were reviewed for any fracture or injury and potential for staff involvement without suspension and investigation. No other resident was identified to be affected.	

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F 607	Continued From page 17 but the CNA could not clearly see the nurse holding onto Resident #2's arm. The Registered Nurse (RN) came to the nursing station "to try and diffuse the situation." The CNA then called 911, and the Police arrived. According to the CNA, Resident #2 said to the Police, [redacted]," referring to LPN #1. According to the Nursing Supervisor/Licensed Practical Nurse (NS), she was upstairs on the second floor and received a call from the RN to come to the first floor. When the NS arrived on the first floor, she observed Resident #2 on a stretcher; two Emergency Medical Technicians (EMTs) and the Police were present. LPN #1 informed the NS that Resident #2 was acting [redacted], and they were sending him/her out. The NS stated she heard Resident #2 say, [redacted]" and pointed to LPN #1. Resident #2 was holding his/her [redacted] out and said see, LPN #1 "has [redacted]." The NS assessed Resident #2's arm but did not see any redness, swelling, or bruising to the [redacted] According to the NS, Resident #2 makes many allegations, so she was more concerned with getting the Resident out to the Hospital. The NS did not suspend LPN #1 or send her home she started the investigation and did interviews on [redacted]. The NS then called the DON and informed her there was an incident between Resident #2 and LPN #1. According to the Assistant Director of Nursing (ADON), Resident #2 has behaviors and gets aggressive at times. The ADON stated that approximately one week ago, on [redacted] Resident #2 was having a bad day, was [redacted] with staff, and threatened to [redacted] residents. Resident #2 also became	F 607	2. On 10/4/22, All residents with aggressive behaviors were reviewed for interventions on de-escalation strategies to avoid any injury to resident or staff. No other resident was identified to be affected. 3. On 10/4/22, All injuries of unknown origin were reviewed for 3 months prior to ensure accused staff was suspended pending investigation. No other resident was identified to be affected. 4. On 10/4/22, The facility policy on Abuse was reviewed by administration and considered to be in compliance with state and federal guidelines. 5. On 10/4/22, The facility policy on Accidents and Incidents was reviewed by administration and determined to be in compliance with state and federal guidelines. step 3 The facility policy on abuse was reviewed by facility administration and determined to be in compliance with state and federal guidelines on 10/4/22 Starting from 10/4/2022, the facility educated all staff (including physicians, administration, nursing, social work, dietary, recreation, maintenance, and housekeeping) on the abuse and neglect, injuries of unknown origin. The education will include: a) Education on abuse, neglect, mistreatment, and misappropriation. b) Education on the informing	

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F 607	Continued From page 18 [redacted] toward the Licensed Practical Nurse (LPN #1) and was hitting her. As the LPN moved and held her hands up, the Resident continued to [redacted] her, and the LPN held the Resident's [redacted] until 911 was called. The EMTs and the Police Officers arrived, and Resident #2 continued being [redacted] with the EMTs. The Resident was then taken to the Hospital for [redacted] behaviors." On [redacted], the facility called the Hospital to get a report about Resident #2 and was notified the Resident had [redacted]. A reportable was at this time sent to the New Jersey Department of Health (NJDOH) for the staff-to-resident incident, howevever the reportable did not specify that Resident #2 accused LPN #1 of [redacted] his/her [redacted]. LPN #1 was at this time was taken off the schedule. The facility's failure to implement its "Abuse" and "Behavior Management" policies when the physical altercation occurred between Resident #2 and LPN #1 put all other residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10/13/2022 at 5:25 p.m. The Administrator was presented with the IJ template that included information about the issue on 10/14/2022. The IJ began on [redacted] and continued through [redacted] when the facility started in-services of their staff. The facility implemented the Removal Plan, which included a). Education on abuse, neglect, mistreatment, and misappropriation. b). Education on informing the administration immediately of an allegation of abuse, fracture, or injury of unknown origin. c). Education on the immediate removal of the accused staff member. d). Education on dealing	F 607	administration immediately of an allegation of abuse, fracture, or injury of unknown origin. c) Education on immediate removal of the accused staff member. d) Education on dealing with difficult behaviors. e) Education on de-escalation techniques. On 10/4/22, Brightly colored signage developed and posted to notify staff of importance and requirement of reporting abuse concerns and allegations and whom to report to. step 4 1. Starting on 10/4/22. the administrator/ designee will interview 10 staff members weekly x 4 weeks and then monthly thereafter for a minimum of 6 months or until compliance is met for understanding of reporting abuse immediately to administration. The findings of these audits will be presented at monthly QAPI. 2. Starting on 10/4/22, the DON/Designee will audit the medical record weekly 4 weeks and then monthly for 6 months for any evidence of fracture or injury of unknown origin and compliance with reporting to ensure timely initiation of an investigation and suspension of any staff member that was potentially involved in the resident	

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F 607	Continued From page 19 with difficult behaviors, and e). Education on de-escalation techniques. So, the noncompliance remained on 10/14/2022 as a level G for actual harm that is not an IJ based on the following: Resident #2 was [redacted] to LPN #1. The LPN held Resident 2's [redacted] to prevent the Resident from [redacted] her. The Resident complained of [redacted] before being sent to the Hospital, where an [redacted] was completed, which showed a [redacted]. Acccording to the ADON, the Police Department was notified on [redacted] of the [redacted]. This deficient practice was identified for 1 of 9 residents (Resident #2) and was evidenced by the following: The Facility Reportable Event (FRE), a NJDOH document used by healthcare facilities to report incidents, dated [redacted] with an event date of [redacted] at 5:45 p.m., revealed the following: On [redacted] at approximately 5:25 p.m., Resident #2 was observed with verbal outbursts toward staff and other residents. LPN #1 attempted to redirect Resident #2 to his/her room. However, Resident #2 did not respond to redirecting and became [redacted] towards LPN #1 and [redacted] LPN #1 multiple times. Several staff members were present and attempted to verbally redirect Resident #2 from [redacted] LPN #1 without effectiveness. 911 was called, and Resident #2 was transferred to the Hospital. A verbal report from the Hospital indicated that Resident #2 had a [redacted] and was admitted. Further review of the FRE included a written statement by LPN #1 dated [redacted] According to the statement, on [redacted] at approximately 5:45 p.m., Resident #2 began [redacted]	F 607	sustaining the injury. The findings of these audits will be presented at monthly QAPI. 3. Starting on 10/4/22, Social Work will conduct interviews of 10 alert residents weekly x 4 weeks, then monthly for 6 months for any allegations of abuse or injury. the completion date for this this tag was on 10/4/2022 The results of these audits will be presented at QAPI. The Administrator is responsible for oversight of this POC.	

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other residents in the Activity Room. Resident #2 was redirected by LPN #1 to stop calling other residents names. Resident #2 started pacing but was still [redacted] other residents. When LPN #1 asked Resident #2 to go to his/her room, Resident #2 started [redacted] attacking LPN #1; he/she then started swinging at the LPN. According to the FRE, LPN #1 blocked Resident #2 by holding [redacted] in front of [redacted] and backing up, but Resident #2 kept swinging forcefully, making contact with LPN #1's face, neck, and forearm. LPN #1 reported that she was able to hold Resident #2 until another staff member was able to help get [redacted] off LPN #1. Resident #2 then sat down in a chair, still [redacted], until the Police came to the facility.

A review of the Electronic Medical Record (EMR) for Resident #2 revealed the following:

According to the Admission Record (AR), Resident #2 was initially admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted] a and was readmitted on [redacted] with a diagnosis of [redacted], subsequent encounter for [redacted] with routine healing, dated [redacted].

Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #2 was [redacted]. The MDS also showed Resident #2 required extensive assistance with Activities of Daily Living (ADLs). According to the MDS dated [redacted], Resident #2 had "Physical

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behavioral symptoms" directed towards others (e.g., threatening others, screaming at others, cursing at others) 1 to 3 days and "Verbal behavioral symptoms" directed toward others (e.g., threatening others, screaming at others, cursing at others) 4 to 6 days and had "Other behavioral symptoms not directed toward others" (e.g.., physical symptoms include hitting or scratching self, pacing, rummaging, [redacted] acts, disrobing in public, throwing or [redacted], or verbal/vocal symptoms like screaming and disruptive sounds), 4 to 6 days but less than daily over the look-back period.

A review of the Resident's Care Plan (CP) initiated on [redacted] revealed under "Focus" that Resident #2 exhibits behaviors and symptoms such as self-injurious behavior, history of [redacted] behaviors, [redacted], resistance to care, noncompliance/refusals with medication plan; resident places self on the floor and pretends to have a loss of conciseness (LOC), calls the Police, refuses to maintain a clean environment, and is [redacted] towards other residents. Accusatory towards staff and other residents. "Interventions/Tasks" included but were not limited to: Redirecting negative behavior as needed, ensuring the Resident is safe, and giving the Resident some time and reapproach. The CP also included under "Goals" Resident safety will be maintained through the review date. Further review of Resident #2's CP included under "Focus": Fracture/Joint replacement: Alteration in physical function related to the [redacted] dated [redacted]. Under "Goal:" Resident will improve mobility, strength, and functioning through the next review date, dated [redacted] Interventions

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included: [redacted] as ordered, follow-up with [redacted] as ordered, medications as ordered, and monitoring for decreased [redacted] and [redacted] in affected extremities, dated [redacted].

A review of the "Behavior Monitoring" sheet for Resident #2 revealed the following:

On [redacted] at 10:22 p.m., When Transport arrived at 10:10 p.m., the Resident refused to go to crisis. The Resident stated he/she wanted to go to bed and went to his/her room.

On [redacted] at 5:00 a.m., it revealed, "Resident had to be continuously redirected to room during 3-11 shift for verbal outbursts toward staff and other residents. He/ She responded well to redirecting to room and calm approach."

On [redacted] at 9:00 p.m., revealed documentation by the nurse showed: No behaviors requiring staff interventions.

On [redacted] at 1:00 p.m., [redacted] at 3:00 p.m., and [redacted] at 5:00 p.m., revealed the following documentation by the nurse: "Resident calm, no outburst noted will continue to monitor."

On [redacted] at 5:25 p.m., revealed the following documentation by the nurse: Resident had to be continuously redirected to room during the 3-11 shift for verbal outbursts toward staff and other residents. The Resident did not respond well to redirecting to the room. Resident continues to be [redacted] toward staff. Yelling, cursing, and name-calling. Resident then [redacted] and [redacted] the writer in front of the nursing station. The Resident was transferred to Hospital.

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The MD (Medical Doctor) and the guardian were called with a message left.

Review of Resident #2's Progress Notes (PNs) revealed the following:

On [redacted] at 9:00 p.m., the Registered Nurse (RN) documented: Resident #2 was [redacted], not [redacted], very [redacted], and threatened residents and staff. Resident #2 called 911 several times. Call place to NP (Nurse Practitioner), who heard Resident #2 [redacted] threatening staff. NP gave the order to send the Resident to crisis.

On [redacted] at 5:00 a.m., the LPN documented: The Resident displayed behaviors. The behaviors displayed are the Resident's target behaviors. An increase in verbal outbursts noted. Increase in refusal of care or treatment noted. No change in neurological status or residents' pain from baseline. The behaviors required staff intervention.

On [redacted] at 12:00 p.m., revealed the following: "...was sent to the ER (Emergency Room) with c/o (complaint of) [redacted] on [redacted] (sic) ([redacted]) after an altercation with staff. [redacted] showed a minimally [redacted] .... Patient was placed in a [redacted] in the ER."

The Universal Transfer Form (UTF) dated [redacted] indicated that Resident #2 was transferred to the Hospital due to '[redacted] and [redacted] behaviors."

A review of the Hospital records sent to the facility on discharge on [redacted] verified Resident #2

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F 607	Continued From page 24 was treated in the Emergency Department (ED) on [redacted] and had an [redacted] on [redacted] at 10:53 p.m., after complaining of [redacted]. The [redacted] was of the [redacted] Under "History" was [redacted]. Under Findings:"[redacted] and [redacted]: There is a [redacted] During an interview on 10/13/2022 at 12:19 p.m. with the DON and the ADON, the ADON stated, Resident #2 has behaviors and gets [redacted] at times. One week ago, Resident #2 was having a bad day and was [redacted] with staff and threatening to [redacted] residents. Resident #2 became [redacted] towards LPN #1, hit the nurse, and continued to hit the nurse. As the LPN ambulated and held her hands up, the Resident continued to hit and punch her. LPN #1 held the Residents [redacted] until the Registered Nurse (RN #1) called 911. Resident #2 continued being combative even with the EMTs. During an interview on 10/13/2022 at 12:21 p.m., the DON stated they were told by the Hospital staff that Resident #2 had a [redacted]." The ADON added, at first, we thought it was just a behavior, but when they called us on [redacted] to say it was a [redacted], we sent in the Reportable for the staff-to-resident incident, and LPN #1 was taken off the schedule on [redacted]. During an interview on 10/13/2022 at 1:35 p.m., LPN #1 stated, on [redacted], around 5:30 p.m., Resident #2 was observed [redacted] at other residents, not [redacted], "she was [redacted]." LPN #1 said to Resident #2, "you can go to your room, relax and take a break." Resident #2 hit LPN #1 on the hand, causing LPN #1 to	F 607		

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drop her pen. LPN #1 bent down to get the pen, and Resident #2 started "swinging and punching me." Resident #2 then grabbed LPN #1 by her shirt, and LPN #1 was able to hold both of Resident #2's [redacted]. LPN #1 demonstrated this to the surveyor by applying her hand to her wrist. LPN #1 said she did this in an attempt to defend herself. LPN #1 continued to say she was able to hold Resident #2 by [redacted] and (demonstrated to the surveyor by holding her hand to her wrist) until staff stepped in. "I didn't want to be hit no more." LPN #1 stated Resident #2 did not twist or turn when she held the Resident's [redacted]. The LPN said her right arm was swollen and pointed to her wrist area after the incident, but LPN #1 did not go to the ED or have an x-ray done and returned to work. LPN #1 further stated she did not return to work until [redacted] "they didn't tell me I was suspended; I just didn't return until they told me to come back, which was [redacted]"

During an interview on 10/13/2022 at 2:57 p.m., the CNA assigned to Resident #2 at the time of the [redacted] incident stated, Resident #2 "had been having a rough day, vocal most of the day." LPN #1 came to the nursing station to her medication cart and asked Resident #2 to go to her room. Resident #2 became [redacted] with LPN #1. When LPN #1 turned around, Resident #2 knocked the pen out of LPN #1's hand. LPN #1 bent down to pick up her pen, and Resident #2 was [redacted] and [redacted]. Resident #2 went right into LPN #1's face. LPN #1 was holding onto Resident #2, but the CNA said she did not have a clear view. The Registered Nurse (RN) came to the nursing station "to try and diffuse the situation." The CNA called 911, and the Police arrived. The CNA stated, Resident #2

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F 607	Continued From page 26 said to the Police, "[redacted]," referring to LPN #1. During an interview on 10/13/2022 at 3:32 p.m., the DON stated she received a call from the Nursing Supervisor on [redacted]. The NS reported that Resident #2 was [redacted] toward staff, so she would send her to the crisis center. The DON stated she was unaware of a staff to Resident incident at that time. The DON said, Resident #2 has a [redacted] and is sent out frequently [redacted] for behaviors. During an interview on 10/13/2022 at 4:21 p.m., the NS stated she was [redacted] on the [redacted] floor and received a call from the RN to come to the [redacted]. When the NS arrived on the [redacted] floor, she observed Resident #2 on a stretcher; two EMTs and the Police were present. LPN #1 informed the NS that Resident #2 was acting [redacted], and they were sending him/her out. The NS stated she heard Resident #2 say, "she [redacted]," and pointed to LPN #1. "He/she was holding his/her [redacted] out and said see (name), she (has [redacted]." The NS stated she did not see any redness, swelling, or bruising to [redacted]. The NS further said LPN #1 "told me she held him/her (Resident #2) by his/her [redacted]" but she did not suspend LPN #1 or send her home on [redacted]. The NS started the investigation and did interviews on [redacted] with residents and staff. NS then called the DON and informed her there was an incident between Resident #2 and LPN #1. The NS said she also told the DON that Resident #2 accused LPN #1 of [redacted] his/her [redacted]. On [redacted], the NS received a call from the hospital physician informing her that Resident #2's [redacted].	F 607		

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The NS stated she was aware of the facility's policy for Reportable events for injuries, and staff should be suspended while an abuse investigation is conducted.

During an interview on 10/13/2022 at 5:20 p.m., the DON and the ADON verified that the facility Abuse policy states that if an abuse allegation is made against a staff member, the accused staff member should be sent home immediately. The investigation started, and the NS should know the rules and regulations related to abuse and could have implemented them.

During an interview with the Regional Director of Clinical (RDC) and the DON on 10/14/2022 at 9:40 a.m., the DON stated she was not aware on [redacted] that the Resident made an allegation of abuse. Resident #2 called her from the Hospital on [redacted] and said he/she thought someone was going to give him/her an injection. The RDC further stated, "when we found out on [redacted] morning [redacted] we then suspended the staff member (LPN #1).

A review of the facility's policy titled "Abuse," dated 2/2019 under "Policy:" The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, family, friends, etc. The facility prohibits any exploitation of the mentally and physically disabled Resident in the facility. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Under Protocol "The Shift Supervisor is identified as responsible for immediate initiation

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F 607	Continued From page 28 of the reporting process." The policy also showed under "Protection:" "Immediate suspension of the suspected employee (S), pending outcome of the investigation." Under "Employee Suspension from Duty:" Anytime an allegation is made involving abuse, neglect, or mistreatment of a resident/patient, which names a specific employee, the employee is suspended until the completion of the investigation. The employee is not to remain on duty and is not to be assigned to any other area of the facility. A review of the facility's policy titled "Behavior Management," dated 5/2020 under "Policy:" It is the policy of this facility to provide an interdisciplinary approach for the care of residents who exhibit problem behavioral symptoms which could lead to negative consequences for themselves or others. Residents demonstrating change/s in behavior shall be evaluated to ensure that appropriate interventions, as needed, are instituted in a timely manner. Under "Procedure:" 2. Behavior symptoms that are dangerous or threatening must be controlled before further assessment and planning are done. Techniques for immediate management of a behavioral symptom include but are not limited to: Stay calm and use a firm, confident (but not bossy) tone of voice. Stay at a safe distance from the Resident and respect his/her need for personal space. Do not confront or accuse the Resident of wrongdoing. Do not argue or try to reason with the Resident.	F 607		
F 609 SS=D	N.J.A.C. 8:39-13.4 c (2. iii) Reporting of Alleged Violations	F 609		10/14/22

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F 609	Continued From page 29 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C#: NJ158446, NJ158513 Based on interviews, medical record (MR) review, and review of other pertinent facility documentation on 10/13/2022 and 10/14/2022, it was determined that the facility failed to	F 609	step 1 Resident # was evaluated by nursing and SW with no recollection of incident and no known injury from reported incident. Resident #41[redacted] that	

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F 609	Continued From page 30 immediately report to the New Jersey Department of Health within two hours, an altercation between a staff and resident failed to follow the its policy titled "Abuse." The deficient practice was identified for 1 of 9 residents (Resident #2) and was evidenced by the following: According to the Admission Record (AR), Resident #2 was initially admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted] was readmitted on [redacted] with a diagnosis of [redacted], subsequent encounter for [redacted] with [redacted], dated 1[redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #2 was [redacted]. The MDS also showed Resident #2 required extensive assistance with Activities of Daily Living (ADLs). The Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents, dated [redacted], with an event date of [redacted] at 5:45 p.m., revealed the following: On [redacted] at approximately 5:25 p.m., Resident #2 was observed with verbal outbursts toward staff and other residents. LPN #1 attempted to redirect Resident #2 to his/her room. However, Resident #2 did not respond to redirecting and became [redacted] towards LPN #1 and hit the LPN multiple times. Several staff members were present and attempted to verbally	F 609	was treated and surgically repaired in the hospital. step2 Medical records were reviewed for 3 months of progress notes that would indicate a potential for abuse with no indication of an identifiable reportable event identified for any other resident. The medical record was reviewed for significant injuries of with no known origin. There was no other event identified. All reported incidents were reviewed for timely reporting, no other event identified with staff not reporting incident or alleg step 3 The policy on abuse, significant injuries of unknown origin in regards to timely reporting was reviewed by administration and determined to be in compliance with state and federal guidelines. The Administrator and Director of Nursing were educated by the Regional Director of Clinical Services regarding NJDOH reporting requirements specifically focusing on: abuse allegations and injuries of unknown origin. Staff educator / designee will educate all staff on abuse allegations and significant injury of unknown origin with regard to	

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F 609	Continued From page 31 redirect Resident #2 from hitting LPN #1 without effectiveness. 911 was called, and Resident #2 was transferred to the Hospital. A verbal report from the Hospital indicated that Resident #2 had a [redacted]. During an interview on 10/13/2022 at 12:19 p.m., in the presence of the DON, the ADON stated, Resident #2 has behaviors and gets [redacted] at times. One week ago, Resident #2 was having a bad day and was [redacted] with staff and threatening to hit residents. Resident #2 became [redacted] towards LPN #1, hit the nurse, and continued to hit the nurse. As the LPN ambulated and held her hands up, the Resident continued to hit and punch her. LPN #1 held the Residents [redacted] until the Registered Nurse (RN #1) called 911. Resident #2 continued being combative even with the Emergency Medical Technicians (EMTs). During an interview on 10/13/2022 at 12:21 p.m., the DON stated they were told by the Hospital staff that Resident #2 had a [redacted]. The ADON added, at first, we thought it was just a behavior, but when they called us on [redacted] to say it was a fracture, we sent in the Reportable for the staff-to-resident incident, and LPN #1 was taken off the schedule on [redacted] According to the Accident/Incident Statement by Nursing Supervisor/LPN #2 (NS) on [redacted] LPN #1 reported to the NS that Resident #2 [redacted] and [redacted] assaulted her. Resident #2 stated the nurse [redacted] his/her [redacted] referring to LPN #1. The NS did a "visual assessment" of Resident #2's [redacted] and reported, "there was no swelling, bruises or abrasion on [redacted]	F 609	timely reporting to the NJDOH. A lesson plan and sign in logs will be kept on file for validation. step 4 The administrator will conduct audits of reported incident of abuse for timely reporting to the NJDOH weekly x4 weeks; then monthly until compliance is met at a minimum of 6 months. The results of these audits will be submitted at monthly QAPI. The DON/ designee will significant injury that would be considered an injury of unknown origin and abuse allegations for timely reporting to the NJDOH. The audits will be conducted weekly x 4 weeks and then monthly until compliance is met for a minimum of 6 months. The results of these audits will be submitted at monthly QAPI. Responsible Party: Administrator	

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F 609	Continued From page 32 During an interview on 10/13/2022 at 4:21 p.m., the NS stated the investigation was started with interviews on [redacted] with residents and staff. She notified the DON and informed her there was an incident between LPN #1 and Resident #2. The NS also informed the DON that Resident #2 accused LPN #1 of [redacted] his/her [redacted]. NS stated she was aware of Reportable events for injuries and staff should be suspended while an abuse investigation is conducted. However, the FRE to the NJDOH did not include Resident #2's allegation that his/her [redacted] was [redacted] by LPN #1. A review of the facility policy titled "Abuse," under Protocol: Once an allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator/ Director of Nursing immediately and initiate gathering requested information. an investigation must be directed by the Administrator or designee immediately. If a crime is suspected, the Elder Justice Hotline must be notified. The individual conducting the investigation shall follow the procedure for reporting and investigation when an incident of resident abuse, neglect or misappropriation of property is alleged or suspected. Under "Reporting:" Notify the local law enforcement and appropriate State Agency(s) immediately (no later than 2 hours after allegation/identification of allegation) by Agency's designated process after identification of alleged/suspected incident.... N.J.A.C: 8:39-4.1(a)5	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		11/22/22

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33 §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: C#: NJ158446, NJ158513 Based on observations, interviews, review of the medical record, and other pertinent facility documents on 10/13/2022 and 10/14/2022, it was determined the facility failed to maintain a safe environment and ensure the residents remained free from possible [redacted] accidents or hazards. The facility also failed to follow their [redacted] Program Policy" and "Role Guidelines for [redacted] Monitors" for 1 of 9 residents (Resident #6) reviewed. This deficient practice was evident by the following: On 10/13/2022 at approximately 1:04 p.m., while walking towards the elevator on the [redacted] floor, the surveyors [redacted] of [redacted] coming from a room that leads out towards the patio. As the surveyors approached the room, they observed the facility staff/ [redacted] Monitor (SM) in the room with Resident #6. The SM then [redacted] and gave it to the Resident. Resident #6 then took the [redacted] from the SM, placed it between [redacted], and propelled towards the opened patio door, where he/she exited onto the patio. There were no residents observed in the vicinity of the [redacted] area on oxygen.	F 689	step 1 The [redacted] aid received counseling and education on [redacted] inside the facility and all [redacted] must be [redacted] outside in the assigned [redacted] area on 10/14/22. There was no negative outcome for resident #6. The resident was informed that the [redacted] aid will step outside to [redacted] and [redacted] must follow the [redacted] rules of the facility. step 2 This had the potential to affect all residents. No other resident had thei[redacted] [redacted] inside the facility. step 3 The facility policy on [redacted] was reviewed by administration and it was determined to be incompliance with state and federal guidelines.	

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F 689	Continued From page 34 During an interview on 10/13/2022 at 1:05 p.m., the [redacted] Monitor (SM) stated he usually [redacted] the [redacted] here, pointing toward the threshold between the room and the patio. The SM said he would usually open the door and [redacted] the [redacted] According to the SM, the procedure for residents [redacted] is for them to [redacted] in the [redacted] area on the patio. He further stated he left the door open because the residents went in and out through the door. When asked by the Surveyor why did he [redacted] in the building? The SM stated the [redacted] are not [redacted] in the building, and the only person he does this for is Resident #6 because he/she is always in a rush. "I guess I should not have [redacted] the [redacted] in here; I was not supposed to do that." Review of the Electronic Medical Record (EMR) was as follows: According to the Admission Record (AR), Resident #6 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], Resident #6 had a Brief Interview of Mental Status (BIMS) score of [redacted], which indicated the Resident's [redacted] was [redacted]. The MDS also showed Resident #6 needed extensive assistance with most Activities of Daily Living (ADLs). A review of Resident #6's Care Plan (CP) initiated	F 689	The Inservice Coordinator gave inservice to the [redacted] aids that all [redacted] must be [redacted] outside in the [redacted] area on 10/14/22 A resident council was held with residents that [redacted] to inform them of the requirement that [redacted] are [redacted] outside the facility. step 4 The director of recreation will audit 3 [redacted] sessions per week to ensure that all [redacted] are [redacted] in the [redacted] area. Identified deficient practice will have immediate corrective action. These audits were initiated on 11/14/2022 The results of these audits will be presented at monthly QAPI.	

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F 689	Continued From page 35 on [redacted] revealed under "Focus": that Resident #6 "Is a[redacted]." The CP also included under "Goal": Resident "will be free from injury related to [redacted] through review date." Also, under "Interventions": included, "Provide staff supervision during designated[redacted] times ...." On 10/14/2022 at 10:32 a.m., the Surveyor attempted to interview Resident #6, but he/she refused and stated, "I don't want to talk." During an interview on 10/14/2022 at 2:02 p.m., the Administrator revealed that [redacted] should be [redacted] outside, not inside. The Administrator further stated, "the SM [redacted], and sometimes the SM hands the [redacted] to the residents to [redacted], and the monitor supervises them." A review of the [redacted] Program, last updated 8/2019, reveals: 1. All [redacted] in the facility is supervised and permitted only in designated area(s) and at designated times. a. Any person (s) providing [redacted] supervision to residents must be educated on [redacted] rules and role guidelines. 2.c. A [redacted] log is completed daily by the [redacted] monitor to track Resident's [redacted] attendance and [redacted] usage. A review of the Role Guidelines for [redacted] Monitors, last updated on 7/2019, reveals: The primary function of the [redacted] monitors is to supervise the residents during their [redacted] sessions so that safety is maintained. [redacted] monitors are responsible for [redacted] each Resident [redacted] or supervising the Resident who can [redacted] their own [redacted] ensuring that the [redacted] is returned after [redacted] is [redacted]	F 689		

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F 690	Continued From page 36	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		11/23/22

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F 690	Continued From page 37 C#: NJ158446, NJ158513 Based on observations, interviews, medical record reviews, and other pertinent facility documents on 10/13/2022 and 10/14/2022, it was determined that the facility failed to provide [redacted] care to a resident (Resident #4) for the 7-3 shift. The facility also failed to follow its policies titled "[redacted] Assessment and Management," "ADL-Perineal Care," and the "Certified Nurses Aide (Nursing)" job description. This deficient practice was identified for 1 of 9 residents (Resident #4) and was evidenced by the following: During a tour on 10/14/2022 at 10:35 a.m., the Surveyor requested an [redacted] check for Resident #4 with the Certified Nursing Assistant (CNA) and Licensed Practical Nurse (LPN). The Surveyor with LPN and CNA entered Resident #4's room and asked Resident #4 for permission to observe the CNA providing [redacted] care, and the Resident granted permission. The Surveyor observed the [redacted] was [redacted], and the draw sheet under Resident #4 had a [redacted] approximately [redacted] inches in diameter. The stain appeared dry, indicating it was old. When the CNA turned over the draw sheet to remove it, the Surveyor observed a [redacted] on the other side of the draw sheet. During an interview on 10/14/2022 at 10:35 a.m., the CNA stated that Resident #4 was last cared for during the 11 p.m. to 7:00 a.m. shift. She indicated that she did not provide care today for Resident #4 and checked his/her [redacted] before breakfast while the Resident was asleep,	F 690	step 1 Resident #4 was changed and linen was changed upon discovery. Resident #4 had a subsequent skin assessment with no identified `skin impairment. The assigned C.N.A. received counseling following identification of the resident soiled. step 2 All incontinent residents have potential to be affected by this deficient practice. There was no other identified resident that failed to receive [redacted] care. step 3 The facility policy for incontinence care was reviewed by administration and determined to be in compliance with state and federal guidelines. An in-service was conducted by the in-service coordinator on 11/ 12/2022 with all nursing staff on providing timely [redacted] specifically focusing on ensuring that incontinent residents receive [redacted] care every 2-4 hours including perineal care, changing of incontinence products, sheets, and linen if soiled.	

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F 690	Continued From page 38 and the [redacted] was dry at that time. The CNA further stated that the [redacted] observed during the [redacted] check on the draw sheet must have gotten there while the previous CNA rolled the draw sheet under Resident #4. During an interview on 10/14/2022 at 11:14 a.m., the Unit Manager (UM) stated that the draw sheet should not have [redacted] or [redacted], and it should have been changed. A review of the Electronic Medical Record was as follows: According to the "Admission Record (AR)," Resident #4 was admitted to the facility on [redacted], with an original admission date of [redacted], with diagnoses which included but were not limited to [redacted]. A review of Resident #4's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #4 had [redacted], and was dependent on staff for bed mobility, transfers, and toileting. A review of the facility policy titled [redacted] - Assessment and Management" with a "Creation Date" of 4/2014 and a "Last Date Revised" of 5/2019 reveals under "Policy: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary	F 690	step 4 The Director of Nursing (DON)/ Designee will complete audits of 10% of all incontinent residents to ensure [redacted] care was completed. The audits will be completed weekly x 4 weeks and then monthly at a minimum of 6 months or until compliance is met. The DON is responsible for execution and monitoring of this POC.	

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F 690	Continued From page 39 [redacted] A review of the facility policy titled "ADL-Perineal Care" with a "Creation Date" of 7/2019 and undated "Last Date Revised" reveals under "Policy: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the residents skin condition." A review of the undated facility document titled "Job Description: Certified Nurses Aide (Nursing)" reveals under "Position Summary: Provides to each of your assigned residents with routine daily nursing care and services in accordance with the Resident's assessment and care plan, as directed by your supervisors. Performs a variety of activities for the Resident caring for their personal needs and comfort and under the direction and supervision of the Professional Nursing Staff." The document further reveals under "Specific Responsibilities: Provide direct personal care to the resident such as [...] toileting [...] makes beds [...] takes care of incontinent residents (clean and dry) [...] checks each resident routinely to ensure that personal care needs are being met."	F 690		
F 880 SS=D	N.J.A.C 8:39-27.2 (h) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		10/21/22

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F 880	Continued From page 40	F 880		

development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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F 880	Continued From page 41 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Complaint#: NJ158446, NJ158513 Based on observations, interviews, and the review of other pertinent facility documents on 10/13/2022 and 10/14/2022, it was determined that the facility failed to properly store an ice scoop that was used to give residents ice for drinking water in accordance with the facility's policies titled "Ice Machine and Storage Bins" and "Infection Control." This deficient practice was evidenced by the following: On 10/14/2022 at 3:25 p.m., the Surveyor entered the facility's [redacted]-floor nurses' station area located in the center of the units on the floor, where the Surveyor observed a CNA opening a	F 880	step 1 Identified facility staff (C.N.A.) were counseled for ensuring that the ice scoop is not placed in the ice chest. The facility replaced the ice and placed a container next to the ice chest. Facility also purchased a brand new ice machine for the [redacted] floor. step2 All residents have the potential to be affected by this deficient practice however, no negative deficient practice was noted.	

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F 880	Continued From page 42 portable ice chest and taking a scoop from inside the ice chest with the scoop was laying on top of the ice. The CNA then scooped some ice and poured it into a cup. She then placed the ice scooper back into the ice chest on top of the ice and closed the lid. During an interview on 10/14/2022 at 3:25 p.m., the CNA stated that she was getting the ice for a cup of water to give a resident to drink. The CNA further stated that the scoop holder had been missing for about four months. The Maintenance Director was at the Nurses' station on 10/14/2022 at 3:35 p.m. and told the Surveyor that Maintenance was supposed to replace the ice scoop holder, but it was not reported. He further stated we have the scoop holder in the kitchen and on the [redacted] floor. The scooper should not be in the ice. During an interview on 10/14/2022 at 3:40 p.m., the Unit Manager (UM) stated that the ice scoop does not have a holder because it broke, and the ice scooper should be in a separate container and not be left inside the ice chest. She further stated that she did not report this situation to anyone and did not remember when the scoop holder broke. A review of the facility policy titled "Ice Machine and Storage Bins" with a "Creation Date: 1/2017" and "Last Date Revised: 2/2020" revealed the following under "Policy: Ice machine and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice." The document further revealed under "Procedure: 1. Facility should have a designated location for ice on each nursing unit; 2. Ice	F 880	step 3 The facility used the services of an external consultant for the development of this directed plan of correction. An Ad Hoc QAPI was completed with facility administration and department heads for review of the deficiency and the development of a root cause analysis. From the root cause analysis, targeted education was developed, systems were updated as identified, and audits were developed to ensure the corrective actions were successful and maintained. Corporate policies titles COVID 19 Outbreak Management and Infection Control policies were reviewed by facility administration and determined to be in compliance with state and federal guidelines. An ice scoop holder was purchased to be placed with all ice chests to reduce the risk of contamination on 10/14/22 Directed Plan of Education: All education was initiated on 11/18/2022. The in-service director educated all staff on infection control specifically focusing on the appropriate procedures for the use of the ice scoop and the ice chest to reduce the risk of contamination. DIRECTED IN-SERVICE TRAINING: The facility shall provide in-service training to appropriate staff, with staff competency validated by the Director of Nursing, Medical Director or Infection Preventionist, as follows: Nursing Home Infection Preventionist Training Course Module 1 - Infection	

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F 880	Continued From page 43 machines/bins should be located in a locked location, i.e., unit kitchenette; 3. To help prevent contamination of ice machines, ice storage chests/containers, or ice, staff should follow these precautions: a. Limit access to ice machines or ice storage chests/containers to employees only; [...] d. Keep ice scoop/bin in a covered container when not in use." A review of the facility policy titled "Infection Control" with a "Creation Date: 10/2015" and "Last Date Revised: 11/2019" revealed the following under "Policy: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections." The document further revealed under "Procedure: [...] 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility; b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public." NJAC: 8:39-19.4 (a)	F 880	Prevention & Control Program https://www.train.org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtube/xmYMUly7qiE Provide the training to: Frontline staff Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/108l803/ Provide the training to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module IIB - Environmental Cleaning and Disinfection https://www.train.org/main/course/108l8l5/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/1081802/ Provide the training to: Topline staff and infection preventionist only	

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F 880	Continued From page 44	F 880	Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/108l80S/ Provide the training to: All staff including topline staff and infection preventionist Further optional training is available in the Nursing Home Infection Preventionist Training Course located at https://www.train.org/cdctrain/training_plan/3814. step 4 Infection Preventionist /designee will perform Observations of all unit ice chests to ensure the ice scoop is placed in the appropriate container. The observation rounds will occur weekly x 4 weeks and then monthly x 6 months or until compliance is met. The results of these observations will be submitted at monthly QAPI	
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F 925		11/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/14/2022

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 925	Continued From page 45 §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: C#: NJ158446, NJ158513 Based on observations, interviews, review of Medical Records (MR) review, and review of other pertinent facility documents on 10/13/2022 and 10/14/2022, it was determined that the facility staff failed to provide appropriate pest control to prevent an accumulation of flies and gnats. This deficient practice was evidenced by the following: During a unit tour accompanied by the second-floor Unit Manager (UM) on 10/13/2022 at 9:55 a.m., several flies were observed in room number [redacted] and room [redacted]. Room [redacted] had a strong odor of urine in the bathroom. Eight gnats were observed in the bathroom on the walls, gnats were flying in the bathroom, and stool was smeared on the sink and toilet. The Unit Manager (UM) stated if the staff sees flies, they will contact the House Keeping Director, who will notify Pest Control to come in. The Pest Control will usually come in the following day. They also have a pest management book at the nursing station and a log of pest issues checked by the exterminator when they visit the building weekly. A review of the Pest Management book at the [redacted]-floor nursing station showed a date of 6/20/2022 as the last time fruit flies were reported and 8/8/2022 as the last time flies were reported.	F 925	step 1 Facility's Pest control vendor was immediately called in to service Resident Rooms [redacted] and [redacted] and to service the Resident Bathroom in room [redacted] step 2 All Pest control log books have been reviewed to see if any other areas in the facility were in need of service. Environmental Services Manager rounded throughout the facility to see if there were any other areas in the facility that needed pest control services. No other areas were identified. step 3 Education was provided to the Environmental Manager on reviewing the Pest control log books on a weekly basis to ensure service is provided in a timely manner. in addition education was provided to Environmental Manager to make weekly rounds throughout the facility and to ensure that the facility is free from flies and gnats. step 4 The Administrator will review the Pest	

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

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F 925	Continued From page 46 During an interview on 10/13/2022 at 11:24 p.m., the Housekeeping Director (HD) stated there had been no reports of flies or gnats on the unit for several weeks. The HD stated the exterminator comes in once a week and applies gel around the windows and on the edge of the ceiling for flies and gnat prevention. A review of the Service Inspection Report dated 10/9/2022 verified that the exterminator was in the building, under "pest activity," was "none noted." Under "General Comments/Instructions:" General treatments are applied throughout common areas and the kitchen. No reports were written in the logbooks during time of service. A review of the facility policy titled "Pest Control," undated, showed the following under Policy Statement: Our facility shall maintain an effective pest control program. Under Policy Interpretation and Implementation: This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Review of the document provided by the facility post survey, titled "Pest Management Proposal" date signed 2019, identified a service contract for "weekly service for one year." "Scope of Service" included "mice, rats, ants, and roaches." N.J.A.C: 8:39-31.5	F 925	Control Log books on a monthly basis during the facilities monthly QAPI meeting x 3 months or until compliance is met.	

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	060113	A. BUILDING: _____ B. WING _____	C 10/14/2022

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

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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 158446, 158513 Based on Staffing Sheets obtained for the weeks of 9/18/2022 to 9/24/2022 and 9/25/2022 to 10/1/2022, it was determined that the required minimum staff-to-resident ratios as mandated by the State of New Jersey for Certified Nursing Assistance (CNAs) were short. This deficient practice had the potential to affect all residents. Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with NJSA (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law PL 2020 c 112, codified as NJSA 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	S 560	step 1 No Residents have been negatively affected by the facilities CNA to Resident Ratio. step 2 Facility Staffing Coordinator will continue to reach out to other staffing agencies to ensure facility meets the minimum staffing Ratios. Facility will continue to offer incentives to current facility CNAs for additional shifts picked up. step 3 Administrator, Director of Nursing and staffing Coordinator will continue to have Daily staffing meetings to review staffing needs and to ensure minimum ratios are met. Administrator will review orientation process and hiring / recruitment efforts to ensure facility is effectively retaining their new hires. step 4 Administrator will review facility's recruitment efforts during the facility's QAPI meeting on a monthly basis x 3	11/22/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/22

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 member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA staffing for 14 of 14 day shifts as follows: 09/18/2022 Day shift CNA Staff was 9 for 200 residents. Staffing should have been 25 09/19/2022 Day shift CNA Staff was 8 for 200 residents. Staffing should have been 25 09/20/2022 Day shift CNA Staff was 13 for 200 residents. Staffing should have been 25 09/21/2022 Day shift CNA Staff was 15 for 200 residents. Staffing should have been 25 09/22/2022 Day shift CNA Staff was 15 for 200 residents. Staffing should have been 25 09/23/2022 Day shift CNA Staff was 15 for 200 residents. Staffing should have been 25 09/24/2022 Day shift CNA Staff was 14 for 198 residents. Staffing should have been 25 09/25/2022 Day shift CNA Staff was 11 for 197 residents. Staffing should have been 25 09/26/2022 Day shift CNA Staff was 14 for 197 residents. Staffing should have been 25 09/27/2022 Day shift CNA Staff was 14 for 197 residents. Staffing should have been 25 09/28/2022 Day shift CNA Staff was 13 for 197 residents. Staffing should have been 25 09/29/2022 Day shift CNA Staff was 16 for 195 residents. Staffing should have been 24 09/30/2022 Day shift CNA Staff was 14 for 193 residents. Staffing should have been 24 10/01/2022 Day shift CNA Staff was 16 for 193 residents. Staffing should have been 24 The facility was deficient in CNA staffing for 4 of 14 evening shifts as follows: 09/19/2022 Evening Staff was 17 for 200 residents. Staffing should have been 20	S 560	months or until minimum staffing requirement is met.	

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S 560	Continued From page 2 09/23/2022 Evening Staff was 18 for 200 residents. Staffing should have been 20 09/24/2022 Evening Staff was 18 for 198 residents. Staffing should have been 20 09/25/2022 Evening Staff was 17 for 197 residents. Staffing should have been 20 The facility was deficient in CNA staffing for 1 of 14 evening shifts that required ½ CNAs as follows: 09/19/2022 Evening staff half CNA was 7 for 200 residents. Staffing should have been 8 The facility was deficient in CNA staffing for 11 of 14 overnight shifts as follows: 09/18/2022 Overnight Staff was 9 for 200 residents. Staffing should have been 14 09/20/2022 Overnight Staff was 12 for 200 residents. Staffing should have been 14 09/21/2022 Overnight Staff was 13 for 200 residents. Staffing should have been 14 09/22/2022 Overnight Staff was 12 for 200 residents. Staffing should have been 14 09/23/2022 Overnight Staff was 11 for 200 residents. Staffing should have been 14 09/25/2022 Overnight Staff was 11 for 197 residents. Staffing should have been 14 09/26/2022 Overnight Staff was 11 for 197 residents. Staffing should have been 14 09/28/2022 Overnight Staff was 13 for 197 residents. Staffing should have been 14 09/29/2022 Overnight Staff was 12 for 195 residents. Staffing should have been 14 09/30/2022 Overnight Staff was 13 for 193 residents. Staffing should have been 14 10/01/2022 Overnight Staff was 13 for 193 residents. Staffing should have been 14	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315209 Y1	A. Building B. Wing Y2	12/15/2022 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 F0558	Correction	ID Prefix F0600	Correction	ID Prefix F0607	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(1)-(3)	Completed
LSC	10/14/2022	LSC	10/14/2022	LSC	10/14/2022
ID Prefix F0609	Correction	ID Prefix F0689	Correction	ID Prefix F0690	Correction
Reg. # 483.12(c)(1)(4)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	10/14/2022	LSC	11/22/2022	LSC	11/23/2022
ID Prefix F0880	Correction	ID Prefix F0925	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(4)	Completed	Reg. #	Completed
LSC	10/21/2022	LSC	11/22/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
10/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO