STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	**3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690**

(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
F0000	INITIAL COMMENTS Complaint #: NJ00167920, NJ00170550, NJ00172815, NJ00173598, NJ00174028, NJ00176931, NJ00183474 Survey Date: 2/04/25 to 2/14/25 Census: 39 Sample: 20 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		
F0836 SS = F	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or	F0836	1. What corrective actions will be accomplished for those residents affected by the deficient practice. a. The facility notified CMS via a submitted 855 A form and confirmed electronic notification with CMS for a change in the facility's DBA name. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. a. Residents residing within the confines of the facility have the potential to be affected by the same practice. b. The corrective action is the submission of a DBA (doing busines as) name change to CMS on the CMS 855 A form. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur.	04/01/2025

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 reverse for further 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.

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

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F0836 SS = F	Continued from page 1 national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is NOT MET as evidenced by: Repeat Deficiency Based on observations, interviews, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions:	F0836	Continued from page 1 a. Regulatory requirements specific to name changes required will be achieved by submitting changes of information on the prescribed the CMS 855 A form to CMS. Name changes will be presented to the nursing home administrator the required application supporting the desired name change will be reviewed by the third-party compliance company prior to submission. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a. Any potential name changes will be reviewed through the quality assurance and improvement committee ,the quality assurance and improvement committee meets monthly	04/01/2025

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F0836 SS = F	Continued from page 2 (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (2) All other changes in enrollment must be reported within 90 days." Prior to the survey, the surveyor accessed the facility's website which listed the facility's name as "Accela Post Acute Care at Hamilton" at the address listed for the registered name "Spring Hills Post Acute Hamilton." On 2/4/25 at 7:30 AM, upon arrival to the facility, the surveyors observed signage on the building which read, "Accela Post Acute Care Hamilton." That name did not correspond with the CMS licensed, approved name and provider registered name " Spring Hills Post Acute Hamilton." On 2/4/25 at 7:35 AM, upon entering the facility, the	F0836		04/01/2025

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F0836 SS = F	Continued from page 3 surveyors observed signage on the wall which read "Spring Hills Post Acute Hamilton." The surveyor observed a sign on the receptionist desk in the front lobby which read "Accela Post Acute Care Hamilton-All Visitors, please SIGN IN ..." At that time, License Practical Nurse/Supervisor (LPN/S) #1 greeted the surveyors wearing a black jacket with the logo "Accela." On 2/4/25 at 10:23 AM, during entrance conference with the surveyor, the U.S. FOIA (b)(6) U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) U.S. FOIA (b) U.S. FOIA (b)), the [redacted] stated Accela was managing the facility as of 9/1/24 and "they (Accela) are in the process of buying it." At that time, the surveyor requested the NJ approved license and the application, form 855B, for the name change to CMS from the U.S. FOIA (b) [redacted] A review of the facility provided license revealed the New Jersey Department of Health Division of Certificate of Need & Licensing issued a license to "Hamilton AMOP, LLC (Limited Liability Company)" was licensed to operate "Spring Hills Post Acute Hamilton," effective 5/1/2024, Expires: 4/31/2025, Issued: 4/19/2024. On 2/4/25 at 3:15 PM, the surveyor interviewed the U.S. FOIA (b) [redacted] and the U.S. FOIA (b)(6), who stated the signage on the building was changed on 1/3/25. At that time, the U.S. FOIA (b) [redacted] provided a letter dated 9/10/24, to the Department of Health Certificate of Need and Healthcare Facility Licensure. A review of the letter dated September 10, 2024, revealed ..."effective September 4, 2024, Hamilton AMOP LLC, the licensed operator of the skilled nursing facility formerly doing business as Spring Hills Post Acute Hamilton has changed its trade name to Accela Post Acute Care at Hamilton ...The change is limited to the "doing business as" name only." On 2/7/25 at 10:00 AM, during a follow up interview with the surveyor, the U.S. FOIA (b) [redacted] confirmed no approval for name change could be provided. He stated he spoke to his corporate office and 2 lawyers who stated they (the facility) only needed to do the notification. The U.S. FOIA (b) [redacted] also confirmed at that time the 855B notification to CMS was not completed.	F0836		04/01/2025

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F0836 SS = F	Continued from page 4 On 2/7/25 at 12:59 PM, the survey team met with the U.S. FOIA (b)(6), U.S. FOIA, U.S. FOIA (b)(6), and the U.S. FOIA U.S. FOIA (b)(6) and presented the above concerns. On 2/07/25 at 03:04 PM, a review of 10 employee files revealed 5 of those employees signed an Accela onboarding packet. A review of the packet revealed a memorandum (memo), dated 8/27/2024. The memo was on Accela Healthcare letter head with the Subject Line: Welcome to the Accela Family. Further review of the memo read: On behalf of the entire Healthcare team, we are thrilled to welcome you to the Accela Family...Our goal is to ensure that this transition is as seamless as possible. The letter was signed by the U.S. FOIA (b)(6) and Employee Experience. The packets were signed by the following employees: -Occupational Therapist #1, Date of Hire (DOH) NJ Exec Order 26.4b -LPN/Unit Manager #1 DOH NJ Exec Order 2 -LPN #2, DOH NJ Exec Order 2 U.S. FOIA (b)(6), DOH NJ Exec Order 26.4 -Registered Nurse # 1 DOH NJ Exec Order 26.4b No additional information regarding the facility's name change was provided to the team. NJAC 8:39-5.1 (a)	F0836		04/01/2025
F0622 SS = E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-	F0622	1.Residents 182, 183, 184, 185, 186, 187, and 188 are NJ Exec Order 26.4 Residents here at the facility. 2.All residents, had the potential to be affected by this deficient practice. 3.staff will be educated how to properly document a discharge including the circumstance for which the resident was discarched. If a facility-initiated discharges 30-day notice in accordance with the	03/04/2025

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F0622 SS = E	Continued from page 5 (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of	F0622	Continued from page 5 criteria noted in paragraph 483.15(c)(4) will be issued to the residents and their families, along with a copy to the Office of the state long term care ombudsman. 4.The Administrator or designee will review discharge documentations and the log sent to Office of the state long term care ombudsman monthly for 3 months and as needed thereafter for any additional recommendations. The results of the monthly audits audits completed by the administrator or designee will be brought to the Quality Assurance Performance Improvement meeting for 6 months and based on the results of these audits a decision will be made regarding the need for continued audits. The next scheduled Quality Assurance Performance Improvement meeting is April 8TH 2025.	03/04/2025

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F0622 SS = E	Continued from page 6 this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is NOT MET as evidenced by: Complaint # NJ 183474 Based on interviews, record review, and review of other facility documentation, it was determined that the facility failed to document the circumstance for which randomly selected residents, from the facility provided discharge list from [redacted] to [redacted], were discharged to another long-term care (LTC) facility, for 7 of 7 residents (Resident #182, #183, #184, #185, #186, # 187, #188) reviewed.This deficient practice was evidenced by the following:	F0622		03/04/2025

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F0622 SS = E	Continued from page 7 1.The surveyor reviewed the electronic medical record (EMR) for Resident #182. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] revealed the resident had a Brief Interview for Mental Status (BIMS) of [redacted] out of 15, indicating the resident was NJ Exec Order 26.4b1. A review of the individual comprehensive care plan (ICCP) revealed a focus of resident wants to [redacted] at facility, dated [redacted] A review of the progress notes revealed the following: -On [redacted] at 22:16 (10:16 PM), A Social Service Note, Late Entry: Note Text: [redacted] met with resident and discussed with POA (power of attorney) regarding LTC [redacted]. Provided options would like to proceed with [name redacted] [redacted] next week. -On [redacted] at 9:18 AM, NJ Ex Order 26.4(b)(1) Note, Note Text: Resident scheduled for LTC [redacted] today to [name redacted]. Resident, POA still in agreement with this plan. Additional review of the EMR did not reveal documentation to support the reason for the [redacted] to NJ Ex Order 26.4(b)(1). 2.The surveyor reviewed the EMR for Resident #183. A review of the Admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included but were not limited to;	F0622		03/04/2025

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F0622 SS = E	Continued from page 8 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1). A review of the quarterly MDS dated NJ Exec Order 26 revealed the resident had a BIMS score of NJ Ex out of 15, indicating the resident was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. A review of the ICCP revealed a focus of the resident is LTC at facility, Date initiated: NJ Exec Order 26.4 A review of the progress notes revealed the following: - On NJ Exec Order 26 at 14:03 (2:03PM), Social Service Note. Late Entry: Note Text: U.S. F0 met with resident and spoke with POA via phone to discuss LTC NJ Exec Order. Requested records be sent to [2 LTC facility names redacted]. -On NJ Exec Order 26 at 14:04 PM, Social Service Note. Late Entry: Note Text: U.S. F0 spoke with resident and family who want to proceed with LTC NJ Exec Order 2 to [name redacted]. Set up NJ Exec Order 26 for p/u between 11-2 on NJ Exec O per their request ... All parties in agreement with this plan. -On NJ Exec Order 26.4b at 14:05 (2:05 PM), Social Service Note, Late Entry: Note Text: U.S. F0 spoke with resident, family and [name redacted] to confirm d/c (discharge)for tomorrow. -On NJ Exec Order 26.4b at 15:25 (3:25 PM), Nursing Note, Narrative: Resident NJ Exec Order 26 by family and was discharged to another facility. On 02/14/25 at 11:38 AM, the surveyor interviewed Resident #183's the NJ Exec Order 26.4b1)on the phone. The RR stated Resident #183 told the NJ Exec Order 26.4b1 that they "have to NJ Exec O" because the facility was NJ Exec Order 26.4b1 and the permanent (LTC) residents had to " The RR informed the surveyor that the resident was in that facility because it was NJ Exec O to the family. The RR added that everyday a family member would go to the	F0622		03/04/2025

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F0622 SS = E	Continued from page 9 facility. Resident #183 told the RR they (the facility) called a meeting with the "suit." They gathered in the lunch area and told all the permanent residents that "they" had been [NJ Exec Order 26.4b1] and they (the LTC residents) have to find a [redacted] elsewhere and the facility will help as much as they can." The RR stated, "we were not given a choice, all LTC had to [NJ Exec Or] immediately. We were completely [NJ Exec Order 26.4]." The RR stated the [U.S. FC] was a great help to them. Additional review of the EMR did not reveal documentation to support the reason for the [NJ Exec Order 2] to another long-term care facility. 3. The surveyor reviewed the EMR for Resident #184. A review of the AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [NJ Exec Order 26.4b1] [redacted] and [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1] [NJ Exec Order 26.4]. A review of the comprehensive MDS dated [NJ Exec Order] revealed the resident had a BIMS score of [NJ E] out of 15, indicating the resident was [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1]. A review of the ICCP revealed a focus of resident wishes to [NJ Exec Order] LTC. Date initiated: [NJ Exec Order 26.4] A review of the progress notes revealed the following: -On [NJ Exec Order 26.4b] at 12:42 PM. Social Service Note.Late Entry: Note Text: Annual care conference held with resident and POA, alongside team ...continues with long term care status under [NJ Exec Order 2]. Does not wish to be asked about [NJ Exec Or] to the community ...has [NJ Ex] [NJ Exec Order 26.4b1] and is [NJ Exec Order 26] and [NJ Exec Order 26.4b1] with care, reports [NJ Exec Order 26.4b1] overall.	F0622		03/04/2025

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F0622 SS = E	Continued from page 10 -On [redacted] at 14:24 (2:42PM), Social Service Note.Late Entry: Note Text: [redacted] spoke with resident and POA regarding LTC [redacted]r. Requested records be sent to [name redacted for 2 LTC facilities]. -On [redacted] at 14:24 (2:24 PM). Social Service Note. Late Entry: Note Text: Resident has been accepted to both facilities and would like to proceed with [redacted] to [name redacted] or [redacted] Additional review of the EMR did not reveal documentation to support the reason for the [redacted] to NJ Ex Order 26.4(b)(1). 4. The surveyor reviewed the EMR for Resident #185. A review of the AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted], [redacted]) and [redacted], [redacted]. A review of the quarterly MDS, an assessment tool dated [redacted] revealed the resident had a BIMS score of [redacted] out of 15, indicating the resident was [redacted]. A review of the ICCP revealed a focus of resident wishes to [redacted] at facility. Date initiated: [redacted]. A review of the progress notes revealed the following: - On [redacted] at 18:04 (6:04PM). Physician / Medical Provider Progress Notes ... discharge planning to long-term care facility; Meds reviewed, continue current medication on discharge. - On [redacted] at 12:33 PM. Nursing Note. Narrative: Pt (patient) was [redacted] ... discharging to [name of LTC facility redacted]. Additional review of the EMR did not reveal	F0622		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690

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F0622 SS = E	Continued from page 11 documentation to support the reason for the [redacted] to another long-term care facility. 5. The surveyor reviewed the EMR for Resident #186. A review of the AR, revealed the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] and [redacted]. A review of the comprehensive MDS, an assessment tool dated [redacted], revealed the resident had a BIMS score of [redacted] out of 15, indicating the resident was [redacted]. A review of the ICCP revealed a focus of the resident wishes to return [redacted] with private [redacted]), Date Initiated: [redacted] with an intervention of establish a pre-discharge plan with the resident/family/caregivers and evaluate progress, Date Initiated: [redacted] A review of the progress notes revealed the following: - On [redacted] at 20:17 (8:17PM) Physician / Medical Provider Progress Notes, revealed a Note Text: Pt is [redacted] ...will be [redacted] to [redacted] soon. -On [redacted] at 19:05 (7:05 PM), Nursing Note Narrative: At 5:34 pm, resident was discharged and [redacted] to another nursing facility. Additional review of the EMR did not reveal documentation to support the reason for the [redacted] to another long-term care facility. 6. The surveyor reviewed the EMR for Resident # 187 A review of the AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted]	F0622		03/04/2025

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F0622 SS = E	Continued from page 12 NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 as the cause of diseases A review of the comprehensive MDS, dated revealed the resident had a BIMS score of out of 15, indicating the resident was . A review of the ICCP revealed a focus of [name redacted] wishes to at facility, Date initiated a goal of [name redacted] will be long term placement in the facility, Date initiated A review of the progress notes revealed the following: - On at 14:08 (2:08 PM). Social Service Note, Late Entry: Note Text: Quarterly IDCP (interdisciplinary care plan) meeting held with resident and family via phone alongside team. Resident continues with LTC status, - On at 09:55 AM, Social Service Note, Late Entry: Note Text: spoke with resident and family regarding LTC They would like referrals sent to [names redacted of 5 LTC facilities]. Family will be the facilities in the upcoming days. -On at 09:56 AM, Social Service Note, Late Entry: Note Text: spoke with resident and . They are requesting r on to [name redacted] ... set up transportation for 4:30 pick up. Additional review of the EMR did not reveal documentation to support the reason for the to another long-term care facility. 7. The surveyor reviewed the EMR for Resident #188. A review of the Admission Record revealed the	F0622		03/04/2025

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F0622 SS = E	Continued from page 13 resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] and NJ Exec Order 26.4b1 A review of the quarterly MDS dated [redacted], revealed the resident had a BIMS of [redacted] out of 15, indicating the resident was [redacted]. A review of the ICCP revealed a focus of resident wishes to [redacted] LTC, Date Initiated: [redacted] with a goal of will be long term placement in the facility, Date Initiated: [redacted] A review of the progress notes revealed the following: - On [redacted] at 14:19 (2:19 PM),Social Service Note, Late Entry: Note Text: [redacted] met with resident regarding LTC [redacted]. [identifier redacted] request I send records to [name redacted] and [name redacted]. - On [redacted] at 14:20 (2:20 PM), Social Service Note, Late Entry: Note Text: Resident has been accepted to [name redacted] for LTC [redacted] and would like to proceed with d/c (discharge) on [redacted] Additional review of the EMR did not reveal documentation to support the reason for the [redacted] to another long-term care facility. On 2/14/24 at 10:28 AM, the surveyor interviewed Resident #188 on the telephone. The resident was [redacted] to speak to the surveyor and confirmed that they were at another long-term care facility. The resident stated when they were admitted to the facility in [redacted] they (the facility) "didn't know what my plan (LTC) was. The facility suggested LTC and I was going to [redacted] there ([redacted] The surveyor asked when did the facility tell you that you couldn't [redacted], "They did not tell us that I could [redacted]" The resident asked the surveyor to hold because someone was there helping them [redacted] of [redacted], the call was disconnected. The surveyor tried multiple times to call the resident back but there was no answer.	F0622		03/04/2025

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F0622 SS = E	Continued from page 14 On 2/14/25 at 12:49 PM, the surveyors interviewed the U.S. FOIA (b)(6)), who stated she meets with residents and their family within 72 hours of admission for a care conference to talk about discharge planning. She stated upon request by a resident or their family would be a situation where a resident would leave the facility to another LTC facility. The [redacted] stated if the resident transitions to LTC, she would assist or refer them with NJ Ex Order 26.4(planning, financial planner and/or elder care advisors. She stated the facility has always been both short term and LTC. The [redacted] stated the "new company" came in NJ Exec Order 26.4b1 and the companies U.S. FOIA (b)(6) spoke to the staff that the company was geared more towards short-term rehab. The [redacted] stated between her and the U.S. FOIA (b)(6) U.S. FOIA (b)(6)) they met with residents and educated them on the change in management with the focus of short term rehabilitation and discussed their (the residents) options. She could not recall any facility-initiated discharges but stated she "absolutely would be involved in a transfer to another facility." The [redacted] stated a 30 day notice letting them (the resident) know their rights and she "would look to the U.S. FOIA (D)(6) r to guide me with that process." She added, "I can't force someone out, depending on the reason we would try to work with them." The [redacted] stated, "if it NJ Ex Order 26.4(b)(1) [redacted]) was a request it would be documented." At that time the surveyors reviewed the NJ Exec Order 26.4 of the above-mentioned residents with the [redacted], her responses were as follows: -Resident #182 requested a [redacted] because the [resident's representative] or family [redacted] there. -Resident #183 requested to go there because "I think they knew someone who went there in the past and I think it was [redacted] to the [redacted] NJ Exec Order 26.4b1] who had a NJ Exec Order 26.4b1 in [redacted]" She stated, "there should be a note from me about why the [redacted]" -Resident #184 requested a NJ Exec Order 26.4b1 because "[identifier redacted] was [redacted] here and we were offering transfers to [redacted] here or [redacted] and the resident wanted [redacted] of a NJ Ex Order 26.4(b)(1) environment."	F0622		03/04/2025

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F0622 SS = E	Continued from page 15 -Resident #185 requested the [NJ Exec Order 26 -Resident # 186 requested the [NJ Exec Order 2 because their [U.S. FOIA (b)(6)] works in that facility. She stated "if a resident requested a [NJ Ex Order 26 it would be in my progress note." -Resident #187 requested a [NJ Exec Order 2 because they were working with their family with multiple places. She stated, "I think [identifier redacted] was [NJ Exec Order 2 here. I think the place they went was [NJ Exec Order and the resident would get more [NJ Exec Order 26.4b1 care." The [U.S. FOIA added, "we could have provided care for the resident here but that was their preference." -Resident #188 requested the [NJ Exec Order 2 because they knew someone that was going there. During that same interview, the [U.S. FOIA stated, "the facility did not tell them (the above residents) they could not [NJ Exec O" She could not speak to if a resident was happy here (the facility), in their home, why they (the facility) would give them (the residents) an option to leave. She added, "it was a conversation, kind of a change in management, we (the facility) educated them (the residents) on their options ." At that time the surveyors asked the [U.S. FO to provide the above mentioned documentation. On 2/14/25 at 1:23 PM, the surveyors interviewed the [U.S. FOIA (b), who stated the facility was licensed for Medicare and Medicaid and accepted both short term and long-term care residents. He added, "most people come here for therapy." At that time, the surveyors reviewed the transfers of the above-mentioned residents with the [U.S. FOIA (b). The [U.S. FOIA (b) stated he could only speak to the residents that were transferred since he started at the facility in [NJ Exec Order 26.4b1. His responses for 2 of the above mentioned residents that were transferred after he started at the facility: -Resident #186 "was [NJ Exec Order 26.4b on [NJ Ex O or going [NJ Exec Or. I don't remember if the resident was told they could [NJ Exec here. We (the facility) spoke to the resident about other facilities and recommended [name redacted] NJ Ex Order 26.4(b)(1)) but the	F0622		03/04/2025

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F0622 SS = E	Continued from page 16 resident's [U.S. FOIA (b)] did not practice there. [Identifier redacted] was [NJ Exec Orde] here, [NJ Exec Order 26.4b1]. I am not sure when the conversation started but once the resident's [NJ Exec Orde] part finished, then next step was [NJ Ex Orde]. The [U.S. FOIA (b)] was unable to speak to whether the resident wanted to [NJ Ex] to NJ Ex Order 26.4(b)(1) on their own. He added, " [identifier redacted] just decided on their own, [identifier redacted] they wanted to [NJ Ex] there. I didn't kick [identified redacted] out." He stated, "I don't usually get involved in discharges." -Resident #185 was [NJ Exec Order 26.4b1] "probably because they were finished with [NJ Exec Orde]." He could not say [NJ Exec] wasn't [NJ Exec Orde] "here." During this interview, the [U.S. FOIA (b)] could not speak to why put a resident through [NJ Ex Order 26.4(b)] if they were [NJ Ex Order 26.4(b)(1)] He added, "they could technically [NJ Ex O] On 2/14/25 at 1:42 PM, the surveyors interviewed the U.S. FOIA (b)(6)), who confirmed the facility accepts [NJ Ex Or] residents and could not recall any facility-initiated discharges. At that time, the surveyors reviewed the transfers of the above-mentioned resident's with the [U.S. FOIA], her responses were as follows: -Resident # 182 was a [NJ Ex O] resident but she did not know the reason the resident was [NJ Exec Order 26.4b] to NJ Ex Order 26.4(b)(1) She added the facility was able to care for the resident and that they "seemed [NJ Exec Orde], nothing [NJ Exec Order 26.4b1] Resident # 183 was a [NJ Ex O] resident but she did not know the reason the resident was [NJ Exec Order 26.4b1] to [NJ Ex Order 26.4(b)(1)]. She stated the facility was "able to meet all [identifier redacted] needs, they seemed [NJ Exec Orde] and never NJ Exec Order 26.4b1." -Resident # 184 was a [NJ Ex O] resident but she did not know the reason the resident was [NJ Exec Order 26.4b1] to [NJ Ex Order 26.4(b)(1)]. She added the facility able to meet all of the residents needs for care. -Resident #185 was a [NJ Ex O] resident but she couldn't recall the reason the resident was [NJ Exec Order 26.4b1] to [NJ Ex Order 26.4(b)(1)] She added the facility was able to	F0622		03/04/2025

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F0622 SS = E	Continued from page 17 meet all the residents needs and could not recall the resident making any [NJ Exec Order 26.4b1]. -Resident #186 was [NJ Exec Order 26.4b1] to another facility because of [NJ Exec Order 26.4b1] or maybe [identifier redacted] wanted to [NJ Ex...]." She stated the facility was able to meet all the residents needs and could not recall the resident making any [NJ Exec Order 26.4b1] -Resident #187 was a LTC resident but she couldn't recall the reason the resident was [NJ Exec Order 26.4b1] to [NJ Ex Order 26.4(b)(1)]. She stated the facility was able to meet all the residents need and could not recall the resident making any [NJ Exec Order 26.4b1] -Resident #188 was a LTC resident but she couldn't recall the reason the resident was [NJ Exec Order 26.4b] to [NJ Ex Order 26.4(b)(1)]. She added the resident did not have any [...] or [NJ Exec Orde...NJ Exec Orde] that the facility could not handle. At that time, the [U.S. FOIA ID] stated the discharge process from [NJ Ex Order 26.4(b)(1)] would be for the [U.S. FO...] to get a list of LTC facilities requested by the resident or their family and send out a referral(s). Once a facility was agreed upon, typically the face sheet, discharge medication list, a transfer form, immunizations and any thing else the facility requested was sent to the receiving facility. During the same interview, the surveyors asked the [U.S. FOIA] if the above mentioned residents would be accepted back to the facility, she stated, " I believe that if a resident wanted to come back, we would accept them back. As a [U.S. FOIA ID] I would take back any or all of those residents from a nursing stand point." On 02/14/25 at 03:05 PM, the [U.S. FOIA ID] met with the surveyors and stated the [U.S. FO...] only notifies the ombudsman's office of a discharge if the resident went to the hospital. She confirmed that she was unable to provide the surveyors with a written notification of discharge for the above residents. On 2/14/25 at 03:06 PM, during a follow up interview with the surveyors, the [U.S. FO...] stated the facility had already provided all the progress notes for the above-mentioned residents which would include any of her documentation. She had nothing	F0622		03/04/2025

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F0622 SS = E	Continued from page 18 else to add. On 2/14/25 at 03:15 PM, the surveyors presented the above concerns to the [redacted] and the [redacted] U.S. FOIA (b)(6). A review of the facility's "Admission Agreement" revised 1/2021, revealed "3. Resident Rights...v.)The Resident is entitiled to at least thirty (30) days advance notice of transfer or discharge." A review of the facility's policy, "Transfer or Discharge Notice" revised 3/2021, revealed Policy Statement: Residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to transfer or discharge. 1. B. discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. 2. Residents are permitted to stay in the facility and not be transferred or discharged unless: a. the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility. 3. Except as specified below, the resident and his or her representative are given thirty (30)-day advance written notice of impending transfer or discharge from this facility. 5. The resident and representative are notified in writing of the following information: a. specific reason for the transfer or discharge; b. the effective date of the transfer or discharge; c. the location to which the resident is being transferred or discharged; ...8. The reason for the transfer or discharge are documented in the resident's medical record. NJAC 8:39-4.1(a)(31) (32)	F0622		03/04/2025
F0623 SS = E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office	F0623	1.Residents 182, 183, 184, 185, 186, 187, and 188 are [redacted] NJ Exec Order 26 residents here at the facility. 2.All residents who are in the facility have the potential to be affected by this deficient practice. However, no other residents have been affected by this deficient practice. 3.The Administrator or designee will in-service the [redacted] U.S. FOIA (b)(6) and the Interdisciplinary Team with the proper protocol for Transfers and Discharge Requirements.	03/04/2025

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F0623 SS = E	Continued from page 19 of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an	F0623	Continued from page 19 4.The Administrator or designee will review discharges and log sent to Office of the state long term care ombudsman biweekly x 4 weeks, then monthly x 3 months unless significant trends are identified. Results of the monthly audits will be reported monthly to the facility Quality Assurance Performance Improvement Committee x 3 months.	03/04/2025

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F0623 SS = E	Continued from page 20 appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is NOT MET as evidenced by: Complaint #NJ00183474 Refer to F 622 Based on interviews, record review and review of facility documentation, it was determined that the	F0623		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0623 SS = E	Continued from page 21 facility failed to provide written notification of the [redacted] to the Office of the Long-Term Care (LTC) Ombudsman (LTCO) for 7 of 7 residents (Resident #182, #183, #184, #185, #186, # 187, #188) reviewed for [redacted] to NJ Ex Order 26.4(b)(1) This deficient practice was evidenced by the following: 1.The surveyor reviewed the electronic medical record (EMR) for Resident #182. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to:NJ Exec Order 26.4b1 [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating the resident was NJ Exec Order 26.4b1. A review of the individual comprehensive care plan (ICCP) revealed a focus of resident wants to [redacted] at facility, dated [redacted] A review of the progress notes revealed on [redacted] at 9:18 AM [redacted] Note, Note Text: Resident scheduled for [redacted] today to [name redacted]. Resident, POA still in agreement with this plan. 2.The surveyor reviewed the EMR for Resident #183. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] and NJ Exec Order 26.4b1). A review of the quarterly MDS dated [redacted]	F0623		03/04/2025

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F0623 SS = E	Continued from page 22 revealed the resident had a BIMS score of [redacted] out of 15, indicating the resident was [redacted] NJ Exec Order 26.4b1. A review of the ICCP revealed a focus of the resident is [redacted] at facility. Date initiated [redacted] A review of the progress notes revealed on [redacted] at 15:25 (3:25 PM), Nursing Note, Narrative: Resident [redacted] by family and was discharged to another facility. 3. The surveyor reviewed the EMR for Resident #184. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] and NJ Exec Order 26.4b1. A review of the comprehensive MDS dated [redacted] revealed the resident had a BIMS score of [redacted] out of 15, indicating the resident was [redacted] NJ Exec Order 26.4b1. A review of the ICCP revealed a focus of resident wishes to [redacted] Date initiated: [redacted]. A review of the progress notes revealed on [redacted] at 14:24 (2:24 PM). [redacted] Note. Late Entry:Note Text: Resident has been accepted to both facilities and would like to proceed with [redacted] to [name redacted] on [redacted]. 4. The surveyor reviewed the EMR for Resident #185. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] NJ Exec Order 26.4b1) and NJ Exec Order 26.4b1	F0623		03/04/2025

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F0623 SS = E	Continued from page 23 NJ Exec Order 26.4b1 A review of the quarterly MDS dated NJ Exec Order 2 revealed the resident had a BIMS score of NJ Ex out of 15, indicating the resident was NJ Exec Order 26.4b1. A review of the ICCP revealed revealed a focus of resident wishes to NJ Exec Order at facility. Date initiated: NJ Exec Order 26.4 A review of the progress notes revealed on NJ Ex Order 26.4(b)(1) at 12:33 PM. Nursing Note. Narrative: Pt (patient) was NJ Exec Order 26.4b ... discharging to [name of NJ Ex Order 26.4(b)(1) redacted]. 5.The surveyor reviewed the EMR for Resident #186. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. A review of the comprehensive MDS, an assessment tool dated NJ Exec Order 26, revealed the resident had a BIMS score of NJ Exe out of 15, indicating the resident was NJ Exec Order 26.4b1 A review of the ICCP revealed a focus of the resident wishes to NJ Exec Order 26.4b1 with NJ Ex Order 2 U.S. FOIA (b)(6)), Date Initiated: NJ Exec Order 26.4b1 with an intervention of establish a pre-discharge plan with the resident/family/caregivers and evaluate progress, Date Initiated: NJ Exec Order 26.4b1 A review of the progress notes revealed on NJ Ex Order 26.4(b)(1) at 19:05 (7:05 PM), Nursing Note Narrative: At 5:34 pm, resident was discharged and NJ Exec Order 26.4b1 to NJ Ex Order 26.4(b)(1). 6. The surveyor reviewed the EMR for Resident # 187. A review of the Admission Record revealed the	F0623		03/04/2025

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F0623 SS = E	Continued from page 24 resident was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . A review of the comprehensive MDS, dated NJ Exec Order 26 revealed the resident had a BIMS score of out of 15, indicating the resident was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 A review of the ICCP revealed a focus of [name redacted] wishes to at facility, Date initiated , a goal of [name redacted] will be placement in the facility, Date initiated A review of the progress notes revealed on at 09:56 AM NJ Ex Order 26.4(b)(1) Note, Late Entry: Note Text: spoke with resident and [NJ Exec Order 26.4b1]. They are requesting on to [name redacted] ... set up transportation for 4:30 pick up. 7. The surveyor reviewed the EMR for Resident #188. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to: A review of the quarterly MDS dated , revealed the resident had a BIMS score of out of 15, indicating the resident was NJ Exec Order 26.4b1. A review of the ICCP revealed a focus of [name redacted] wishes to Date Initiated: NJ Exec Order 26.4b1 with a goal: [name redacted] will be long term placement in the facility, Date Initiated: A review of the progress notes revealed on	F0623		03/04/2025

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F0623 SS = E	Continued from page 25 [NJ Ex Order 26.4(b)(1)] at 14:20 (2:20 PM), [NJ Ex Order 26.4(b)(1)] Note, Late Entry: Note Text: Resident has been accepted to [name redacted] for [NJ Ex O] [NJ Exec Order 2] and would like to proceed with d/c (discharge) on [NJ Exec O] On 02/14/25 at 12:43 PM, the surveyor requested the written discharge transfer notices that were given to the above 7 residents from the [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)]) for review. On 02/14/25 at 3:05 PM, the [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)] met with the surveyors and stated the [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)] only notified the ombudsman's office of a discharge if the resident went to the hospital. She confirmed that she was unable to provide the surveyors with a written notification of discharge for the above residents. On 2/14/25 at 3:06 PM, during an interview with the surveyors, the [U.S. FO] stated the facility had already provided all the progress notes for the above-mentioned residents which would include any of her documentation. She had nothing else to add. No additional information was presented to the surveyors. On 2/14/25 at 3:15 PM, the surveyors presented the above concerns to the [U.S. FOIA] and the [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)]. A review of the facility's policy, "Transfer or Discharge Notice" revised 3/2021, revealed Policy Statement: Residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to transfer or discharge. 3. Except as specified below, the resident and his or her representative are given thirty (30)-day advance written notice of impending transfer or discharge from this facility. 5. The resident and representative are notified in writing of the following information: a. specific reason for the transfer or discharge; ...6. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. NJAC 8:39-5.3; 5.4	F0623		03/04/2025

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F0698 SS = E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: REFER to F756 Based on observation, interviews and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication times of administration to accommodate for [NJ Exec Order 26.4b1] [redacted] scheduled times from [NJ Exec Order 26.4b] [NJ Exec O] until surveyor inquiry [NJ Exec Order 26.4b1]. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was identified for one (1) of one (1) resident, (Resident #21), reviewed for [NJ Exec Order]	F0698	1. Resident #21 is currently [NJ Exec O] a resident here at the facility. The laws were changed and [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] medications are to be provided by the patient's [NJ Exec Order 2] center. All [NJ Ex Order 26.4(b)(1)] patients medication was reviewed to ensure their medication was in the facility. The [NJ Ex Order 26] centers will be contacted upon admission to review medications that will be provided by the [NJ Ex Order 26] center. 2. All residents on hemodialysis have the potential for be at risk of running out of medication Sevelamer (Renvela). However, no other residents have been affected by this deficient practice. 3. Upon acceptance of an End Stage Renal Disease resident on hemodialysis the Director of Nursing or designee will call the dialysis center to facilitate the shipment of the medications, obtain an alternative, and/or discontinue the medication. 4.The Director of Nursing or designee will audit 3 residents weekly to ensure medications are provided by the dialysis center. Audit will be conducted weekly x 4 weeks then monthly x 3 months unless any significant trends are identified. Results of the monthly audits will be reported monthly to the facility Quality Assurance Performance Improvement Committee x 3 months.	03/04/2025

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F0698 SS = E	Continued from page 27 services and was evidenced by the following: On 2/4/25 at 10:09 AM, the surveyor interviewed Resident #21, who stated that they had been here (in the facility) since late [NJ Exec Order 26.4b] but had gone to the hospital for a [NJ Exec O] in [NJ Exec Order 26.] and [NJ Exec Order 26]. The resident also stated that they (the nurses) frequently [NJ Exec Order] of their medications. The resident added specifically "I don't get my NJ Exec Order 26.4b1)." The resident also stated that they went out of the facility for [NJ Exec Order] on Tuesdays, Thursdays and Saturdays at approximately 10 AM and returned from [NJ Exec Order] approximately 4 PM. The resident added that they were waiting to be picked up this morning. On 2/5/25 at 8:32 AM, during the morning medication administration (med pass) observation, the surveyor with Licensed Practical Nurse (LPN #1) reviewed the electronic administration record (EMAR) for Resident #21. LPN #1 stated that she was not administering the resident's NJ Exec Order 26.4b1 because the EMAR computer screen indicated "d/c (discontinue) pending confirmation." LPN# 1 explained that meant they were verifying orders because there may be multiple orders. The surveyor reviewed the electronic medical record for Resident #21. A review of the Admission Record revealed diagnoses that included, but not limited to, [NJ Exec Order 26]) and NJ Exec Order 26.4b1 A review of a comprehensive admission Minimum Data Set, an assessment tool used to facilitate the management of care, with an assessment reference date of [NJ Exec Order 26.4b], reflected the resident had a brief interview for mental status score of [NJ Ex] out of 15, indicating that the resident had ar NJ Exec Order 26.4b1 . A review of the resident's individualized interdisciplinary care plan revealed a focus area, with an initiated date of [NJ Ex Order 26], "Resident has [NJ Exec]	F0698		03/04/2025

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F0698 SS = E	Continued from page 28 NJ Exec Order 26.4b1 [name and place redacted] on T (Tuesday)-TH (Thursday)-SAT (Saturday) chair time 11 AM." An intervention/task included, but not limited to, "Ensure medication schedule is adjusted to administer medications when I am in the facility." A review of the resident's NJ Exec Order 26.4b1 Order Summary Report (OSR) reflected a physician's order (PO) dated NJ Exec Order 2 for NJ Exec Order 26.4b1 Tue, Thurs, Sat @ (at) [name of NJ Exec Order facility, address and phone number redacted] P/U (pick up) time: 10 AM chair time: 11AM." Further review revealed a PO with a start date of NJ Exec Order 2 for "NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Oral tablet NJ Exec NJ Ex O NJ Exec Order 26.4b1), Give 3 tablet by mouth with meals for NJ Exec Orde until NJ Exec Order 26". There was no PO found to "d/c (discontinue) pending confirmation." A review of the NJ Exec Order 26.4b1 electronic medication administration record (EMAR) indicated a medication administration time of 12 NOON that occurred during the time that the resident was NJ Exe of the facility at NJ Exec Order 2. Further review of the EMAR revealed the following: -on NJ Exec Orde at 8:00 AM, 12 NOON and 5 PM, on NJ Exec Orde at 8 AM and 12 NOON and on NJ Exec Orde at 8 AM and 5 PM, all had a code number "NJ E entered for administration which corresponded to "Other/see progress notes." A review of the corresponding electronic progress notes (EPN) had the following: -on NJ Exec Orde and NJ Exec Orde had no "Note Text" with an explanation. -on NJ Exec Orde at 8:02 AM had a "Note Text: pharmacy contacted awaiting from pharmacy." -on NJ Exec Orde at 4:41 PM had a "Note text: pending pharm delivery as is new order , 0 [name of electronic back up medication supply machine redacted]."	F0698		03/04/2025

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F0698 SS = E	Continued from page 29 On 2/5/25 at 11:02 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that she was unaware that there was an issue with NJ Exec Order 26 or any medications for Resident #21. The U.S. FOIA (b)(6) was aware that the medications had to be scheduled for when the resident was in the facility because they NJ Exec O NJ Ex of the facility for NJ Exec Order 2. The surveyor, with the U.S. FOIA (b)(6) reviewed the NJ Exec Order 26.4 EMAR. The U.S. FOIA (b)(6) was unable to explain why there was a code number "9" entered for administration. The U.S. FOIA (b)(6) verified that "9" meant the medication was not administered and there should be a progress note explaining. The surveyor with the U.S. FOIA (b)(6) went to the medication cart and the U.S. FOIA (b)(6) stated that there was NJ Exec Order 26 tablets labeled for Resident #21 available in the medication cart. The U.S. FOIA (b)(6) was unable to speak to why there was an issue with the NJ Exec Order 26. The U.S. FOIA (b)(6) added that there should not be a time of 12 NOON for the NJ Exec Order 26 on Tuesdays, Thursdays and Saturdays because the resident was NJ Ex to NJ Exec Order . Further review of the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 EMAR and EPN revealed the following: -on NJ Exec Order 26.4b1 the 12:00 PM doses of NJ Exec Order 26 indicated that the medication was not administered. The EMAR indicated on NJ Exec Order 26.4b1 that the resident was "Absent from NJ Exec Ord without meds." There was a corresponding EPN for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Ord that indicated the resident was at NJ Exec Order 2. -on NJ Exec Order 26. and NJ Exec Order 26. the 9 AM doses of NJ Exec Order 26.4b1 Oral capsule NJ Exec O NJ Ex Order 26.4(b)(1) Give NJ Exec O NJ Ex Ord by mouth one time a day every NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 " indicated that the medication was not administered. There was a corresponding EPN on NJ Exec Order 26. "n/a (not available)" and on NJ Exec Order 26 "awaiting." -on NJ Exec Order 26.4b1 the 2:00 PM doses of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) NJ Exec O NJ Ex O NJ Exec Order 26.4b1 every hours for prevention" indicated that the medication was not administered. The EMAR	F0698		03/04/2025

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F0698 SS = E	Continued from page 30 indicated on [redacted] and [redacted] that the resident was [redacted] from [redacted] without meds." In addition, on [redacted] the EMAR indicated [redacted] from [redacted] with meds." There was a corresponding EPN for [redacted] and [redacted] that indicated the resident was at [redacted] -on [redacted] and [redacted] the 12:00 PM doses of [redacted] oral tablet [redacted]) Give [redacted] tablet by mouth with meals for [redacted] indicated that the medication was not administered. There was a corresponding EPN for [redacted] and [redacted] that indicated the resident was at [redacted] -on [redacted] and [redacted] the 12:00 PM doses of [redacted] indicated that the medication was not administered. The EMAR indicated on [redacted] that the resident was [redacted] from [redacted] without meds." There was a corresponding EPN for [redacted], [redacted] and [redacted] that indicated the resident was at [redacted]. In addition, the corresponding EPN for [redacted] and [redacted] indicated that for the 8 AM, 12 NOON and 5 PM doses of [redacted] were "not available", "awaiting from pharmacy" or "on order." On 2/7/25 at 8:58 AM, the surveyor interviewed the [redacted]) via the telephone. The [redacted] stated that she completed medication administration observations as requested by the facility and had not completed a medication administration inservice for the nurses. The [redacted] added that she will do an inservice after completing a med pass with that specific nurse. The [redacted] also stated that she tells the nurses that if a medication was not available then to enter the code number [redacted]" in the EMAR but then the physician had to be called to get instructions on what can be done about not having the medication. The [redacted] added that the nurses cannot just document that the medication was not available or awaiting from pharmacy. The [redacted] also stated that the nurses needed to get instructions from the physician fairly quickly when a medication was not available. The [redacted] then stated that a resident that goes out to [redacted] had to have their medications scheduled to accommodate them being [redacted] of the facility. The [redacted] added that the physician would be contacted, and specific orders would be given as to the timing. On 2/7/24 at 10:34 AM, the surveyor interviewed the	F0698		03/04/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690

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F0698 SS = E	Continued from page 31 U.S. FOIA (b)(6), who stated that she was unsure why the PO for Resident #21 had not been updated to accommodate the times the resident was NJ Exec to NJ Exec Order 26 The U.S. FOIA (b)(6) added that usually a medication ordered for three times a day would only be ordered twice a day on NJ Exec Order 2 days and scheduled for times when the resident was in the facility. On 2/7/25 at 3:18 PM, the surveyor interviewed the U.S. FOIA (b)(6)), who acknowledged medications had to be scheduled to accommodate the resident being NJ Exec to NJ Exec Order 2. A review of a facility policy "Administering Medications" dated as revised April 2019 provided by the DON reflected "Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals orders)." A review of the undated facility policy "End-Stage Renal Disease, Care of a Resident with" provided by the U.S. FOIA reflected "Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care." In addition, the policy revealed "Education and training of staff includes, specifically....f. timing and administration of medications, particularly those before and after dialysis." NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)	F0698		03/04/2025
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F0756	1. Resident #21 is currently NJ Exec a resident at the facility. Medications were not timed around NJ Exec Order 26 All hemodialysis patients were audited to ensure medication is timed around their hemodialysis schedule. Staff were educated on timing medication around the resident dialysis times. 2. All residents on hemodialysis have the potential to be at risk of medications not being timed properly around hemodialysis. However, no other residents have been affected by this deficient practice. 3. Residents that are admitted that require hemodialysis will have their medications timed around their hemodialysis schedule. The Unit manager, Director of Nursing or designee will review the medication times during the next morning	03/04/2025

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F0756 SS = E	Continued from page 32 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: REFER to F698 Based on observation, interview and record review, it was determined that the facility failed to respond in a timely manner to the U.S. FOIA (b)(6) monthly recommendations from NJ Exec Order 26.4b1 until surveyor inquiry for one (1) of six (6) residents, (Resident #21), reviewed for medication management. The deficient practice was evidenced by the following: On 2/4/25 at 10:09 AM, the surveyor interviewed Resident #21, who stated that they had been here (in the facility) since late NJ Exec Order 26.4b1 but had gone to the hospital for a NJ Exec O in NJ Exec Order and NJ Exec Order 26. The resident also stated that they (the nurses) frequently NJ Exec Orde of their medications. The resident added specifically "I don't get my NJ Exec Order 26.4b1	F0756	Continued from page 32 meeting. 4. The Director of Nursing or designee will audit 3 residents weekly to ensure medications are timed around the patients hemodialysis schedule. Audit will be conducted weekly x 4 weeks then monthly x 3 months unless any significant trends are identified. Results of the monthly audits will be reported monthly to the facility Quality Assurance Performance Improvement Committee x 3 months.	03/04/2025

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F0756 SS = E	Continued from page 33 The resident also stated that they went [NJ Exec] of the facility for [NJ Exec Order 2] on Tuesdays, Thursdays and Saturdays at approximately 10 AM. The resident added they were waiting to be picked up this morning. On 2/5/25 at 8:32 AM, during the morning medication administration observation, the surveyor with Licensed Practical Nurse (LPN#1) reviewed the electronic administration record (EMAR) for Resident #21. LPN#1 stated that she was not administering the resident's [NJ Exec Order 26.4b1]) because the EMAR computer screen indicated "d/c (discontinue) pending confirmation." LPN#1 explained that meant they were verifying orders because there may be multiple orders. The surveyor reviewed the medical record for Resident #21. A review of the resident's [NJ Exec Order 26.] Order Summary Report (OSR) reflected a physician's order (PO) dated [NJ Exec Order 2] for '[NJ Exec Order 26.4b1] Tue, Thurs, Sat @ (at) [name of [NJ Exec Order 2] facility, address and phone number redacted] P/U (pick up) time: 10 AM chair time: 11AM." Further review revealed a PO with a start date of [NJ Exec Order 2] for '[NJ Exec Order 26.4b1]) Oral tablet [NJ Exec] [NJ Ex] [NJ Exec Order 26.4b1] Give 3 tablet by mouth with meals for [NJ Exec Order] until [NJ Exec Order 2]." There was no PO found to "d/c (discontinue) pending confirmation." A review of the [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] EMARs indicated there were medication administration times for [NJ Exec Order 26], [NJ Exec Order 26.4b1] and [NJ Exec Order 2] that occurred during the time that the resident was [NJ Exec] of the facility at [NJ Exec Order 26] A review of corresponding electronic progress notes for [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] indicated that the [NJ Exec Order 26.4b1] and [NJ Exec Order 2] were not administered because the resident was [NJ Exec] of the facility at [NJ Exec Order 26] On 2/5/25 at 11:02 AM, the surveyor interviewed the [U.S. FOIA (b)(6)]), who stated that she was unaware that there was an issue with [NJ Exec Order 26]	F0756		03/04/2025

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F0756 SS = E	Continued from page 34 or any medications for Resident #21. The U.S. FOIA (b)(6) was aware that the medications had to be scheduled for when the resident was in the facility because they went NJ Exec of the facility for NJ Exec Order 26. On 2/7/25 at 8:58 AM, the surveyor interviewed the U.S. FOIA (b)(6) via the telephone. The U.S. FO stated that a resident that goes NJ Exe to NJ Exec Order 2 had to have their medications scheduled to accommodate them being NJ Exe of the facility and she has made the recommendation. The U.S. FO added that the physician would be contacted, and specific orders would be given as to the timing. In addition, the U.S. FO stated that she felt the facility had improved in responding to her recommendations. A review of the "Nursing Summary Report" provided by the U.S. FOIA (b)(6) dated NJ Ex Order 26.4(b)(1) that was completed by the U.S. FO revealed that a recommendation was made for Resident #21, "Please be sure that the medication times are charted to accommodate resident's NJ Exec Order 2 schedule." The report was signed as completed by the U.S. FOIA (b)(6) U.S. FOIA (b)(6) NJ Exec Order 26 and dated A review of the "Nursing Summary Report" provided by the U.S. FOIA (b)(6), dated January 7, 2025 that was completed by the U.S. FO revealed that a recommendation was made for Resident #21, "Please be sure that the medication times are charted to accommodate resident's NJ Exec Order 2 schedule. Please evaluate NJ Exec Order 26.4b1 scheduled NJ Exec O on NJ Exec Order 2 days" The report was signed as completed by the U.S. FOIA (b)(6) and dated NJ Exec Order 26 On 2/7/25 at 10:30 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated that the evening U.S. FOIA (b)(6) completed the U.S. FO recommendations. The U.S. FOIA verified that the "Nursing Summary Report" indicated that the U.S. FOIA (b)(6) had acted upon the U.S. FO recommendations. On 2/7/25 at 10:53 AM, the surveyor attempted to contact the U.S. FOIA (b)(6) via telephone. On 2/7/24 at 10:34 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated she was unsure why the POs for Resident #21 had not been updated to accommodate the times the resident was NJ Exe to	F0756		03/04/2025

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F0756 SS = E	Continued from page 35 [redacted]. The [redacted] added that usually a medication ordered for three times a day would be only ordered twice a day on [redacted] days. On 2/7/25 at 3:18 PM, the surveyor interviewed the [redacted], who acknowledged that medications had to be scheduled to accommodate the resident being [redacted] to [redacted]. The [redacted] stated that she thought the recommendations were completed because the [redacted] had signed the reports. The [redacted] added that she had put a call out to the [redacted]. A review of the facility's policy "Pharmacy Services-Role of the Consultant Pharmacist" dated as revised April 2019 was provided by the [redacted] had not included a time frame for the facility's response to the CP recommendations pertaining to medication irregularities. NJAC 8:39-29.3(a)(1)	F0756		03/04/2025
F0947 SS = E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by:	F0947	1. Conduct an immediate audit of all certified nurses aides training records to identify those missing the mandatory 12 hours of annual in-service training or specific topics. 2. An audit of all certified nurses aides training records was be conducted to ensure facility wide compliance with training requirements. 3. Monthly in-service training sessions to be scheduled to cover mandatory topics on a rotating basis. 4. The Director of Nursing or designee will conduct monthly audits of training records. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations.	03/04/2025

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F0947 SS = E	Continued from page 36 Based on interview and review of facility documentation, it was determined that the facility failed to ensure that all Certified Nursing Assistants (CNAs) received 12 hours of mandatory in-service training as required for 3 of 5 randomly selected CNA (CNA # 3, #4, #5) files reviewed for in-service training. This deficient practice was evidenced by the following: On 2/07/25 at 9:17 AM, the surveyor reviewed in-service education hours for five randomly selected CNA files which were provided by the U.S. FOIA (b)(6)). The surveyor reviewed the following for the NJ Ex Orde to NJ Ex Orde calendar year, corresponding with the CNA hire dates: CNA #3 was hired on NJ Exec Orde, CNA #4 was hired on NJ Exec Order 2, and CNA #5 was hired on NJ Exec Order 2. The facility could not provide evidence of in-service education training for the current 12-month period from hire date. On 2/07/25 at 2:01 PM, the U.S. FOIA (b)(6) U.S. FOIA (b)(6)), in presence of survey team, stated that the facility cannot find the education for CNAs # 3,4 and 5. The U.S. FOIA (b) stated the responsibility for ensuring the annual education on the regulatory topics, such as abuse, were completed by himself as well as with assistance from the corporate team as needed. He stated that the annual education should be reviewed when the annual evaluation was completed. He stated he was not versed on the exact topics, but he knew 12 hours were required. The U.S. FOIA (b) stated the "CNA education was important to make sure they (the CNAs) have their skills to know what they are doing." He further stated that the CNA in-service files were maintained by the Human Resource department. A review of the facility policy "In-service Training Program, Nurse Aide" dated May 2019, included "Annual in-services ... are no less than 12 hours per employment year." A review of an undated facility job description for "Human Resource Director" included "Ensure	F0947		03/04/2025

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F0947 SS = E	Continued from page 37 training and in-services are provided on a regularly scheduled basis ...," and "Ensure that appropriate training records are maintained for staff personnel." A review of an undated facility job description for "Director of Nursing Services" included "Develop and participate in the planning, conducting, and scheduling of timely in-service training classes ...," and assist in developing annual in-service training programs for the nursing staff and ensure these programs meet the continuing education requirements. A review of an undated facility job description for "Certified Nursing Assistant" included "Attend and participate in scheduled training and educational classes." NJAC 8:39-43.17 (b)	F0947		03/04/2025
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §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 §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of	F0607	1. The Human Resource Director immediately reviewed all employee files within the last 8 months to ensure there were reference checks for employees. 2. There was no harm, and no one was hurt by this deficient practice. 3. The Regional Human Resource Director will educate the [redacted] on what belongs in an employee file and implementation of a reference check form. 4. The Human Resource, or designee will audit new employee files bi-weekly for 3 months. Then monthly thereafter to ensure compliance with reference checks. The results of the audits will be reported will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations.	03/04/2025

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F0607 SS = D	Continued from page 38 employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of pertinent documentation provided by the facility it was determined that the facility failed to ensure reference checks were completed for 6 of 10 newly hired employee files reviewed. This deficient practice was evidenced by the following: On 2/7/25, the surveyor reviewed Ten (10) randomly selected new employee files which revealed the following: 1. U.S. FOIA (b)(6)) U.S. FOIA (b)(6) with a Date of Hire (DOH) of NJ Exec Order 2, did not have a previous employee reference on file. 2. LPN #2 with a DOH of NJ Exec Order 2, did not have a previous employee reference check on file. 3. U.S. FOIA (b)(6) with a DOH of NJ Exec Order 2, did not have a previous employee reference check on file. 4. Registered Nurse #1 with a DOH NJ Exec Order 2, did not have a previous employee reference check on file. 5. U.S. FOIA (b)(6) with a DOH NJ Exec Order 2 did not have a previous employee reference check on file. 6. U.S. FOIA (b)(6) with a DOH of NJ Exec Order, did not have a previous employee reference check on file. On 2/7/25 at 11:04 AM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated he was responsible for the employee files since NJ Ex Order 26.4(b)(1) He added the U.S. FOIA (b)(6) U.S. FOIA (b)(6) was responsible for the	F0607		03/04/2025

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F0607 SS = D	Continued from page 39 therapist's files. He stated new employees should have a physical, NJ Ex Order 26.4(b)(1) test for NJ Ex Order 26.4(b)(1) a background check, a license check and 3 reference checks before they start work. The U.S. FOIA (b)(6) reviewed the above mentioned files in the presence of the surveyor and confirmed that the 6 employees did not have an employee reference check in their files. He stated he identified some of the employee files were missing physicals and the NJ Ex Order 26.4(b)(1) test in October of 2024. He added he started a Quality Assurance & Performance Improvement Plan (QAPI) in October. On 2/7/25 at 11:51 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated she was responsible for reference checks for her therapists. She stated she remembered doing the reference check for the above mentioned U.S. FOIA (b)(6) but she does not keep a copy of it. She was unable to explain why she doesn't keep a copy. On 2/7/25 at 2:35 PM, the surveyor conducted a follow up interview with the U.S. FOIA (b)(6), in the presence of the survey team. He presented the surveyor with a copy of his QAPI dated 1/14/25. A review of the QAPI revealed Tracking and Reporting: "As of 1/14 we are at less than 35 % completion ...Working on completing Physicals and PPD (TB Test) files. At that time the U.S. FOIA (b)(6) stated that he will now add the employee reference checks to his QAPI since the surveyor brought it to his attention. On 2/7/25 at 12:59 PM, the survey team met with the U.S. FOIA (b)(6), U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) and presented the above concerns. No addition information was presented. A review of the facility provided "New Employee Checklist" for HR (Human Resources) revealed Human Resource: reference form and references checks (back of application): check box reference #1, check box reference #2.	F0607		03/04/2025
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F0610	1.Resident #232 is NJ Exec Order 26.4 a resident here at the facility and NJ Exec was not a resident here at the time the complaint was made. Education to be provided to staff to familiarize them with the proper steps to take when a complaint is made to them.	03/04/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0610 SS = D	Continued from page 40 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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: Complaint #NJ00176931 Based on interviews, record review and pertinent facility documents, it was determined that the facility failed to investigate an [NJ Ex Order 26.4b] of [NJ Exec O] nursing care for 1of 4 residents (Resident #232) reviewed for [NJ Exec Orde]. This deficient practice was evidenced by the following: A review of the facility provided "Reportable Event Record Report" dated [NJ Exec Order 26.4], revealed the facility reported an event [NJ Exec Order 2] that the resident had [NJ Ex Or] nursing care while at the facility to the New Jersey Department of Health (NJDOH). The surveyor reviewed the electronic medical record (EMR) for Resident #232. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]) and NJ Exec Order 26.4b1 [redacted]	F0610	Continued from page 40 2.All residents have the potential to be at risk of the facility failing to investigate an allegation of [NJ Exec O] nursing care. However, no other residents have been affected by this deficient practice. 3.Staff were educated on the facility's Investigation Policy specifically on Misappropriation of Funds and Abuse. The Administrator, Director of Nursing, or designee to assess the start of and follow through with the investigation process. 4.The Administrator, Director of Nursing, or designee will discuss and investigate any allegations of poor nursing care. Upon review, investigations will be conducted and reported to all appropriate agencies within the recommended time frame. Audit will be conducted weekly x 4 weeks then monthly x 3 months unless any significant trends are identified. Results of the monthly audits will be reported monthly to the facility Quality Assurance Performance Improvement Committee x 3 months.	03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

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F0610 SS = D	Continued from page 41 NJ Exec Order 26.4b1). A review of the admission Minimum Data Set, an assessment tool dated NJ Exec Order 26, revealed the resident had a Brief Interview for Mental Status of NJ Ex out of 15, indicating the resident was NJ Exec Order 26.4b NJ Exec Ord A review of the individual comprehensive care plan (ICCP) revealed a focus of potential for a NJ Exec Order 26.4b1 related to [their] recent admission to the center, Date Initiated: NJ Exec Order 26.4b1 with Interventions: Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance, Date Initiated: NJ Exec Order 26.4b1 A review of the progress notes did not revealed any notes on NJ Exec Order 26.4b1 of the above mentioned event. On 2/5/25 at 2:24 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated examples of NJ Ex Order was NJ Ex Order 26.4(b)(1) . She stated she would ask what happened and then notify the U.S. FOIA (b)(6) U.S. FOIA (b)(6) LPN #1 stated an incident report would be done, and written statements would be obtained. On 2/5/25 at 12:31 PM, the surveyor interviewed LPN/Unit Manager (UM) #1, who stated examples of NJ Ex Order was NJ Ex Order 26.4(b)(1) . She stated she would have to report it immediately to the U.S. FOIA and the U.S. FOIA (b)(6) U.S. FOIA (b)(6) . LPN/UM #1 stated it would have to be reported to the state (NJDOH), an incident investigation would be done and statements would be obtained. On 2/5/25 at 12:36 PM, the surveyor interviewed Certified Nursing Assistant # 1, who stated "I would go to U.S. FOIA and have to give a statement." On 2/5/25 at 12:39 PM, the surveyor interviewed the U.S. FOIA (b who stated types of NJ Ex Order was NJ Ex Order 26.4(b)(1) She stated she	F0610		03/04/2025

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F0610 SS = D	Continued from page 42 would interview the resident ask for more information date and time. The [U.S. FOIA] stated an overall investigation would be done which included going back 72 hours and interview from all the nurses and aides that took care of patient. She stated she would report the event to Ombudsman and the NJDOH within 2 hours. She added "definitely a written investigation would be done" and the investigation would be kept. On 2/5/25 at 12:50 PM, the surveyor interviewed LPN/Nursing Supervisor (LPN/NS) #1, who stated types of [NJ Ex Order] was NJ Ex Order 26.4(b)(1) [redacted] She stated she would report it to the [redacted] and the [U.S. FOIA (b)] [redacted], a grievance would be taken and statements would be taken from "all parties involved." LPN/NS #1 stated the purpose of the investigation was "to get to the bottom of the situation and to make sure they feel safe in the building." She stated she remembered Resident #232 but did not remember the resident or their [NJ Exec] "complaining about anything." On 2/5/25 at 12:55 PM, the surveyor conducted a follow up interview with the [U.S. FOIA], who stated the purpose of an investigation was to "substantiate the claim, every claim should be taken seriously to see what was going on, to help us to know our patients and our staff and to follow through to make sure the concerns were addressed." On 2/05/25 at 1:02 PM, the surveyor interviewed the [U.S. FOIA (b)], who stated he was the [NJ Exec Orde] officer. He stated types of [NJ Ex Order] was NJ Ex Order 26.4(b)(1) [redacted] He stated, "I would call the state (NJDOH) and complete the form to the Ombudsman." The [U.S. FOIA (b)] stated an investigation would be started that included collecting statements from residents or family members and staff, a summary would be written, and draw up a conclusion. He stated it was important to do an investigation to "see if other residents are in harm's way." During that same interview, the [U.S. FOIA (b)] confirmed that there was no investigation for the above mentioned reportable event for Resident #232. He stated "they (the facility) looked through the files and no one could not find anything else (for the event)." He added the event should have had an investigation but "we (the facility) could not find one."	F0610		03/04/2025

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F0610 SS = D	Continued from page 43 On 2/7/25 at 12:59 PM, the survey team met with the U.S. FOIA (b)(6), U.S. FOIA, U.S. FOIA (b)(6), and the U.S. FOIA (b)(6) and presented the above concerns. No additional information or investigations were presented. A review of the facility's policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" revised April 2021, revealed Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy Interpretation and Implementation: ...8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect resident from any further harm during investigation. A review of the facility's policy "Grievances/Complaints, Record, and Investigating" revised April 2017, revealed Policy Statement: All grievances and complaints filed with the facility will be investigated and corrective actins will be taken to resolve the grievance(s). Policy Interpretation and Implementation: 1. The administrator has assigned the responsibility of investigating grievances and complaints to the grievance officer. 2. Upon receiving a grievance and complaint report, the grievance office will begin an investigation into the allegations ...4. The investigation and report will include, as applicable: ...b. the circumstances surrounding the alleged incident ...9. A copy of the "resident Grievance/Complaint Investigation Form: must be attached to the "Resident Grievance/complaint form" and filed in the business office. 10. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident. NJAC 8:39 4.1 (a) (5)	F0610		03/04/2025
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F0759	1. Residents #21 and #82 are currently NJ Exc resident at the facility. The nurses were educated to ensure they are administering the correct medication and the process when a medication is not available.	03/04/2025

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F0759 SS = D	Continued from page 44 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 2/5/25, the surveyor observed three (3) nurses administer medications to five (5) residents. There were 28 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.14%. The deficient practice was identified for two (2) of five (5) residents, (Resident #21 and #82), that were administered medications by two (2) of three (3) nurses that were observed. The deficient practices were evidenced by the following: 1. On 2/5/25 at 8:36 AM, during the morning medication administration pass, the surveyor observed Licensed Practical Nurse (LPN#1) administering medications to Resident #21. The resident stated that they would like their [NJ Exec O] medication and their [NJ Exec Orde] medicine. On 2/5/25 at 8:37 AM, the surveyor observed LPN#1 preparing to administer the resident's [NJ Exec O] medication and [NJ Exec Orde] medication. LPN#1 reviewed the electronic medication administration record (EMAR) which revealed a physician's order (PO) for [NJ Exec Order 26.4b1] Oral Liquid [NJ Exec] [NJ Ex Order 26] [NJ Exec Order 26.4b1]), Give [NJ Ex] [NJ Ex O] by mouth every 6 hours as needed (PRN) for [NJ Exec O] [NJ Ex Ord] LPN#1 removed a bottle of [NJ Exec Order 26.4b1] [NJ Exec] [NJ Ex Order 26.4(b)(1)] [NJ] [NJ Ex Order 26.4(b)(1)] from the medication cart and stated that the [NJ Exec Order 26.4b1] was an over-the-counter/house stock (OTC/HS) medication, meaning that the bottle was not labeled for a specific resident because the facility purchased the medication, and it could be administered to any resident that had a PO. LPN#1 stated that [NJ Exec Order 26.4b1] was the OTC/HS [NJ Exec Orde] medicine. On 2/5/25 at 8:41 AM, the surveyor observed LPN#1 administer [NJ Ex] [NJ Ex] of [NJ Exec Order 26.4b1] to Resident #21.	F0759	Continued from page 44 2. All residents residing at the facility has the potential to be at risk for a medication error. However, no other residents have been affected by this deficient practice. 3. Nurses will receive an education on how to complete a proper medication pass. 4. The Pharmacy Consultant, or designee, will conduct a medication pass within 30 days of new hire and monthly thereafter until deficient medication error rate is at or below the state average. The Pharmacy Consultant or designee will review findings with the nurse, and Director of Nursing. The Director of Nursing will educate the nurse on deficient practice. The results of the audits will be reported at the monthly x 3 months unless any significant trends are identified. Monthly to facility Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations.	03/04/2025

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F0759 SS = D	Continued from page 45 On 2/5/25 at 8:44 AM, upon returning to the medication cart, the surveyor with LPN#1 reviewed the electronic medication administration record (EMAR) for the PRN [redacted] medication. The surveyor asked LPN #1 why the EMAR indicated [redacted] but had not indicated [redacted]). The LPN#1 stated that the [redacted] did not matter and that was the OTC/HS that was in the medication cart. (ERROR #1) The surveyor reviewed the electronic medical record for Resident #21. A review of the Admission Record revealed diagnoses that included but not limited to [redacted] and [redacted]). A review of the comprehensive admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of [redacted] reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident had an [redacted]. A review of the Order Summary Report (OSR) revealed an active physician's orders (PO) with a start date of [redacted] for [redacted]), Give [redacted] by mouth every 6 hours as needed for [redacted]. On 2/5/25 at 1:30 PM, the surveyor interviewed the [redacted]), who stated that she was responsible for educating the staff and that medication administration observations were performed by the [redacted]). The [redacted] added that medications were administered as per PO. A review of the facility OTC/HS list provided by the [redacted] indicated that the facility supplied [redacted]). There was no [redacted] listed.	F0759		03/04/2025

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F0759 SS = D	Continued from page 46 On 2/5/25 at 11:02 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated that NJ Exec Orde NJ Exec cannot be substituted for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1). The surveyor, with the U.S. FOIA (b)(6) observed the NJ Exec Order 26.4b1 in medication cart #1. The U.S. FOIA (b)(6) stated there was no NJ Exec Order 26.4b1 in medication cart #1 and would have to look into it. On 2/5/25 at 11:13 AM, the U.S. FOIA (b)(6) returned to the surveyor and stated that medication cart #2 had the OTC/HS NJ Exec Order 26.4b1 and showed the surveyor a bottle labeled NJ Exec Order 26.4b1 NJ Ex O NJ E NJ Ex O and stated that should have been administered to Resident #21. The U.S. FOIA (b)(6) explained that the assignment of residents was split between the nurses and depending on the census, the room Resident #21 was in could have their medications kept in either medication cart #1 or #2. On 2/7/25 at 8:58 AM, the surveyor interviewed the U.S. FO via the telephone. The U.S. FO stated that she completed medication administration observations as requested by the facility and had not completed a medication administration inservice for the nurses. The U.S. FO stated that she was not familiar with LPN#1 and thought she may have been an agency nurse. The U.S. FO also stated that the PO must match the medication being administered and that NJ Exec Order 26.4b1 could not be substituted for NJ Exec Order 26.4b1. On 2/7/25 at 3:18 PM, the surveyor interviewed the U.S. FOIA who stated that LPN#1 had no medication administration observation completed. The U.S. FOIA added LPN#1 was an agency nurse and had reached out to the agency but had not received documentation of a medication administration observation. There was no facility medication administration inservice provided to the surveyor. 2. On NJ Exec Orde at 8:49 AM, during the morning medication administration pass (med pass), the surveyor observed LPN #2 preparing to administer five (5) medications to Resident #82. LPN#2 removed an OTC/HS NJ Exec Order 26.4b1 NJ Ex Orde from the medication cart and then stated that the PO on the EMAR indicated NJ Exec Order 26.4b1 for Resident #82. LPN #2 returned the NJ Exec Order 26.4b1 NJ Ex Orde to the medication cart and stated the NJ Exec Order 26.4b1 NJ Ex Orde had to come	F0759		03/04/2025

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F0759 SS = D	Continued from page 47 from the provider pharmacy and there was none in the medication cart for Resident #82. On [redacted] at 8:37 AM, the surveyor observed LPN#2 administer four (4) medications to Resident #82. The [redacted] patch was not administered. On 2/5/25 at 9:31 AM, the surveyor interviewed LPN#2 who stated Resident #82 was [redacted] and [redacted] to person, place and time. LPN #2 also stated that she would have to call the provider pharmacy to obtain the [redacted] for Resident #82. On 2/5/25 at 12:54 PM, the surveyor interviewed Resident #82, who stated that they had not received any [redacted] today, but they were not in [redacted] at the moment and knew that they could ask the nurse for a [redacted] if needed. The resident also stated that they thought the physician had said the [redacted] would help and thought the physician would have to order the [redacted] and the nurses would have to get it delivered but wasn't sure if that had happened. On 2/5/25 at 12:57 PM, the surveyor interviewed LPN #2, who stated that she had sent a message to the provider pharmacy via an app on her phone but had not heard back yet. LPN#2 also stated that the process when a medication was not available was to call the pharmacy and wait until the medication came in. LPN #2 then added that maybe she could call the physician to see if the [redacted] could be used. (ERROR #2) The surveyor reviewed the medical record for Resident #82. A review of the Admission Record revealed diagnoses that included but not limited to: [redacted]). A review of the OSR revealed an active PO with a start date of [redacted] for "[redacted]), [redacted] to per additional directions [redacted] one time a day for [redacted] for [redacted] days." A review of the resident's electronic progress notes	F0759		03/04/2025

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F0759 SS = D	Continued from page 48 (EPN) indicated on [redacted] at 9:04 AM, LPN #2 had entered a "Note Text: [redacted] to per additional directions [redacted] one time a day for [redacted] for [redacted] days, awaiting from pharmacy. Sending followup." In addition, the EPN revealed at 1:16 PM, after surveyor inquiry, LPN#2 indicated "Called [redacted] calling service to speak with [redacted] to see if [redacted] order can be changed to house stock [redacted] Awaiting call back." Then, at 1:33 PM, LPN#2 indicated "Spoke with Dr. [name redacted] received new order for [redacted] daily. Order placed." On 2/5/25 at 1:30 PM, the surveyor interviewed the [redacted], who stated that she was responsible for educating the staff and that medication administration observations were performed by the [redacted] The [redacted] also stated that if a medication was not available to be administered then the physician was to be contacted for follow up as to what to do and that the physician can order an alternative medication. The [redacted] added that she would solicit help to follow up as soon as possible in order to provide the medication in a timely manner. A review of a "Medication Pass Observation" dated [redacted] provided by the [redacted] and was completed by the [redacted] for LPN#2 indicated that the percent error rate was 14.6%. The form indicated that one of the errors that occurred was a medication that was not administered within one hour of prescribed time. On 2/7/25 at 8:58 AM, the surveyor interviewed the [redacted] via the telephone. The [redacted] stated that she completed medication administration observations as requested by the facility and had not completed a medication administration inservice for the nurses. The [redacted] added that she will do an inservice after completing a med pass with that specific nurse. The [redacted] also stated that she tells the nurses that if a medication was not available then to enter "Code 9" in the EMAR but then the physician had to be called to get instructions on what can be done about not having the medication. The [redacted] added that the nurses cannot just document that the medication was not available or awaiting from pharmacy. The [redacted] also stated that the nurses needed to get instructions from the physician fairly quickly when a medication was not available.	F0759		03/04/2025

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F0759 SS = D	Continued from page 49 On 2/7/25 at 3:18 PM, the surveyor interviewed the [U.S. FOIA], who stated that the medication observation completed by the [U.S. FO] was followed up with an inservice with that nurse by the [U.S. FO] after the observation. The [U.S. FOIA] added that there was no further follow-up. A review of a facility policy "Administering Medications" dated as revised April 2019 provided by the DON reflected "Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals orders)." Further review reflected "The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." NJAC 8:39-11.2(b), 29.2(a)(d)	F0759		03/04/2025
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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:	F0880	1. Audited all residents for the need of [NJ Ex Order 26.4(b)] [redacted]. NJ Ex Order 26.4(b)(1) were put in place to include proper Personal Protective Equipment available for staff for Resident #7. Education provided to nursing staff on [NJ Ex Order 26.4(b)] [redacted] and proper Personal Protective Equipment to be placed in a bin outside the room. 2. All residents residing in the facility have the potential to be affected by this deficient practice. 3. In-service was provided to nursing staff on Enhanced Barrier Precautions and proper Personal Protective Equipment to be placed in a bin outside the room. 4.The Director of Nursing or designee will complete weekly audit to ensure infection control protocols are in place to include, but not limited to, resident who require Enhanced Barrier precautions have Personal Protective Equipment available. Audit will be conducted weekly x 4 weeks then monthly x 3 months unless any significant trends are identified. Results of the monthly audits will be reported monthly to the facility Quality Assurance Performance Improvement Committee x 3 months.	03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690

(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
F0880 SS = D	Continued from page 50 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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: Based on observation, record review, interview, and facility policy review, the facility failed to prevent the potential for cross contamination by placing a resident with NJ Ex Ord NJ Exec Order 2 on NJ Exec Order 26.4b1	F0880		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 51 NJ Exec Order 26.4b1), meaning a gown and gloves be worn when performing high contact care, for one of two residents (Resident #7) with open NJ Exec Order 26 The deficient practice was evidenced by the following: On 2/4/25 at 10:21 AM, the surveyor observed Resident #7 NJ Exec Order 26.4b1 their wheelchair in the hallway. The resident stated they can wheel the chair but can not NJ Exec Or. The surveyor observed a NJ Exec Order 26 on the NJ Exec Order 26. The surveyor reviewed the electronic medical record (EMR) for Resident #7. A review of the "Order Summary Report" revealed a physician order (PO) dated NJ Exec Order 26 for NJ Exec Order 26.4b1 l External Sheet NJ Exec Order 26.4b1) to the NJ Exec Order 26.4b1 NJ Ex Order 26.4 NJ Exec time a day." There was also a PO dated Exec Order 2 for "Weekly NJ Exec Order 26.4b1 every day shift every Friday." A review of the comprehensive admission Minimum Data Set (MDS), (an assessment tool) dated NJ Exec Order 26 revealed a Brief Interview for Mental Status (BIMS) of NJ Ex out of 15, indicating an NJ Exec Order 26.4b1. In addition, the MDS reflected diagnoses that included but not limited to; NJ Exec Order 26.4b1 , and the NJ Exec Order 26.4b1 . The Individual Comprehensive Care Plan (ICCP), initiated NJ Ex Order 26.4b1 included a focus area of impaired NJ Exec Orde . Interventions included NJ Exec O and NJ Exec Order 26.4b1 as ordered and monitoring for signs of On 2/5/25 at 9:30 AM, the surveyor observed Resident #7, lying in bed. The resident stated NJ Exec Order2 is going NJ Exec but NJ Exec O. The resident also stated their NJ Exec Order 26.4b1 gets NJ Exec Order 26 every day, and that it was not done yet today. The surveyor asked Resident #7 if the surveyor could observe the NJ Exec Order 26.4b1. The resident stated yes, that was fine.	F0880		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

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F0880 SS = D	Continued from page 52 On 2/5/25 at 10:38 AM, the surveyor observed the treatment to the [NJ Exec Order 26] by Licensed Practical Nurse (LPN) #1. LPN #1 pre-medicated Resident #7 for [NJ Exec O] and then performed the treatments to the [NJ Exec Order 26] and [NJ Exec Or] as ordered with only gloves on. The surveyor had not observed [NJ Exec O] signage or personal protective equipment (PPE) supply bin at the resident's doorway or in the room. On 2/05/25 at 12:43 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that [NJ Exec O] meaning a gown and gloves should be worn when performing high contact care, and were needed for the presence of [NJ Exec Order 26]. When asked about Resident #7, she stated that the resident's [NJ Exec Orde] was a [NJ Exec Order 26.4b1] which was resolved today. When reminded that [NJ Exec O] was not in place prior to today, she further stated that prior to today, the [U.S. FOIA (b)(6)] classified the resident's [NJ Exec Order 2] as [NJ Exec Order 2], and that her understanding was that since the [NJ Exec Order 2] were classified as [NJ Exec Order 2] and no [NJ Exec Order 26.4b1] then [NJ Exec O] was not needed. On 2/7/25 at 09:33 AM, the surveyor observed the resident lying in bed, with a [NJ Exec Order 26] noted to the [NJ Exec Order 26] On 2/7/25 at 11:07 AM, the surveyor interviewed the [U.S. FOIA (b)(6)], who stated that if a resident had a [NJ Exec Orde], [NJ Exec O] were needed. On 2/7/25 at 11:47 AM, the [U.S. FOIA (b)(6)] thanked the surveyor for bringing to her attention Resident # 7 had [NJ Exec Orde][NJ Exec Order 2] and was not on [NJ Exec O]. The [U.S. FOIA (b)(6)] stated that she double checked, and the [NJ Exec Order 2] were [NJ Exec Order], including a current [NJ Exec Order 26.4b1]. She further stated that she just put the resident on [NJ Exec O] When asked what should have been done, she stated the resident should have been on [NJ Exec O] all along since there were [NJ Exec O][NJ Exec Order 2]. On 2/07/25 at 12:59 PM, the surveyor interviewed the [U.S. FOIA] and the [U.S. FOIA (b)(6)], and both confirmed that Resident #7 should have been on [NJ Exec O] since admission due to the presence of [NJ Exec O][NJ Exec Order 26]	F0880		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	**3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690**

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F0880 SS = D	Continued from page 53 A review of facility provided policy "Isolation - Categories of Transmission-Based Precautions" Revised October 2018 revealed: Enhanced Barrier Precautions Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs(multi-drug resistant organisms) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiting gown and glove use for Enhanced Barrier Precautions include: .... Wound care: any skin opening requiring a dressing. N.J.A.C. 8:39-19.4 (a)	F0880		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11014	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments No Information	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint # NJ00170550, NJ00173598, NJ00183474 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed a) to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for 11 of 28 day shifts reviewed and b.) failed to meet the 45 percent overall occupancy by Medicaid-eligible residents in its general long-term care (LTC) beds. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and	S0560	1. No residents were negatively affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A Staffing and Recruitment and Retention committee including the Director of Nursing, Staffing Coordinator, and Administrator/ designees will meet once a week to review retention efforts, open positions, recruitment tactics, and changes to improve outcomes staffing for upcoming week. The facility currently has contracts with staffing agencies to assist when needed. We are currently using an outside Recruitment and Retention company to oversee recruitment and retention tactics, open positions, and scheduling possible new hire interviews. The facility also has in place, sign on bonuses, incentives for picking up extra shifts, job fairs and referral bonuses. 4. During resident council meetings the Administrator or designee will review any concerns residents may have with care monthly for 3 months and then quarterly. The results will be reviewed then presented to at Quality Assurance Performance Improvement for 3 months and as needed thereafter for any recommendations.	03/04/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11014	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

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S0560	Continued from page 1 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. This deficient practice was evidenced by the following: A. The surveyor requested staffing for the weeks of 1/14/2024 to 1/20/2024, 5/05/2024 to 5/11/2024, 1/19/25 to 1/25/25, and 1/26/25 to 2/1/25. For the four (4) weeks requested, as per the "Nurse Staffing Report", the facility was deficient in CNA staffing as follows: 1. For the one (1) week of Complaint staffing from 1/14/2024 to 1/20/2024, the facility was deficient in CNA staffing for residents on seven (7) of seven (7) day shifts as follows: -01/14/24 had 3 CNAs for 51 residents on the day shift, required at least 6 CNAs. -01/15/24 had 3 CNAs for 51 residents on the day shift, required at least 6 CNAs. -01/16/24 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. -01/17/24 had 3 CNAs for 51 residents on the day shift, required at least 6 CNAs. -01/18/24 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. -01/19/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -01/20/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. 2. For the one (1) week of Complaint staffing from 5/05/2024 to 5/11/2024, the facility was deficient in	S0560		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11014	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690

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S0560	Continued from page 2 CNA staffing for residents on four (4) of seven (7) day shifts as follows: -05/05/24 had 4 CNAs for 45 residents on the day shift, required at least 6 CNAs. -05/07/24 had 4 CNAs for 45 residents on the day shift, required at least 6 CNAs. -05/10/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -05/11/24 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. On 2/7/25 at 11:00 AM, the surveyor interviewed the Staffing Coordinator (SC), who stated he was familiar with the staffing ratios and that the facility has been meeting the ratios since he started doing staffing in August of 2024. A review of the facility policy "Staffing" dated as revised 10/2017 provided by the Licensed Nursing Home Administrator (LNHA) revealed, "Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care and applicable laws and regulations." B. Reference: 8:33H-1 .2 Definitions ..."General long-term care bed" means a long-term care bed for which there is no restriction imposed by statute (for example, subacute long-term care), certificate of need approval requirements (for example, pediatric long-term care, specialized long-term ventilator care, specialized long-term care of residents with severe behavior management problems) or stipulations and/or licensure standards that would limit the type of nursing home resident who may occupy the bed or the type of nursing home care which may be provided to the occupant of the bed. "Long-term care" means a wide range of personal care, psycho-social, nursing, and other supportive services for people with functional limitations due to	S0560		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11014	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

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S0560	Continued from page 3 chronic-and frequently degenerative-physical or cognitive disorders. Long-term care services range from in-home assistance provided by family members or a home care agency to nursing home care. "Medicaid-eligible patient" means, for the purpose of this chapter, a person who has received a determinationo f medical and financiale ligibility for Medicaid coverage, or a person who qualifiesm edicallya nd financially for Medicaid but who does not apply for Medicaid coverage, or a person whose care is paid for through General Assistance funds. A review of the facility completed "Longterm Care Facility Application for Medicare/Medicaid" Form CMS-671 completed the facility's Licensed Nursing Home Administrator (LNHA) on 2/4/25 at 4:27 PM revealed F8a Medicare: 34; F8b: Medicaid: 0; F8c Other: 8; F8d Total Residents: 39. Further review revealed F9: 03: SNF/NF (skilled nursing facility/nursing facility)-Medicare/Medicaid. On 2/14/25 at 12:49 PM, the surveyors interviewed the Social Worker (SW), who stated she meets with residents and their family within 72 hours of admission for a care conference to talk about discharge planning. The SW stated if the resident transitions to LTC, she would assist or refer them with Medicaid planning, financial planner and/or elder care advisors. The SW stated if residents remains in the facility she educated them on their "rights." She stated the facility has always been both short term and LTC. The SW stated the "new company" came in September and the companies regional spoke to the staff that the company was geared more towards short term rehab. On 2/14/25 at 1:23 PM, the surveyors interviewed the LNHA, who stated the facility was licensed for Medicare and Medicaid and accepted both short term and long-term care residents. He added, "most people come here for therapy." On 2/14/25 at 1:42 PM, the surveyors interviewed the Director of Nursing (DON), who confirmed the facility accepted LTC residents and stated that they have one currently inhouse that was Medicaid pending.	S0560		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11014	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

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S0560	Continued from page 4 On 2/14/25 at 2:04 PM, the surveyors interviewed the Admissions Director (AD), who stated the facility screened referrals from whatever source (hospitals, other facilities) for appropriateness, making sure the facility could clinically handle them (the resident) as we typically accept. She stated the facility gets a lot of subacute referrals but recently accepted a LTC resident back. A review of the facility's "Admission Agreement" revised 1/2021 revealed viii. Medicaid a...The facility does participate in the Medicaid program and has a provider agreement with the state.	S0560		03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **02/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCELA POST ACUTE CARE AT HAMILTON	**3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690**

(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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/04/2025. Spring Hill Post Acute Hamilton was found to be in NONCOMPLIANCE with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Spring Hill Post Acute Hamilton is a Single-story, Type II Protected building that was built in February 2015. The facility is divided into 4 smoke zones.	K0000		
K0225 SS = F Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 02/04/2025 in the presence of the U.S. FOIA (b)(6) [redacted]) and U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that stairway enclosures used as exits where kept free of storage in accordance with NFPA 101:2012 edition sections 7.2, 19.2.2.3 and 19.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:06 PM revealed that the exit stairway enclosure was being used to store 2 chairs and a geriatric chair. In an interview at the time, the U.S. FOIA [redacted] confirmed that	K0225	Chairs were being stored in the stairway blocking Egress of the stairwell through the path of egress. The chairs were in place for the therapy department to use the stairwell for Activity of daily living training with residents. The Pyicial therapy team was notified that the chairs cannot be left in the stairwell. This has potential to affect all residents and staff. The action taken was to remove the chairs A sign was put upstairs, reminding everybody to keep it clear. The administrator or desicnee will do monthly checks for 3 months to ensure this is being adhered to. to ensure no chairs or other items being in the hallway and will be documented. The results of the audits will be reported will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations. Date of corrective action completion was 3/4/2025.	03/04/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

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ACCELA POST ACUTE CARE AT HAMILTON	3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690

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K0225 SS = F Bldg. 01	Continued from page 1 there should not be any items stored in the exit stairway enclosure and stated that they would inform rehab not to leave items in the stairway enclosure after treatments. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e)	K0225		03/04/2025
K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K0321	321 The maintenance shop and vacuum pump room did not have an automatic lock or self-closing door. These areas need this due to them being identified as hazardous areas. This could potentially affect all residents. The facility will install automatic door closers and automatic locking knobs. The maintenance director will check all hazardous areas to ensure all door-closers and locking mechanisms are in working order every week for 3 months. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations. . Date of Correction was 3-4-2025	03/04/2025

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K0321 SS = F Bldg. 01	Continued from page 2 g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 02/04/2025 in the presence of the U.S. FOIA (b)(6) [redacted] and U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7, 8.4 and NFPA 13. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:21 PM revealed that the Maintenance shop door was not provided with a self-closing or automatic-closing door. An observation at 1:30 PM revealed that the vacuum room was being used for storage of combustible items and was not provided with a self-closing or automatic-closing door. In interviews at the time, the U.S. FOIA [redacted] confirmed the observations. The facility's U.S. FOIA (b)(6) [redacted] was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e)	K0321		03/04/2025
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K0324	An oven and cooktop was in place in the patients Gym without any locking and or preventative measures to stop prolonged heating, or the potential for the range or oven to be left on and left in that condition. This could be a fire hazard and a potential hazard to burning for residents and staff. The plan of correcting the issue is to unplug and shut the breaker for the specified high voltage outlet for the range and oven. The steps taken are unplugging and shutting the	03/04/2025

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K0324 SS = F Bldg. 01	Continued from page 3 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 02/04/2025 in the presence of the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that cooking facilities were protected and comply with the conditions of NFPA 101:2012 Edition, Sections 19.3.2.5.4 and 19.3.2.5.3(1) through (10) and (13).This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:50 PM revealed that the OT/PT rehabilitation gym contained a functioning 4 burner cooking range. Protective devices such as a timer, keyed switch, locked switch, or a switch in a restricted location that deactivates the cook-top or range independent of staff action was not provided. In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e)	K0324	Continued from page 3 breaker are the plan of correction so that the staff will no longer use this range for cooking and only for the practice that it is intended for. NJ Ex Order 26.4(b)(1) director will audit the breaker to ensure its not being turned back on. The results of the audits will be reported will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations. This was completed on 3/4/2025.	03/04/2025
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K0345	1. We are requesting a Time Limited Waiver 2. Our original plan was to repair the trouble on the fire alarm control panel (FACP) The fire alarm company replaced the device for room NJ Ex Or it was then noted that the FACP had another	06/25/2025

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K0345 SS = F Bldg. 01	Continued from page 4 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 02/04/2025 in the presence of the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) it was determined that the facility failed to ensure that fire alarm panels were free of trouble conditions and that all components are functioning properly in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:25 PM revealed that the fire alarm panel was indicating a trouble condition on Loop 1 Device 065. In an interview at the time, the U.S. FOIA confirmed the observation and stated that the fire alarm panel was clear of trouble conditions when check earlier in the morning. The U.S. FOIA then stated that they would call their fire alarm company to come out right away to correct the problem. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 70, 72	K0345	Continued from page 4 issue requiring old and new hardware working together. The fire alarm company called in multiple subcontractors to try and diagnose and repair the issue. Ultimately the result of the visit was the realization that the entire system will need to be replaced. The need for the waiver is to source parts and have installation completed. A proposal has already been approved ON 4/18/25 and proof has been emailed to the department of health on 5/12/25 3. The panel is fully functional as intended, and the fire department will be notified should there be a fire however the fire department would not be able to locate the exact location of the fire upon arrival. our plan is to implement a fire watch program with half hour checks so a staff member can meet the fire fighters and direct them to the exact location of the fire. 4. The administrator and maintenance director will be monitoring the project monthly 5.The parts were ordered on 05/06/25 we are estimating the parts will arrive by 06/10/25 and the install be complete by 06/24/25 6. each of the monthly quality assurance and performance improvement meeting , we will review the status of the project	06/25/2025
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and	K0353	During a tour of the building, it was noted that several areas had corrosion and build up on them. This buildup was a combination of chemicals, dust, steam and other chemical and physical barriers building up on the metal framing and bulbs of the sprinkler system. After visibly noting these issues the sprinkler contractor was contacted in order to replace the necessary heads in the noted areas. Including; the kitchen, dish area, laundry rooms,	03/31/2025

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K0353 SS = F Bldg. 01	Continued from page 5 Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 02/04/2025 in the presence of the U.S. FOIA (b)(6) [redacted] M) and U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that the facility's automatic sprinkler system was inspected, tested, and maintained in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:48 PM revealed that the Pool room contained 6 fire sprinkler heads that were heavily corroded and green in color. An observation at 1:30 PM revealed that the laundry washing room contained 2 fire sprinkler heads that had heavy buildup of a foreign material on the frangible bulb. An observation at 1:31 PM revealed that the laundry dryer room contained a fire sprinkler head that had heavy buildup of a foreign material on the frangible bulb. An observation at 1:35 PM revealed that the dishwashing area contained fire sprinkler heads that had heavy buildup of a foreign material.	K0353	Continued from page 5 and the pool area. This has the potential to affect all residents. outside vendor was called out and will be on site to complete the repair by 3/31/2025. To ensure the sprinklers stay in a properly functioning state, the Maintenance Director will check for the sprinkler condition monthly for 6 months . The results of the audits will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations.	03/31/2025

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K0353 SS = F Bldg. 01	Continued from page 6 An observation at 1:37 PM revealed that the fire sprinkler heads in the kitchen area were corroded. In interviews at the time, the [U.S. FOIA] confirmed the observations. The facility's [U.S. FOIA (b)(6)] was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 25	K0353		03/31/2025
K0363 SS = F Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K0363	Door to the gym had a gap of ¿ in between the two swinging doors RM [NJ Ex C] was not capable of staying close if a force of 5lb was applied. This was noted as we toured the facility, the door to the gym was originally mounted with this gap in place, and the door to room [NJ Ex C] latch did not catch. This had the potential to affect all residents that come to the gym or in rm [NJ Ex C] The door spacing was rectified and there was a smoke proof barrier placed to ensure that any spacing was not permeable to smoke between the compartments. This was repaired on March 4, 2025. For the period of one year there will be a mounthly inspection and documentation of all door gaps bt the Maintenance Director. The results of the audits be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations.	03/04/2025

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K0363 SS = F Bldg. 01	Continued from page 7 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 02/04/2025 in the presence of the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) it was determined that the facility failed to ensure : A) doors in the corridor were capable of being closed and maintained closed against the force of 5-lb applied at the latch edge of the door and B) doors in the corridor were constructed to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6.3.2 and 19.3.6.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:50 PM revealed that the OP/PT gym contained a pair of swinging doors that had a 1/2-inch gap between the meeting edges of the door. An observation at 1:07 PM revealed that when closed, the door to resident room NJ Ex C was not capable of keeping closed if a force of 5-lb was applied at the latch edge of the door. In interviews at the time, The U.S. FOIA confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e)	K0363		03/04/2025
K0372 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K0372	During a tour of the facility there was an inspection done above the smoke barrier of the ceiling grid, specifically done where the smoke doors indicate a smoke compartment. This is to ensure there are no openings between the compartments to allow the passage of smoke from one compartment to another. During this inspection it was found that two of the areas had openings being used a as a wire conduit. The plan is to use smoke barrier puddy patches	03/11/2025

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K0372 SS = F Bldg. 01	Continued from page 8 fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 02/04/2025 in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) it was determined that the facility failed to ensure that penetrations through fire/smoke barriers were protected by a system or materials capable of restricting the transfer of fire/smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:17 PM revealed that the fire/smoke barrier wall in Unit 1 contained two unprotected 4-inch penetrations for the pass through of wires. An observation at 1:05 PM revealed that the fire/smoke barrier wall near room 135 contained an unprotected 4-inch penetration for the pass through of wires and (2) unprotected 2-inch penetrations. In interviews at the time, the U.S. FO confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e)	K0372	Continued from page 8 -four hour fire resistance designed for through penetrations and used for electrical conduit to close the ends of each opening on the chase being used as a wire conduit. meets ASTM-BASED EGO E814 and UL listed (ul -1479). This had the potential to affect all residents. Smoke patches arrived and were installed on 3/11/2025 To ensure the continued integrity of the smoke barriers the Maintenance director will check monthly, and will additionally inspect any time there is a vendor that comes and accesses the plenum above the ceiling grid. The results of the audits will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations.	03/11/2025
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K0918	While touring with the surveyor it was noted that we were required to do a specific gravity test on the battery for the generator. The Maintenance Director will contract the generator company and have them come out and show him how to perform this test.	03/21/2025

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K0918 SS = F Bldg. 01	Continued from page 9 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 02/04/2025 in the presence of the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that maintenance and testing of generators in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 8.3.7.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:20 PM revealed that the emergency generator contained a lead-acid battery. In an interview at the time, the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid batteries. The U.S. FOIA confirmed that the battery was not a sealed lead-acid battery and stated that although they do not record specific gravity test in house, they	K0918	Continued from page 9 This has the potential to affect all residence The battery testing will be added to the documentation for the monthly generator load test, and will be done before the test is performed. The U.S. FOIA (b)(6) will be educated by the generator maintenance company on how to perform the test.Adminiistrator or decegneee will autid the monthly checks The results of the audits will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations.	03/21/2025

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K0918 SS = F Bldg. 01	Continued from page 10 believed that the emergency generator servicing company did and would contact the generator company to see how frequently the test are being conducted. No further documentation regarding monthly specific gravity testing was provided. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e), 31.2(g) NFPA 99, 110, 111	K0918		03/21/2025
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K0923	In the 2 medicine rooms, the exterior O2 room, and also the PT gym it was found that the O2 cannisters were not separated by full and not full signage. It was found that the signage was not in place so the facility ordered FULL and EMPTY O2 tank storage signs. These signs will be mounted on left and right sections of the room to identify where the corresponding tanks will be lined up for use. All residents could be affected. For the next 3 months during routine movement of the full and empty tanks the Maintenance Director will be documenting to ensure the signs stay in place and that the staff is putting them in the appropriate areas as identified by the signage. This will completed on 3/18/2025. and audited monthly for six months The results of the audits will be reported at the monthly Quality Assurance Performance Improvement meeting for 3 months and as needed thereafter for any additional recommendations.	03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCELA POST ACUTE CARE AT HAMILTON	3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690

(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
K0923 SS = F Bldg. 01	Continued from page 11 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 02/04/2025 in the presence of the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) , it was determined that the facility failed to ensure : A) when empty and full oxygen cylinders were stored in the same enclosure, empty cylinders were segregated and marked to avoid confusion and delay and B) free-standing cylinders were properly chained or supported in a proper cylinder stand or cart in accordance with NFPA 99:2010 Edition, Sections 11.6.2.3, 11.6.5.2 and 11.6.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:40 PM revealed that 1 of 2 oxygen cylinders in resident room 115 was freestanding and not properly chained or supported. An observation at 12:43 PM revealed that the oxygen storage room contained both full and empty cylinders. Two of 5 cylinders in the storage rack were empty. The oxygen cylinders were not segregated nor marked to avoid confusion. In interviews at the time, the U.S. FOIA confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K0923		03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCELA POST ACUTE CARE AT HAMILTON	**3 HAMILTON HEALTH PLACE , HAMILTON, New Jersey, 08690**

(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
E0000	Initial Comments This facility is in Substantial compliance with Appendix Z Emergency Preparedness for all provider and supplier types Interpretive Guidance 483.73. Requirements for Long Term Care (LTC) Facilities.	E0000		

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 reverse for further 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.

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