STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 000	INITIAL COMMENTS Complaint #: NJ00167935, NJ00168143, NJ00151270, NJ00154148, NJ00154610, NJ00155628, NJ00155869, NJ00157428, NJ00166867, NJ00167007, NJ00158542, NJ00161041, NJ00160764, NJ00162773, NJ00162453, NJ00165948, NJ00166024, NJ00166186 and NJ00154720. A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Survey Dates: 10/16/23-10/20/23 Survey Census: 44 Sample Size: 27 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		11/20/23

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

Electronically Signed | 11/20/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Complaints: NJ 157428, NJ 160764, NJ 161041, NJ 162453, NJ 167007 Based on observations, interviews, and record review, the facility failed to respond in a timely manner to the resident's requests for assistance for one Resident (R)27 of 27 sample residents. Findings include: Review of R27's "Admission Record" located in	F 550	All residents had the potential to be affected by the deficient practice stated in the (SOD) Statement of deficiencies. Resident #27 call bell was in reach after the deficient practice was identified. Resident # 27 was not negatively affected from the deficient practice stated in the deficiencies as all her needs were met, Ex.Order 26.4(b)(1) [redacted] Upon being made	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 550	Continued From page 2 the resident's electronic medical records (EMR) section titled "Profile" revealed the resident was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses that included Ex.Order 26.4(b)(1) [redacted] Review of R27's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of Ex.Order 26.4(b)(1) revealed the resident Brief Interview for Mental Status Score (BIMS) of Ex.Order 26.4(b)(1) out 15 points indicating that she had Ex.Order 26.4(b)(1) [redacted] cognition. The resident was Ex.Order 26.4(b)(1) on staff for Ex.Order 26.4(b)(1) [redacted] . The resident was occasionally Ex.Order 26.4(b)(1) and frequently Ex.Order 26.4(b)(1) During an interview on 10/16/23 at 11:30 AM R26 revealed that on the 3-11 and 11-7 shifts there was usually a two-to-three-hour delay in staff responding to call lights. Observation on 10/16/23 at 2:20 PM revealed the flashing call light over R27's room. R27 could be heard calling for help. No staff observed at the nurses' station. Observation on 10/16/23 at 2:31 PM revealed R27's call light remained on and the resident was calling for assistance. Unidentified staff observed walking down the hallway but did not acknowledge R27's call light. Observation on 10/16/23 at 2:47 PM revealed the resident's call light was still flashing and the resident was calling for assistance. Staff member (Speech Therapist) returned another R1 to his room from activities. The therapist walked past R27's room and did not acknowledge the resident's call for assistance.	F 550	aware of concern on 10/18/23 an audit was completed that all call bells are within reach and the Director of nursing educated the staff on the importance of call bell response time. Initiated weekly in-service on call bell response time and call bell accessibility for 2 weeks and monthly for 1 quarter. A minimum of 2 call bell audits will be completed daily by the department heads. Results of the audits will be brought by the Director of Nursing to facility monthly QAPI to determine if further interventions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 550	Continued From page 3 Observation on 10/16/23 at 3:05 PM revealed R27's call light was still flashing, and the resident was calling for assistance. A Nursing Assistant (NA)7 returned to the unit and went to R27's room. The resident had Ex.Order 26.4(b)(1) [redacted]. The CNA Ex.Order 26.4(b)(1) [redacted]. Interview on 10/16/23 at 3:10 PM with NA7 revealed that staff had been trained to answer the resident's call light as soon as possible. She was unaware how long the resident's call light had been on. NA7 stated she was not assigned to the resident but would find out who was. Observation 10/17/23 at 10:00 AM revealed R27 was in bed with her breakfast. The resident had two water bottles that had spilled in her bed. The top and bottom sheets on the bed were wet. The resident's bed jacket and gown were wet. The resident's call light was placed on the night stand out of the resident's reach. The resident stated she needed help in getting cleaned up. The call light was placed within the resident's reach to call for assistance. R27 stated it took a long time for the staff to answer her call light, and sometimes it was almost two hours that she must wait. Observation on 10/17/23 at 10:14 AM revealed R27's call light was flashing, and she was calling for help. At 10:15 AM the Assistant Administrator stuck his head in the door. R27 told the Assistant Administrator that she had been calling for help. The resident showed the Assistant Administrator that her bedding and clothing was wet. The Assistant Administrator left the room without turning off the resident's call light. The Assistant Administrator could be heard telling the staff that	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 550	Continued From page 4 the resident needed to be changed. At 10:17 AM a NA8 entered the room and told the resident that he would be back to get her cleaned up and left the room. NA8 entered another resident's room and did not return to R27's room. The resident's call light was still flashing. At 10:20 AM the Infection Preventionist (IP) entered the room and told the resident she would be back to clean her up. At 10:23 AM the Assistant Administrator entered the resident's room and observed the resident and left. At 10:26 AM a female staff member entered the resident's room to remove breakfast tray but did not tell the resident the staff would be in to assist her in getting changed. At 10:31 AM R27's call light remained flashing with no staff member responding. At 10:35 AM NA8 answered the resident's call light and proceeded to provide care to the resident. During an interview on 10/18/23 at 10:45 AM NA8 stated he was not assigned to the resident and had assumed the person assigned to the resident would respond to her call light. NA8 stated that he was busy trying to get his resident ready for physical therapy. Interview with the Assistant Administrator on 10/18/23 12:45 PM revealed that it was an expectation that resident's call lights were answered in a timely manner. The Assistant Administrator stated that the resident should not have waited that long before her wet bedding and clothing were changed. The Assistant Administrator stated that every attempt was made to meet the residents' needs in a timely manner. NJAC 8:39-4.1(a)12	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		10/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 580	Continued From page 5 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 580	Continued From page 6 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #: NJ 151270, NJ 162453 Based on interview, record review and review of facility policy, the facility failed to notify the responsible party/family of one Resident (R)5 of 27 sample residents regarding R5's return to the facility with the Ex.Order 26.4(b)(1) [redacted]. Findings include: Review of R5's "Admission Record" located in the resident's electronic medical records (EMR) revealed the resident was admitted to the facility Ex.Order 26.4(b)(1) with diagnoses that included Ex.Order 26.4(b)(1) [redacted] The resident was Ex.Order 26.4(b)(1) [redacted]. Review of R5's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of Ex.Order 26.4(b) 1 located in the resident's EMR section titled "MDS" revealed the resident had a Brief Interview for Mental Status (BIMS) score of Ex.Ord out of 15 indicating the resident had Ex.Order 26.4(b)(1) [redacted] cognition status; the resident was Ex.Order 26.4(b)(1) on staff for all Ex.Order 26.4(b)(1);	F 580	All residents had the potential to be affected by the deficient practice stated in the (SOD) Statement of deficiencies. On 10/20/2023 The Director of Nursing In-serviced the nursing staff on proper family notification and timely notification related to all resident incidents and change of condition. Director of nursing will audit resident charts bi-weekly for 1 quarter to ensure compliance. The results of the audits will be brought to monthly facility QAPI to determine if further interventions are needed. F580 All residents had the potential to be affected by the deficient practice stated in the (SOD) Statement of deficiencies. Resident #5 is no longer a resident at the facility. On 10/20/2023 The Director of Nursing In-serviced the nursing staff on proper family notification and timely notification related to all resident incidents and change of condition. . Incident reports are reviewed daily by the nursing management team to ensure the correct process of notifications are being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 580	Continued From page 7 Ex.Order 26.4(b)(1) [redacted] at home. Review of R5's "Nurses' Notes," dated Ex.Order 26.4(b)(1) [redacted] at 5:57 PM, located in the resident's EMR section titled "Progress Notes" revealed a noise was heard coming from R5's room. The resident was found lying on his right side on the floor. The resident stated he was trying to go to the other room Ex.Order 26.4(b) [redacted]. The resident was examined, and skin assessment completed. Ex.Order 26.4(b)(1) [redacted] were noted at this time. It was documented that the physician and the family were notified Ex.Order 26.4(b)(1) [redacted]. Review of R5's "Nurses Notes," dated Ex.Order 26.4(b)(1) [redacted] at 8:00 PM, located in the resident's EMR section titled "Progress Notes" revealed the resident was sitting in a wheelchair at the nurses' station when the resident attempted to stand up. Before the nurse could reach the resident, he Ex.Order 26.4(b)(1) [redacted]. The resident was assessed for injuries. It was discovered the resident had Ex.Order 26.4(b)(1) [redacted]. The resident sustained Ex.Order 26.4(b)(1) [redacted]. R5's spouse was notified of Ex.Order 26.4(b)(1) [redacted] The physician was also notified. The resident was later transported to the emergency room for evaluation and treatment. The nurse attempted to contact R5's spouse but there was no answer. Review of R5's "Nurses' Notes," dated Ex.Order 26.4(b)(1) [redacted] at approximately 3:00 AM, located in the resident's EMR section titled "Progress Notes" revealed the resident returned from the emergency room wit Ex.Order 26.4(b)(1) [redacted] It was documented that the resident had Ex.Order 26.4(b)(1) [redacted] and Ex.Orde [redacted]	F 580	followed. The Director of nursing will audit 5 resident charts bi-weekly for 1 quarter for Lab, change of condition, and acute notifications. The results of the audits will be brought to monthly facility QAPI to determine if further interventions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 580	Continued From page 8	F 580		

Ex.Order 26 done which were Ex.Order 26.4(b)(1). However, there was no documentation that resident's wife/family was notified of the resident's returned to the facility.

On 10/17/23 at 8:40 PM a telephone interview was conducted with R5's family member. The family member stated no one from the facility notified them that the resident was sent to the emergency room for Ex.Order 26.4(b)(1). When the family received a bill from the hospital, they began to ask questions as to how the resident sustained Ex.Order 26.4(b)(1)

On 10/20/23 at 1:30 PM a telephone interview was conducted with Licensed Practical Nurse (LPN)5. LPN5 stated she remembered the resident and the Ex.Order 26.4(b)(1). LPN5 stated R5 attempted to stand up from the wheelchair without the brakes in place and the resident Ex.Ord [redacted] before she could reach him. LPN5 stated the resident did Ex.Order 26.4(b)(1) [redacted]. LPN5 stated that she attempted to contact R5's spouse but there was no answer when she called. LPN5 acknowledged that she did not remember notifying the resident's spouse of the resident's return to the facility. She assumed that the day shift nurse would notify the family.

Interview with the Director of Nursing (DON) on 10/20/23 at 1:45 PM revealed she was not the DON at that time. However, there was an expectation that the nurse would have notified the family of the resident's return to the facility after receiving treatment.

Review of the facility's policy titled "Change in a Resident's Condition or Status," with a revision date of 05/23, read in part "Our facility promptly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 580	Continued From page 9 notifies the resident, his or her attending physician and the resident's representative of changes in the resident's medical/mental condition or status. The nurse will notify the resident's representative when it is necessary to transfer to a hospital/treatment center." NJAC 8:39-13.1 (c)	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Complaint # NJ 166867 Based on interview, record review, and policy review, the facility failed to ensure the resident assessment accurately reflected the resident's Ex.Order 26.4(b)(1) for one (Resident (R) 9) of 27 sampled residents. This failure could result in the residents' individual needs not being addressed. Findings include: Review of R9's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on Ex.Order 26.4(b)(1) Review of R9's "Admission Assessment Form," dated Ex.Order 26.4(b)(1) and located in the resident's EMR under the "Assessments" tab, revealed R9 was admitted to the facility with Ex.Order 26.4(b)(1) Review of R9's admission "Minimum Data Set	F 641	All residents had the potential to be affected by the deficient practice stated in the (SOD) statement of deficiencies. Upon being made aware of the deficient practice the MDS coordinator modified the MDS for Resident #9. On 10/19/2023 upon being made aware of the deficient practice the administrator and MDS consultant in-serviced the MDS coordinator on proper MDS coding. The MDS consultant will conduct bi-weekly audits for 1 month and monthly thereafter for 1 quarter on accuracy of MDS coding. The results of the audit will be brought by the administrator to the facility monthly QAPI to determine if further interventions are needed.	10/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 641	Continued From page 10	F 641		

(MDS)," located in the resident's EMR under the "MDS" tab and with an Assessment Reference Date (ARD) of Ex.Order 26.4(b)(1), indicated R9 was not at risk for Ex.Order 26.4(b)(1) and did not have any Ex.Order 26.4(b)(1).

Review of R9's modified admission MDS, located in the resident's EMR under the "MDS" tab with an ARD of Ex.Order 26.4(b)(1), revealed an updated "Section M," dated Ex.Order 26.4(b)(1) at 3:05 PM, to reflect R9 was Ex.Order 26.4(b)(1) upon admission and had Ex.Order 26.4(b)(1)) upon admission.

During a telephone interview with the MDS Coordinator (MDSC) on 10/19/2023 at 11:23 AM, the MDSC was asked why the resident's admission "MDS" was modified. The MDSC stated she thought the Ex.Order 26.4(b)(1) between then and now, but the Director of Nursing (DON) said the Ex.Order 26.4 was present on admission and had Ex.Order 26.4(b)(1). The MDSC stated she had received the information from DON this week. The MDSC stated there had been confusion because it was Ex.Order 26.4(b)(1) The MDSC stated the original admission "MDS" had been incorrect.

Review of the facility's undated "MDS Coordinator Job Description" document revealed that the MDS coordinator is responsible to "Develop preliminary and comprehensive assessments of the nursing needs of each resident, utilizing the forms required by current rules or regulations and Center policies ... Ensue that appropriate health professionals are involved in the assessment and ensure that all members of the assessment team arc aware of the importance of completeness and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 641	Continued From page 11 accuracy in their assessment functions and that they are aware of the penalties, including civil money penalties, for false certification." NJAC 8:39-11.1	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		11/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 655	Continued From page 12 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Complaint # NJ 167007 Based on interviews, record review, and review of facility policy, the facility failed to provide a baseline care plan within 48 hours of admission for three residents (Resident (R) 3, R26 and R27) reviewed for base line care plans out of 30 sampled residents. Findings include: 1. Review of R3's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of Ex.Order 26.4(b)(1) and located in the electronic medical record (EMR) section titled "MDS," documented the resident had a "Brief Interview for Mental Status (BIMS)" score of Ex.Or out of 15, indicating the resident's cognition Ex.Order 26.4(b)(1). It was documented that the resident required Ex.Order 26.4(b)(1) [redacted]	F 655	All residents had the potential to be affected by the deficient practice stated in the deficiencies. On 10/19/2023 Resident/Responsible parties for residents #3 #26 and #27 were given their baseline Care plan upon being notified of the deficient practice. The Director of nursing in-serviced the nursing staff on 10/20/23 that the baseline care plan is a part of the admission process and is to be completed on admission. The facility updated the admission checklist to include baseline care plans. The Social services director was educated by the administrator on 10/19/23 on the requirement to have baseline care plan signed within 48 hours. All admissions to the facility will be discussed at the next morning clinical meeting and the following day will be determined to complete the baseline care plan meeting within the 48 hour time frame. An audit will be completed by the administrator to check for the signed baseline care plans on 5 charts monthly for 1 quarter on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 655	Continued From page 13 Review of R3's "Care Plans," located in the resident's EMR section titled "Care Plans," failed to reveal a baseline care plan for R3. During an interview on 10/18/23 at 2:30 PM, R3 stated that he never received any document discussing his plan of care within the 48 hours of his admission to the facility. The resident stated he and his sister have attended the care plan meetings since his admission to the facility and he never received any document describing his care and treatment. 2. Review of R26 admission "MDS," with an ARD of Ex.Order 26.4(b)(1) and located in the resident's EMR section titled "MDS," revealed the resident had a "BIMS" score of Ex.Order 26 15, indicating the resident had Ex.Order 26.4(b)(1) . It was documented that the resident required Ex.Order 26.4(b)(1) [redacted] Review of R26's "Care Plan," located in the resident's EMR section titled "Care Plans," revealed the resident had only a comprehensive care plan developed and no baseline care plan. An interview on 10/18/23 at 12:39 PM with R26 and his significant other revealed they did not remember receiving or signing for a baseline care plan within the first 48 hours of his admission to the facility. 3. Review of R27's admission "MDS," with ARD of Ex.Order 26.4(b)(1) and located in the resident's EMR section titled "MDS," revealed the resident had a BIMS score of Ex.Order 26.4(b)(15, indicating the resident had Ex.Order 26.4(b)(1) cognition. It was	F 655	baseline care plan requirement within the 48 hour period. The results of the audit will be by the administrator to the facility monthly QAPI to determine if further interventions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 655	Continued From page 14 documented that the resident required Ex.Order 26.4(b)(1) [redacted] Review of R27's "Care Plans," located in the resident's EMR section titled "Care Plans," revealed the resident had comprehensive care plan but not a baseline care plan within 48 hours after admission to the facility. Interview on 10/19/23 at 9:10 AM with Licensed Practical Nurse (LPN) 9 revealed the baseline care plan is developed during the admission process. LPN9 stated that she did not know who was responsible for ensuring that the resident received a copy of the care plan. Interview on 10/19/23 at 10:48 AM with the Minimum Data Set Coordinator (MDSC) revealed the baseline care plan was completed by the floor nurse during the admission process. The MDSC also stated that she did not participate in the care plan process, so she did not know if the resident or responsible party receives a copy of the baseline care plan. The MDSC also stated that she assumed the Social Services Director probably ensured the baseline care plan was given to the resident and/or family. During an interview on 10/19/23 at 2:58 PM, the Social Services Director (SSD) provided copies of the comprehensive care plan. The SSD stated the baseline care plan is completed by the floor nurse with the resident's admission date. The SSD stated she was unaware that the baseline care plan should be signed by the resident or responsible party and the signed copy of the	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 655	Continued From page 15 baseline care plan given to the resident within 48 hours of the resident's admission. Review of the facility policy titled "Care Plans - Baseline," with a revision date of 05/2023 reads in part " . . . A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission ...The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: a. The stated goals and objectives of the resident . . ." NJAC 8:39-11.1	F 655		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 155628, NJ 158542, NJ167007, NJ 166867	F 686	All residents had the potential to be affected by the deficient practice stated in the deficiencies. The resident #3 was not	10/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 686	Continued From page 16 Based on record review, interviews, and facility policy review, the facility failed to ensure [redacted] was documented as provided according to physician orders for one Resident (R)3 out of 27 sample residents. Findings include: Review of R3 "Admission Record" located in the resident's electronic medical record (EMR) section titled "Profile" revealed the resident was admitted to the facility [redacted] with diagnoses that included Ex.Order 26.4(b)(1) [redacted] Review R3's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the EMR section titled "MDS" revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] 15 indicating the resident's cognition was [redacted]. The resident required Ex.Order 26.4(b)(1) [redacted] The resident had Ex.Order 26.4(b)(1) [redacted]. The resident was Ex.Order 26.4(b)(1). The resident had an Ex.Order 26.4(b)(1) [redacted] Review of R3's physicians' orders, revised on [redacted] located in the resident's EMR section titled "Orders" revealed the [redacted] orders to Ex.Order 26.4(b)(1) [redacted] Review of R3's physician orders, dated [redacted]	F 686	negatively affected by the deficient practice stated in the deficiencies as evidenced by no signs or symptoms of infections. Ex.Order 26.4(b)(1) [redacted] Infectious disease providers followed resident throughout his stay with no concern for decline. EMR and documentation for Resident 3 were monitored for proper completion for the remainder of his stay in facility. The Director of nursing in-serviced the nursing staff on 10/20/23 on documentation of wound care to properly reflect the care that is being done. The Director of nursing will audit the EMR bi-weekly for 1 quarter to ensure the documentation reflects the care given. The results of the audits will be brought by the Director of nursing to the facility monthly QAPI to determine if further interventions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 686	Continued From page 17	F 686		

located in the resident's EMR section titled "Orders" revealed the orders for Ex.Order 26.4(b)(1) to Ex.Order 26.4(b)(1) [redacted] care.

Review of R3's "Nursing Notes," dated Ex.Order 26.4(b)(1) at 3:01 PM, located in the resident's EMR section titled "Progress Notes," revealed "Ex.Order 26.4(b)(1) [redacted] noted to Ex.Order 26.4(b)(1) No Ex.Order 26.4(b)(1) noted. The Ex.Order 26.4(b)(1) [redacted]

Review of R3's "Treatment Administration Records (TAR)" located in the resident's EMR section titled "Order - Reports" revealed the resident's Ex.Order 26.4(b)(1) was not documented on the following dates: 08/30/23, 08/31/23, 09/04/23, 09/08/23, 09/10/23, 09/11/23, 09/26/23, 09/27/23, 10/04/23, 10/10/23, 10/12/23, and 10/13/23.

Interview on 10/19/23 at 3:15 PM with Licensed Practical Nurse (LPN)1 revealed that she worked on 9/10/23, 09/26/23, and 09/27/23 but did not remember if she performed the resident's Ex.Order 26.4(b) [redacted] those days. LPN1 stated that sometimes they were short staffed and not all the residents' treatments were performed. But even though short staffed she did her best to meet the residents' care needs.

Interview on 10/20/23 at 9:45 AM with LPN7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 686	Continued From page 18	F 686		

revealed that she worked the 7:00 AM to 7:00 PM shift on 10/10/23 and was familiar with R3's Ex.Order 26.4(b)(1). LPN7 stated that the resident's sister was very insistent about have the resident's Ex.Order 26.4(b)(1) and sometimes the sister would take it upon herself to Ex.Order 26.4(b)(1) LPN7 stated she believed she provided the Ex.Order 26.4(b)(1) but forgot to document the Ex.Order 26.4(b)(1) in the resident's EMR.

Interview on 10/20/23 at 10:10 AM with the Director of Nursing (DON) revealed that she was aware of the R3's sister's concern about the resident's Ex.Order 26.4(b)(1). The DON stated the staff had tried with the resident and the family member to ensure the resident's needs were being met including Ex.Order 26.4(b)(1). The DON did not document it on the grievance logs because she thought the concern was resolved. During the interview, the resident's TAR was reviewed for August 2023, September 2023, and October 2023. The DON acknowledged that Ex.Order 26.4(b)(1) was not documented consistently and if the Ex.Order 26.4(b)(1) was not done as ordered this could have slowed down the healing process. The DON was asked to identify the nurses responsible for Ex.Order 26.4(b)(1) on the identified days. By the end of the survey DON had not provided the requested information.

Review of the facility's undated policy titled "Wound Care" revealed "Review the resident's orders and care plan for special needs of the resident ...The following information should be recorded in the resident's medical record: I. The date and lime the wound care was given. 2. The type of wound care given. 4. Any change in the residents' condition ... Report other information in accordance with facility policy and professional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 686	Continued From page 19 standards of practice." NJAC 8:39-27.1 (a)	F 686		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 12 hours of required in-service training was provided for one (Certified Nurse Aide (CNA) 4) of five CNAs whose training records were reviewed. Findings include: On 10/19/23 at 11:00 AM, the Assistant Administrator was asked to provide the employee records for five CNAs employed at the facility. Review of the employee records revealed no documentation CNA4 had received 12 hours of in-service education in the past year. On 10/20/23 at 10:30 AM, the Assistant Administrator confirmed CNA4 did not receive the required in-service education. NJAC 8:39-43.17 (b)	F 730	All residents had the potential to be affected by the deficient practice stated in the deficiencies. Additional education was started with the CNA#4 identified in the statement of deficiencies on 10/20/2023 and with the additional education is in compliance with the CNA education requirement. Multiple residents were interviewed and with review of the resident council minutes there were no residents that were affected by the deficient practice stated on the statement of deficiencies. Human resources will audit current CNA staff employee records for required education. Director of nursing will provide CNA in-servicing monthly according to regulations and a roster was created to ensure all required education is completed timely. Human Resources will audit employee records quarterly to ensure compliance. Results of the quarterly will be brought by human	10/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 730	Continued From page 20	F 730	resources to the facility QAPI to determine if further interventions are needed.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Complaint # NJ 161041 Based on observation and interview, the facility failed to secure resident medications in one of four medication carts and one of one treatment cart to prevent an unauthorized person from	F 761	All residents had the potential to be affected by the deficient practice stated in the deficiencies. An audit was completed and no residents were affected by the deficient practice stated in the statement of deficiencies. The LPN #10 stated in the	10/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 761	Continued From page 21 accessing the residents' medications. Findings include: 1. Observation of a medication cart in the hallway near resident room [redacted] on 10/17/23 at 8:51 AM with the Assistant Administrator revealed Licensed Practical Nurse (LPN) 10 was in room [redacted] and the medication cart was unlocked. The medication cart was not in the visual path of any staff member, and residents were noted in the hallway. Interview with the Assistant Administrator during the observation confirmed an unauthorized person could access the residents' medications on the cart without staff knowledge. Interview with LPN10 on 10/17/23 at 8:53 AM confirmed the medication cart was not secured and an unauthorized person could have accessed the mediations. 2. Observation on 10/18/23 at 4:35 PM revealed the Director of Nursing (DON) performing [redacted] R26. After obtaining the [redacted] supplies from the treatment cart, the cart was left unlocked. The unlocked treatment cart was positioned in the hallway facing the resident's room. The DON was assisting in providing [redacted] R26 who was in the bed next to the window with the privacy curtain pulled to the foot of the resident's bed. The DON was unable to observe the unlocked treatment cart from her position in the room. The DON returned to the unlocked treatment cart for additional supplies. The DON returned to the resident's bedside leaving cart unlocked and closed the room door. The unlocked cart was completely out of the DON's view.	F 761	statement of deficiencies was in-serviced by the director of nursing on 10/17/2023 on proper medication storage. The nursing staff including the DON was in-serviced on locking medication cart and treatment carts on 10/20/23 by the Nurse consultant. Audit of the unit medication and treatment carts daily for 1 week, then weekly for 1 month, and monthly thereafter, to be performed by the Director of nursing and Infection preventionist on proper medication storage. Results of the audit will be brought to facility monthly QAPI to determine if compliance was met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 761	Continued From page 22 During an interview on 10/18/23 at 5:10 PM the DON acknowledged that she left the treatment cart unlocked leaving wound treatment items unsecured. The DON stated unsecured treatment items could pose a hazard to cognitively impaired residents wandering in the halls. Review of the facility policy titled "Storage of Medications," with a revision date of 05/23, read in part "Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended." NJAC 8:39-29.4 (h)	F 761		
F 880 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	F 880		10/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 880	Continued From page 23	F 880		

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 880	Continued From page 24 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 167007 Based on observation, interview, and record review, the facility failed Ex.Order 26.4(b)(1) after use for one (Resident (R) 21) of one resident observed receiving a Ex.Order 26.4(b)(1) and failed to perform Ex.Order 26.4(b)(1) s in a manner to prevent cross-contamination for one (R26) of one sampled resident observed during Ex.Order 26.4(b)(1) Finding included: 1. Review of R21's electronic medical record (EMR) revealed R21 was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses that included Ex.Order 26.4(b)(1) Observation of Licensed Practical Nurse (LPN) 9 on 10/17/23 at 11:50 AM revealed LPN9 obtained a plastic basket which contained the Ex.Order 26.4(b)(1) and supplies from the medication cart and carried the basket into R21's room. LPN9 placed the basket on R21's bed. LPN9 removed the Ex.Order 26.4(b)(1) from the basket and placed it on R21's over bed table, next to the resident's personal items without cleaning the table surface. LPN9 obtained R21's Ex.Order 26.4(b)(1), disposed of the Ex.Order 26.4(b)(1) and placed the Ex.Order 26.4(b)(1) in the basket with the Ex.Order 26.4(b)(1) supplies. LPN9 picked up the	F 880	All residents had the potential to be affected by the deficient practice stated in the deficiencies. R#21 was not negatively affected by deficient practice stated in deficiency as evidenced by Ex.Order 26.4(b)(1) . Upon being made aware of the concern on 10/17/23 the Ex.Order 26.4(b)(1) was properly cleaned, the nursing staff was immediately in-serviced on proper Ex.Order 26.4(b)(1). Other residents were monitored to ensure no infection related to the deficient practice with the Ex.Order 26.4(b)(1) LPN #9 Stated in the statement of deficiencies was immediately in serviced by the nurse consultant on proper infection prevention and Ex.Order 26.4(b)(1) dwell times. Ancillary storage staff ensured all medication carts were stocked with the appropriate wipes. Education was provided by Infection preventionist on dwell time to the nursing staff. Initiated weekly observations of nursing staff while using glucometers. A weekly audit will be conducted by the Director of Nursing or Infection preventionist for one month then monthly thereafter. The results of the audits will be brought by the infection preventionist to the monthly QAPI committee to determine if additional measures are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 880	Continued From page 25 basket, placed the basket back into the top drawer of the medication cart, and documented R21's Ex.Order 26.4(b)(1) in the EMR. When LPN9 was asked when the Ex.Order 26.4(was to be disinfected. LPN9 removed the Ex.Order 26.4(from the basket in the top drawer of the medication cart and obtained a wipe from a tub of "PH5B alcohol wipes," wiped the Ex.Order 26.4(b)(1) briefly, and returned the Ex.Order 26.4(b)(1) to the basket in the top drawer of the medication cart. Review of the "PH5B Alcohol Wipes" used to wipe the Ex.Order 26.4(b)(1) revealed there was no indication on the label for use on medical equipment, no Environmental Protection Agency (EPA) registry number, and no instructions for use including wet contact time. The wipes expiration date had been exceeded. Interview with LPN9 on 10/17/23 at 12:00PM revealed the "PH5B alcohol wipes" were provided to her earlier that day. LPN9 confirmed the wipes were expired and that the label of the wipes did not indicate if the wipes were intended for medical equipment disinfecting. Interview with the Director of Nursing (DON) on 10/17/23 at 12:10 confirmed LPN9 did not disinfect the Ex.Order 26.4(b)(1) before returning the meter to the basket and medication cart. The facility reported there are ten residents with Ex.Order 26.4(b)(1) residing on Ex.Order 26.4 Ex.Order 26.4 with R21. There are three residents on Ex.Order 26.4 on transmission-based precautions, one diabetic resident with blood glucose monitoring has vancomycin resistant enterococci with sepsis, and there are two residents with c-diff infections which are on precautions.	F 880	Part B All residents had the potential to be affected by the deficient practice stated in the deficiencies. Upon being made aware of the concern on 10/20/23 the DON was in-serviced by the Nurse consultant on proper hand hygiene and proper wound care. On 10/20/2023 the nursing staff were in-serviced on hand hygiene and wound care, the in-service will be conducted weekly for 1 month then monthly for 1 quarter. The infection preventionist and Director of nursing will observe staff performing hand hygiene twice a week for 1 month then Director of nursing and shift supervisor will perform 15 observations of hand hygiene monthly. Monthly observations will be brought to facility QAPI by Director of nursing. Director of nursing and infection preventionist will observe nursing performing wound care weekly for 1 month then monthly for 1 quarter. Observations will be brought to monthly QAPI by Director of nursing. R26 was not negatively affected by deficient practice stated in deficiency evidenced by no signs and symptoms of infection, vital signs remained within normal limits, physician assessed resident with no acute changes noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 880	Continued From page 26	F 880		

Review of the facility's policy titled, "Blood Glucose Meter Cleaning, Disinfecting, and Storage "revealed, ". . . Each medication cart will have a container of appropriate wipes for cleaning and disinfecting." 4. After use, the blood glucose meter must be cleaned and disinfected per the manufacturer's instructions . . . "

2. On 10/18/23 at 4:35 PM, the Director of Nursing (DON) was observed preparing Ex.Order 26.4(b)(1) on R26's Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1). The DON was observed scratching her head before entering the resident's room. As the DON entered the resident's room, she donned a pair of gloves without performing hand hygiene. The DON created a clean field for the Ex.Order 26.4(b)(1) on the overbed table. The Ex.Order 26.4(b) physician removed the Ex.Order 26.4(b)(1) from the resident's Ex.Order 26.4 and the DON took the Ex.Order 26.4 from him and discarded the Ex.Order 26.4 in the trash can. The DON proceeded to Ex.Order 26.4(b)(1) on the resident's Ex.Order 26. The DON did not change gloves and perform hand hygiene after touching the Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) The DON then applied Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) to the resident's Ex.Order 26.4(b)(1). The Ex.Order 26.4(b) physician performed hand hygiene and donned new gloves while the DON removed disposable items from the table and set up for the next Ex.Order 26.4(b)(1). The Ex.Order 26.4(b)(1) physician removed the Ex.Order 26.4(b)(1) from the resident's Ex.Order 26 The DON did not change gloves or perform hand hygiene between Ex.Order 26.4(b)(1). Wearing the same gloves, the DON cleaned the resident's Ex.Order 26.4(b)(1) with Ex.Order 26.4(b)(1) and applied the Ex.Order 26.4(b)(1).

Interview on 10/18/23 at 5:10PM with the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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
F 880	Continued From page 27	F 880		

revealed that she was not aware that she had scratched her head prior entering the resident's and had not performed hand hygiene before donning the gloves at the start of the dressing change. The DON acknowledged that she had not changed her gloves or performed hand hygiene during the entire Ex.Order 26.4(b)(1) process on both resident's Ex.Order 26.4(b)(1). The DON stated she should perform hand hygiene and changed gloves when removing Ex.Order 26.4(b)(1) and applying Ex.Order 26.4(b)(1).

Review of the facility's policy titled "Wound Care," with revision date of May 2023, read in part, ". . . perform hand hygiene and don clean gloves. Remove soiled dressing and discard into designated container. Remove gloves and perform hand hygiene. Put on clean gloves. Evaluate the appearance of the wound and surrounding skin. Cleanse the wound with the ordered cleanser. Apply treatment as ordered using sterile tongue blades/applicator to remove the ointment from their containers. Apply the dressing as ordered. Perform hand hygiene . . . "

NJAC 8:39-19.4 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ00167935, NJ00168143, NJ00151270, NJ00154148, NJ00154610, NJ00155628, NJ00155869, NJ00157428, NJ00166867, NJ00167007, NJ00158542, NJ00161041, NJ00160764, NJ00162773, NJ00162453, NJ00165948, NJ00166024, NJ00166186 and NJ00154720. The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C# NJ00165948, NJ00162773, NJ00158542 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 20 of 49 day shifts as follows: This deficient practice had the potential to affect all residents.	S 560	All residents have the potential to be affected by the deficient practice stated on the Statement of deficiencies (SOD) A staffing and Recruitment/Retention committee including Director of Nursing, Staffing Coordinator, and Administrator/designees has been convened on 10/123/2023 and will meet 3x times a week to review retention	11/10/23

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

Electronically Signed | 11/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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) COMPLETE DATE
S 560	Continued From page 1 Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 7 weeks of staffing from 03/12/2023 to 03/25/2023, 07/23/2023 to 08/05/2023 and 09/24/2023 to 10/14/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: 1. For the 2 weeks of staffing from 03/12/2023 to 03/25/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows:	S 560	efforts, open positions, recruitment tactics, and changes to improve outcomes staffing for upcoming week. The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed. The facility has secured a new outside Recruitment/Retention company to oversee recruitment/retention tactics, open position and they participate in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. Contract staff utilization is reviewed bi- weekly to identify trends and opportunities. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Implementation of Hosted Time, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Rate adjustments, Benefit adjustments and Contract staff utilization. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for two months and then quarterly. The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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) COMPLETE DATE
S 560	Continued From page 2 -03/23/23 had 2 CNAs for 38 residents on the day shift, required at least 5 CNAs. -03/25/23 had 4 CNAs for 37 residents on the day shift, required at least 5 CNAs. 2. For the 2 weeks of staffing from 07/23/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -07/23/23 had 4 CNAs for 41 residents on the day shift, required at least 5 CNAs. -07/25/23 had 4 CNAs for 40 residents on the day shift, required at least 5 CNAs. -07/26/23 had 4 CNAs for 40 residents on the day shift, required at least 5 CNAs. -07/28/23 had 3 CNAs for 40 residents on the day shift, required at least 5 CNAs. -07/29/23 had 4 CNAs for 45 residents on the day shift, required at least 6 CNAs. -07/30/23 had 4 CNAs for 43 residents on the day shift, required at least 5 CNAs. -07/31/23 had 4 CNAs for 43 residents on the day shift, required at least 5 CNAs. -08/02/23 had 4 CNAs for 42 residents on the day shift, required at least 5 CNAs. -08/04/23 had 3 CNAs for 40 residents on the day shift, required at least 5 CNAs. 3. For the 3 weeks of staffing from 09/24/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 9 of 21 day shifts as follows: -09/25/23 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -09/29/23 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -09/30/23 had 4 CNAs for 50 residents on the day	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11014	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 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) COMPLETE DATE
S 560	Continued From page 3 shift, required at least 6 CNAs. -10/02/23 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -10/05/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs. -10/06/23 had 4 CNAs for 45 residents on the day shift, required at least 6 CNAs. -10/10/23 had 4 CNAs for 39 residents on the day shift, required at least 5 CNAs. -10/11/23 had 4 CNAs for 39 residents on the day shift, required at least 5 CNAs. -10/12/23 had 4 CNAs for 39 residents on the day shift, required at least 5 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315519 Y1	A. Building B. Wing Y2	11/30/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 08690

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0580	Correction	ID Prefix F0641	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.20(g)	Completed
LSC	11/20/2023	LSC	10/23/2023	LSC	10/23/2023
ID Prefix F0655	Correction	ID Prefix F0686	Correction	ID Prefix F0730	Correction
Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.35(d)(7)	Completed
LSC	11/15/2023	LSC	10/24/2023	LSC	10/25/2023
ID Prefix F0761	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	10/24/2023	LSC	10/25/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/20/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
11014 Y1	A. Building B. Wing Y2	11/30/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 08690

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/10/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
10/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO