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 05/14/2024

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

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F 000	INITIAL COMMENTS Complaint #: NJ171631 Census: 48 Sample Size: 5 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 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: Complain #: NJ171631 Based on interview and record review on 05/13/2024 and 05/14/2024, it was determined that the facility failed to accurately encode a resident's [NJ Ex Order 26] in the Minimum Data Set (MDS) assessment for 1 of 5 residents (Resident #2) reviewed for MDS accuracy. This deficient practice was evidenced by the following: Reference: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 October 2023, under "Section M: Skin Conditions...M0210 Unhealed Pressure Ulcers/Injuries...Coding Instructions Code based on the presence of any pressure ulcer/injury (regardless of stage) in the	F 641	1. Resident #2 stated on the statement of deficiencies has discharged from the facility [NJ Ex Order 26.4b1]. 2.All residents had the potential to be affected by the deficient practice stated in the (SOD) statement of deficiencies. 3. Upon being made aware of the deficient practice on 5/14/2024 the MDS (Minimum Data Set) coordinator immediately conducted an audit. On 05/14/24 upon being made aware of the deficient practice the administrator and Director of Nursing educated the MDS Coordinator on the process that should be taken when completing section M of the Minimum Data Set. 4. The MDS Coordinator will conduct weekly audits of 2 charts for 1 month and	5/31/24

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

Electronically Signed | 06/14/2024

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

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F 641	Continued From page 1 past 7 days. Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers. Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Coding Tips If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury. Under "DEFINITIONS STAGE 1 PRESSURE INJURY An observable, pressure related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters...persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues. NON-BLANCHABLE Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device. The surveyor reviewed the closed medical record for Resident #2: According to the Admission Record, Resident #2 was admitted to the facility with medical diagnoses that included but were not limited to NJ Ex Order 26.4b1 [redacted] NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 [redacted] . Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1 indicated that Resident #2 had a BIMS (brief interview for	F 641	then 1 chart bi-weekly thereafter for 1 quarter on accuracy of section M of the Minimum Data Set. The results of the audit will be brought to the facility□s monthly (QAPI) Quality Assurance and Performance Improvement Meeting by the MDS Coordinator to determine if further interventions are needed for 1 quarter.	

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F 641	Continued From page 2	F 641		

mental status) score of [redacted] indicating the resident was [redacted]. The MDS further indicated under "Section [redacted] (used to assess [redacted] during a 7-day look-back period), [redacted] is this resident at [redacted] " Indicated No. [redacted], [redacted] " indicated that the Resident did not have a [redacted].

Review of Resident #2's Admission Evaluation Assessment dated [redacted], under diagram revealed the resident was admitted with a [redacted].

Review of facility documentation showed on [redacted] Resident #2 was seen by the [redacted] for "[redacted]."

During the interview with the Surveyor on 05/13/2024 at 2:18 P.M., the [redacted]) confirmed Resident #2 was admitted to the facility with [redacted].

During the interview with the Surveyor on 05/14/2024 at 10:36 A.M, the [redacted] confirmed that previous [redacted] (who no longer work in the facility) miscoded the [redacted] assessment, Section [redacted]. She further stated the MDS should have reflected that Resident #2 had a [redacted].

The Surveyor attempted to reach the previous [redacted] but was unsuccessful.

The job description for "Care Navigator/MDS Coordinator" Job Description," undated, indicated "Duties and Responsibilities Conducts patient assessments to determine the patient's prior level

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F 641	Continued From page 3 of function to establish patient centered goals, treatment plans that focus on recovery and discharge planning." Review of the facility policy titled "Comprehensive Assessment," dated 04/2023, indicated "Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual." NJAC 8:39-11.2(e)(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	F 655		6/4/24

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F 655	Continued From page 4 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). §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 171631 Based on interview, medical record review, and review of other pertinent facility documentation on 5/13/2024 and 5/14/2024, it was determined that the facility failed to develop a Baseline Care Plan (BCP) for a newly admitted resident with a [redacted]. This deficient practice was identified for Resident #2, 1 of 5 residents reviewed for BCP. This deficient practice was evidenced by the following: The surveyor reviewed the closed medical record for Resident #2: According to the Admission Record, Resident #2 was admitted to the facility with medical diagnoses that included but were not limited to	F 655	1. Resident #2 mentioned in the (SOD) statement of deficiencies was [redacted]. 2. All residents had the potential to be affected by the deficient practice stated in the deficiencies. 3. The Director of Nursing has in-serviced all appropriate departments who are involved with (BCP) baseline care plans on 05/14/2024 that the baseline care plan is a part of the admission process and is to be completed on admission. All baseline care plans (BCP) will be completed within 48 hours of admission. During the next day□s morning meeting the clinical team will review the (BCP) baseline care plans for completion and accuracy. Once completed each	

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F 655	Continued From page 5 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 . Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1 indicated that Resident #2 had a BIMS (brief interview for mental status) score of NJ Ex indicating the resident was NJ Ex Order 26.4b1. Review of Resident #2's Admission Evaluation Assessment revealed the resident was admitted with a NJ Ex Order 26.4b1 with NJ Ex Order 26. Review of facility documentation revealed there was no BCP initiated for Resident #2 upon admission to address Resident #2's NJ Ex Order 26 . During an interview with the Surveyor on 5/13/2024 at 1:3 P.M, the US FOIA (b)(6)) stated that Resident #2 should have had a BCP in place for their NJ Ex Order 26.4b1. The US FOIA (b)(6) continued that all newly admitted residents should have a BCP upon admission. During an interview with the Surveyor on 5/13/2024 at 2:18 P.M., the US FOIA (b)(6) stated the BCP is a roadmap to the resident so that all parties (departments) know the care of the resident. The US FOIA (b) continued to say, "if a resident is admitted with a NJ Ex Order 26.4b1 , the admitting nurse will put in a NJ Ex Order 26 , document the NJ Ex Order 26, obtain treatment for the NJ Ex Order 26 and initiate a BCP with all appropriate interventions." When presented with	F 655	department will then sign off on their section as confirmation of completion. 4. The Director of Nursing or designee will generate a weekly report of all new admissions for the week and an audit for (BCP) baseline care plans. The results of the audit will be presented by the Director of Nursing to the facility monthly QAPI committee (Quality Assurance and Performance Improvement committee) to determine if further interventions are needed for 1 quarter.	

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F 655	Continued From page 6 Resident #2's CP, the [redacted] acknowledged there was no BCP initiated upon admission. During the survey, the Surveyor attempted to reach the admitting nurse for Resident #2 but was unsuccessful. Review of the facility policy, "Care Plans-Baseline" with a revised date of 04/2023, indicated under "Policy Statement" that, "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission." The facility policy continued under "Policy Interpretation and Implementation" 1. "The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. physician orders; c. Dietary orders; d. Therapy orders." NJAC 8:39-11.2(d).	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		6/4/24

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F 677	Continued From page 7 Complaint #: NJ171631 Based on interview, observation, record review, and facility policy reviewed on 5/13/2024 and 5/14/2024, it was determined that the facility failed to provide 1 of 5 residents (Resident #2) reviewed for Activities of Daily Living (ADLs) with NJ Ex Order 26.4b twice a week as scheduled. The US FOIA (b)(6)) also failed to follow their job description. This deficient practice was identified for Resident #2, and was evidenced by the following: The surveyor reviewed the closed medical record for Resident #2: According to the Admission Record, Resident #2 was admitted to the facility with medical diagnoses that included but were not limited to NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1 indicated that Resident #2 had a BIMS (brief interview for mental status) score of NJ Ex indicating the resident was NJ Ex Order 26.4b1 . The MDS also indicated the resident needed partial/moderate assistance with ADL. Review of Resident #2's comprehensive "Care Plan (CP)," identified that Resident #2 has a self -care NJ Ex Order 26.4b1 . A CP "Intervention." indicated, "NJ Ex Order 26.4b1 : Assist-one."	F 677	1. Resident #2 stated on the statement of deficiencies has discharged from the facility on NJ Ex Order 26.4b1 2. All residents had the potential to be affected by the deficient practice stated in the (SOD) statement of deficiencies. 3. An in-service was started on 5/14/2024 by the Director of Nursing on location of the schedules, along with the shower/bed bath policy. To ensure accuracy of shower/bed bath and completion of the Point of Care charting. Announcements will be made prior to the end of the shift as a reminder for POC documentation. The Point of Care documentation will be reviewed daily by Director of Nursing and Unit Managers. 4. The Director of Nursing will bring the findings of the audit to the monthly QAPI (Quality Assurance and Performance Improvement) committee monthly for one quarter to determine if compliance has been met	

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Review of the facility "Documentation Survey Report v2 (DSR)" dated for NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1, revealed Resident #2's NJ Ex Order 26.4 days were on Wednesdays and Saturdays during the 7:00 A.M to 3:00 P.M. shift.

Review of Resident #2's NJ Ex Order 26.4b1, DSR, indicated no NJ Ex Order 26. was provided on NJ Ex Order 26.4b1 (Saturday), NJ Ex Order 26.4b1 (Saturday), NJ Ex Order 26.4b1 (Saturday), NJ Ex Order 26.4b1 (Wednesday) and NJ Ex Order 26.4b1 (Saturday).

Review of Resident #2's NJ Ex Order 26.4b1 DSR, indicated no NJ Ex Order 26. was provided on NJ Ex Order 26.4b1 (Saturday).

Review of Resident #2's Progress Notes (PNs) dated for NJ Ex Order 26.4b1 through NJ Ex Order 26.4b1, revealed no documentation for refusal of NJ Ex Order 26. on the aforementioned dates.

During a telephone interview on 5/14/2024 at 12:26 P.M., with the US FOIA (b)(6) assigned to Resident #2, she stated, the CNAs were responsible to provide NJ Ex Order 26.4b to all residents twice weekly on their scheduled NJ Ex Order 26. days. The US FOIA (b stated that "if the ADL sheet was left blank, then more than likely I did not do the NJ Ex Order 26.4b". She further stated, sometimes the resident (Resident #2) would refuse their NJ Ex Order 26.4b When asked if refusal should be documented, she said "Yes, if a resident refuses NJ Ex Order 26.4, we (US FOIA (b)( ) should document refusals in the Point of Care (POC) and also inform the nurse."

During an interview on 5/14/2024 at 11:43 A.M., the US FOIA (b)(6)

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US FOIA (b)(6)), revealed the CNAs were responsible to provide NJ Ex Order 26. to the residents twice weekly on their scheduled NJ Ex Order 26. days, and document in the POC. She confirmed blank spaces on the POC will indicate the task was not completed. The US FOIA (b)(6) said the expectation is for all task to be completed and documented daily.

During an interview on 5/13/2024 at 2:18 P.M., the US FOIA (b)(6)) stated her expectation is for all task and documentation to be completed daily by the CNAs. She further stated blank spaces on the POC will indicate the task was not done. When asked by the Surveyor about the blank spaces on Resident #2's DSR, the US FOIA (b said, "technically there should be no blanks on the POC."

During the exit conference on 5/14/2023 at 2:26 P.M., the US FOIA (b) in the presence of the US FOIA (b)(6) and US FOIA (b)(6) confirmed Resident #2 NJ Ex Order 26.4b1 were Wednesday and Saturdays on the 7:00 A.M. to 3:00 P.M., shift and acknowledged the blank spaces.

Post survey, an email was sent by the US FOIA (b)(6) on 5/15/2024 containing a written statement dated 5/14/2024 from US FOIA (b)(6) previously interviewed by the Surveyor during the survey. The statement revealed: "I recall having Resident #2 as an aide during their stay at Spring Hills Hamilton. Resident #2 did refuse NJ Ex Order 26.4b often during his/her stay here and would (I) give he NJ Ex Order 26.4b1 at his/her request. I recognize that I should've documented all the care that I performed in POC. However, there was at no time I did not provide care as scheduled and as needed at the resident's request."

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F 677	Continued From page 10 Review of the facility's policy titled; "Bathing and Showering", dated 04/2023, under "Policy" indicated: The facility will offer showers and tub baths to residents in accordance with their preferences. Under "Policy Interpretation and Implementation", indicated: 1. The facility will offer showers and tub baths to residents twice per week. 4. Provision and refusals of shower and or tub baths will be documented in the medical record by the certified nursing assistant and /or licensed nurse. Review of the facility undated job description for "Certified Nursing Assistant" under "Purpose" revealed: The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors. Under "Duties and Responsibilities" Assist residents with bath functions (i.e., bed bath, tub, or shower, etc..) as directed. NJAC 8:39-27.2(i)	F 677		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Complaint #: NJ171631 Based on interviews and review of facility documents on 5/13/2024 and 5/14/2024, it was determined that the facility failed to ensure staffing ratios were met for 17 of 28-day shifts and 1 of 28 evening shifts reviewed as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	1. No residents were negatively affected by the deficient practice stated on the SOD as seen by the review of the resident council minutes the prior few months. 2. All residents have the potential to be affected by the deficient practice stated on the SOD 3. A staffing and Recruitment/Retention committee including Director of Nursing, Staffing Coordinator, and Administrator/designees has been convened on 05/15/2024 and will meet 3x times a week to review retention efforts, open positions, recruitment tactics, and changes to improve outcomes staffing for upcoming week. The facility has contracts in place with	6/4/24

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

Electronically Signed | 06/14/24

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 05/14/2024

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 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. 1. For the 2 weeks of Complaint staffing from 01/07/2024 to 01/20/2024, the facility was deficient in CNA staffing for residents on 13 of 14-day shifts and was deficient in CNAs to total staff on 1 of 14 evening shifts as follows: On 01/07/24 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. On 01/09/24 had 4 CNAs for 49 residents on the day shift, required at least 6 CNAs. On 01/10/24 had 4 CNAs for 49 residents on the day shift, required at least 6 CNAs. On 01/11/24 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. On 01/12/24 had 4 CNAs for 49 residents on the day shift, required at least 6 CNAs. On 01/12/24 had 3 CNAs to 10 total staff on the evening shift, required at least 5 CNAs. On 01/13/24 had 3 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 01/14/24 had 3 CNAs for 51 residents on the day shift, required at least 6 CNAs.	S 560	multiple staffing agencies in 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. 4. 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 the Resident Council minutes as well as recruitment data will be reviewed by the Administrator or Director of Activities at the monthly (QAPI) Quality Assurance and Performance Improvement meeting monthly for 1 quarter to determine if compliance has been met.	

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 05/14/2024

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 On 01/15/24 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 01/16/24 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 01/17/24 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 01/18/24 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 01/19/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 01/20/24 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. 2. For the 2 weeks of staffing prior to survey from 04/28/2024 to 05/11/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: On 04/29/24 had 4 CNAs for 45 residents on the day shift, required at least 6 CNAs. On 04/30/24 had 4 CNAs for 45 residents on the day shift, required at least 6 CNAs. On 05/02/24 had 4 CNAs for 47 residents on the day shift, required at least 6 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	6/25/2024 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 F0641	Correction	ID Prefix F0655	Correction	ID Prefix F0677	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	06/04/2024	LSC	06/04/2024	LSC	06/04/2024
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/14/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
11014 Y1	A. Building B. Wing Y2	6/25/2024 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	06/04/2024	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	
5/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO