STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	**2300 HAMILTON AVE HAMILTON, NJ 08619**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ181916 Census: 195 Sample Size: 5 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		

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

Electronically Signed | 04/28/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ181916 Census: 195 Sample Size: 5 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ181916 Based on interviews and review of facility documents on 04/15/2025, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents.	S 560	. Corrective Action for Residents Found to Have Been Affected by the Deficient Practice All residents had the potential to be affected by the deficient staffing levels. Immediate corrective action was initiated as follows: " A staffing surge plan was implemented, including use of per diem	5/19/25

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

Electronically Signed | 04/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to complaint survey from 03/23/2025 to 04/5/2025, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts as follows: On 03/23/25 had 14 CNAs for 196 residents on the day shift, required at least 24 CNAs. On 03/24/25 had 16 CNAs for 195 residents on the day shift, required at least 24 CNAs. On 03/25/25 had 18 CNAs for 195 residents on the day shift, required at least 24 CNAs. On 03/26/25 had 18 CNAs for 195 residents on the day shift, required at least 24 CNAs. On 03/27/25 had 18 CNAs for 195 residents on the day shift, required at least 24 CNAs.	S 560	staff, agency CNAs, and overtime to meet required ratios. " No adverse clinical outcomes were found to be related to the staffing deficiency during the review period. 2. How the Facility Will Identify Other Residents Who May Have Been Affected " A comprehensive review of resident records, incident reports, and grievance logs from March 23 through April 5, 2025, was conducted to identify any resident care delays or missed services that may have resulted from staffing shortages. " Clinical staff reviewed care documentation, ADL logs, and nurse notes for signs of unmet needs. No residents were identified as being affected by this practice. 3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur To ensure compliance with required staffing ratios and avoid recurrence, the following systemic changes were implemented: " Recruitment & Retention Plan: The facility enhanced recruitment efforts through job fairs, sign-on bonuses, and referral incentives. A list of all previous employed staff was created and a call center was setup to call and recruit CNAs. For retention, strategies now include shift differentials, employee recognition programs, and flexible scheduling. " Real-Time Staffing Monitoring: The facility adopted a daily monitoring system that is monitored by the Director of Nursing (DON) and Director of Human Resources to ensure compliance with ratios in real time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 On 03/28/25 had 18 CNAs for 195 residents on the day shift, required at least 24 CNAs. On 03/29/25 had 15 CNAs for 200 residents on the day shift, required at least 25 CNAs. On 03/30/25 had 16 CNAs for 193 residents on the day shift, required at least 24 CNAs. On 03/31/25 had 16 CNAs for 193 residents on the day shift, required at least 24 CNAs. On 04/01/25 had 19 CNAs for 192 residents on the day shift, required at least 24 CNAs. On 04/02/25 had 21 CNAs for 192 residents on the day shift, required at least 24 CNAs. On 04/03/25 had 19 CNAs for 192 residents on the day shift, required at least 24 CNAs. On 04/04/25 had 17 CNAs for 192 residents on the day shift, required at least 24 CNAs. On 04/05/25 had 17 CNAs for 197 residents on the day shift, required at least 25 CNAs.	S 560	4. How the Facility Will Monitor the Effectiveness of Corrective Actions " Daily Staffing Audits are conducted by the Staffing Coordinator and reviewed by the DON. " A weekly compliance report is presented during the facility's monthly QA and Performance Improvement (QAPI) meeting. " Monthly trends will be analyzed for staffing adequacy, overtime use, call-outs, and agency dependency. " The Director of Nursing or their designee will conduct weekly audits for 4 weeks of the required staffing levels. Audits will then transition to monthly for 3 months to ensure sustained compliance. Audit findings and any corrective actions taken will be reviewed during the next quarterly Quality Assessment and Assurance (QAA) meeting to ensure continuous monitoring to prevent recurrence and to determine if additional oversight of this area is required.	
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus	S1680		5/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1680	Continued From page 3 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1680	Continued From page 4 This REQUIREMENT is not met as evidenced by: Complaint #181916 Based on review of the AAS-12 staffing from 03/23/2025 to 04/05/2025, it was determined that the facility was deficient in total staffing for 3 of 14 days as follows: For the week of 03/23/25 Required Staffing Hours: 539.25 On 03/23/25 had 504 actual staffing hours, for a difference of -35.25 hours. On 03/29/25 had 520 actual staffing hours, for a difference of -19.25 hours. For the week of 03/30/25 Required Staffing Hours: 530.25 On 03/30/25 had 496 actual staffing hours, for a difference of -34.25 hours.	S1680	Corrective Action for Residents Found to Have Been Affected by the Deficient Practice All residents in the facility on the cited dates had the potential to be affected by insufficient nursing coverage. Immediate corrective actions were taken as follows: " A review of all resident care notes, and incident reports, was conducted to identify any resident care concerns that occurred during these shifts. " The facility's nursing management ensured all resident needs were met and no harm resulted from the staffing shortfall. " No adverse clinical outcomes were found to be related to the staffing deficiency during the review period. 2. How the Facility Will Identify Other Residents Who May Have Been Affected " The facility conducted a retrospective review of nursing documentation, ADL completion logs, and resident complaints during the affected dates. " Residents with high acuity needs (e.g.,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1680	Continued From page 5	S1680		

those requiring wound care, IV therapy, or respiratory support) were prioritized for follow-up assessments to ensure care plans were fully implemented and needs were met. No residents were identified as affected by this practice.

3. Measures or Systemic Changes to Ensure the Deficient Practice Does Not Recur

" Recruitment Expansion: The Human Resources department expanded recruitment to include additional full-time and per diem licensed staff to build a more robust scheduling pool.

" Daily Staffing Reviews: A new process was implemented to conduct daily reviews by the Director of Nursing, Director of Human Resources, and Staffing Coordinator, to review scheduled vs. required staffing hours.

" Contingency Coverage: A formal call-in protocol was revised to ensure immediate coverage through float pool or agency partnerships in case of unplanned staff absences.

4. How the Facility Will Monitor the Effectiveness of Corrective Actions

" The Director of Nursing (DON) will generate a weekly staffing report comparing actual hours worked against required staffing hours, based on census and acuity adjustments.

" A Quarterly Staffing Review will be conducted to ensure long-term compliance and adjust recruitment and retention strategies as needed.

" The Director of Nursing or their designee will conduct weekly audits for 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061103	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHAE	2300 HAMILTON AVE HAMILTON, NJ 08619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1680	Continued From page 6	S1680	weeks of the reported scheduled vs. required staffing hours. These audits will be reported to Quality Assurance & Performance Improvement (QAPI) Committee weekly. Audits will then transition to monthly for 3 months to ensure sustained compliance. Audit findings and any corrective actions taken will be reviewed during the next quarterly Quality Assessment and Assurance (QAA) meeting to ensure continuous monitoring to prevent recurrence and to determine if additional oversight of this area is required.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061103		5/13/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	2300 HAMILTON AVE HAMILTON, NJ 08619

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/19/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 05/19/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON 4/15/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

 EVENT ID: 30LM12