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 _____	01/12/2023

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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E 000	Initial Comments This facility is in Substantial compliance with Appendix Z Emergency Preparedness for all provider and supplier types Interpretive Guidance 483.73. Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 1/12/23 Census: 40 Sample: 12 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		2/3/23

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

Electronically Signed | 01/27/2023

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.

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F 732	Continued From page 1 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to routinely post the Nursing Home Resident Care Staff Report (NHRCSR) since 12/23/22 (13 days) in a place within the facility readily accessible to the residents and the visitors. This deficient practice was evidenced by the following: On 1/5/23 at 9:45 AM, the surveyor observed the NHRCSR dated 12/23/22 for the day, evening, and night shift. Each shift indicated a census of 39. The NHRCSR was observed posted behind the mounted glass wall display case to the left of the receptionist desk in the front lobby.	F 732	" On 1/5/2023, when the facility became aware of the concern, the Director of Nursing posted the Nursing Home Resident Care Staff Report (NHRSCSR) in an area that is readily accessible to the residents and visitors. Staffing has been posted every day thereafter. " All residents of the facility have the potential to be affected. An audit was completed and no residents were found to have been negatively affected. " A new process was put in place regarding posting the NHRSCSR which includes a multi-tier backup checks/balances system. Including checks by assigned facility team	

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F 732	Continued From page 2 On 1/5/23 at 1:05 PM, the surveyor interviewed the Director of Nursing who stated that a staff person from Medical Records was responsible for posting the daily nursing staffing ratio but that staff member has been out of work for two weeks and the Human Resource/Staffing Coordinator was responsible for posting the daily nursing staffing ratio. On 1/5/23 at 1:30 PM, the surveyor interviewed the Human Resource Coordinator who confirmed she was responsible for posting the nursing staffing ratio daily in the lobby. She stated she couldn't print the Nursing Home Resident Care Staff Report. "We don't have access to the website." She stated the medical records staff person would normally do it for the week. "We are trying to reset the password." She acknowledged that the nursing staffing ratio should be posted for each shift daily. On 1/12/23 at 12:35 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing, Infection Control Preventionist, and the Regional Director of Operations who were made aware of the above findings. A review of the facility's undated policy for "Posting Direct Care Daily Staffing Numbers" provided by the LNHA included that the facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The policy also included that within two (2) hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent	F 732	members and manager on duty on the weekend to ensure the NHRSCSR is readily accessible to the residents. Inservice education of this process was provided by the NHA to the responsible team members (HR, Staffing coordinator and Director of Nursing) to ensure this is completed daily. " The NHA will perform an audit of the NHRSCSR once weekly for 3 months to ensure that it is readily accessible to the residents and visitors. This audit will include off hour and weekend monitoring. The results of the audit will be reported to the facility Quarterly QAPI Committee for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit. " Completion date 1/27/23	

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F 732	Continued From page 3 location accessible to residents and visitors and in a clear and readable format. NJAC 8:39-41.2 (a)(b)(c)(1)	F 732		
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of	F 836		2/3/23

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F 836	Continued From page 4 non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review of pertinent facility documents, it was determined that the facility failed to notify the Centers for Medicare & Medicaid Services (CMS) and apply for a change in ownership and facility name change upon 30 days of their sale in July 2021 in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act.	F 836	" There was potential for all residents at the facility to be affected by the deficient practice. " A Medicare Enrollment Application (Tracking ID: T011220230004225CMS) (including form 855A) was submitted on January 12, 2023 by Spring Hills Post-Acute Hamiltons in-house counsel. " An audit was done by Hamiltons In house council with other related certifications/licenses to ensure that they were completed timely. No findings noted. " Director of Operations provided in-service to the facility NHA on ensuring licensure and certifications are in compliance with applicable regulations. " For a period of 3 months the administrator will review applicable licensure/certifications to ensure timely completion and bring the findings to the facility Quality Assurance Committee by the quarterly meeting for monitoring and follow-up.	

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F 836	Continued From page 5	F 836		

(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76.....
(d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.
Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:
(1) Within 30 days -
(i) A change of ownership;
(ii) Any adverse legal action; or
(iii) A change in practice location.
(2) All other changes in enrollment must be reported within 90 days."

On 1/5/23 at 9:15 AM, the surveyor observed a large white sign on the facility which indicated "Spring Hills Post-Acute Hamilton." The name on the sign did not correspond with the CMS approved name and provider registered name which was Atrium Post-Acute Care of Hamilton.

On 1/5/23 at 10:48 AM, during the Entrance Conference with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the LNHA could not speak to when the name change occurred. He stated that he began his position as the LNHA on [redacted] and the facility's name was already changed to Spring Hills. The surveyor requested a copy of the facility's license.

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F 836	Continued From page 6	F 836		

A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of 5/6/22 and an expiration date of 4/30/23. The NJDOH issued the license for the facility name of Spring Hills Post-Acute Hamilton not Atrium Post-Acute Care of Hamilton.

On 1/9/23 at 10:47 AM, the surveyor interviewed the Regional Director of Operations (RDO) who could not speak to when CMS was notified for a change in ownership and facility name change. The RDO stated that he will attempt to obtain information from the facility's lead attorney for the survey team.

On 1/10/23 at 10:12 AM, the surveyor interviewed the LNHA who stated, "I was not involved in the facility's name change." The LNHA had no information regarding when the change of ownership and facility name change occurred.

On that same day at 10:48 AM, the surveyor interviewed the RDO who stated he began his position as the RDO in April 2022 and further stated "the CHOW (change of ownership) has not happened yet." He further stated that he hopes to have information for the survey team "tomorrow," 1/11/23.

On 1/12/23 at 10:50 AM, the survey team met with the LNHA, DON, Infection Control Preventionist (IP), and the RDO. The RDO stated that facility was sold to Spring Hills on 7/1/2021, and provided a copy of the Certificate of Closing to the survey team which indicated that the "Transfer Closing Date" was dated 7/1/2021. The RDO further stated that the application for a change in ownership and name change was not

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F 836	Continued From page 7 submitted according to the attorney. He further stated that "the attorney did not file anything to CMS until yesterday," 1/11/23. On 1/12/23 at 10:55 AM, the RDO provided a printed email from the lead attorney which indicated that he filed the CMS 855 A application dated 1/11/23. On 1/12/23 at 12:35 PM, the survey team met with the LNHA, DON, IP, and the RDO and were made aware of the above findings.	F 836		
F 880 SS=E	NJAC 8:39-5.1 (a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		2/3/23

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F 880	Continued From page 8 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 transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 9 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents it was determined that the facility failed to a.) ensure the soiled and clean laundry areas were maintained and operated in a sanitary manner to prevent infection control breaches and b.) maintain mop bucket systems in a sanitary manner. This deficient practice was evidenced by the following: On 1/11/23 at 12:10 PM, the surveyor observed the hallway leading to the laundry area as well as both the soiled and clean laundry rooms in the presence of a second surveyor which revealed the following: 1. In the hallway just prior to entering the soiled laundry room, there was a yellow mop bucket that had a shallow amount of dark colored soiled standing water and a soiled mop head. 2. In that same area, there was a black oval mop bucket on a yellow housekeeping cart with a shallow amount of dark colored soiled standing water and a soiled mop head which sat directly in the soiled water. 3. In the soiled laundry room, there were two yellow mop buckets both of which had a shallow amount of dark colored soiled standing water in them. 4. There was a chemical dispenser nozzle which was in direct contact with the dark colored soiled standing water in one of the mop buckets. 5. There was a handwashing sink that was blocked by a cart and boxes. The faucet handle	F 880	• Upon being made aware of the concerns, on 1/11/23, the facility corrected all of the issues to ensure the soiled and clean laundry areas were maintained and operated in a sanitary manner to prevent infection control breaches (removed and disposed of all items/areas identified in the SOD). The mop bucket systems were checked and corrected to ensure they were maintained in a sanitary manner. • All residents have the potential to be affected. An audit was completed, and no residents were found to have been negatively affected. • On 1/11/2023 housekeeping and laundry department had an immediate extensive in-service provided by facility Infection Preventionist related to maintaining the laundry area in a sanitary manner to prevent infection control breaches and the mop bucket system. o In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction was imposed on the facility. As part of the Directed Plan of Correction a Root Cause Analysis (RCA) was completed. o As part of the Directed Plan of Correction the following additional education was provided: ¿ Nursing Home Infection Preventionist Training Course Module 11B Environmental Cleaning and Disinfection	

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F 880	Continued From page 10 was missing. There was no soap in the dispenser and the hands-free towel dispenser was jammed. And there was an uncovered unlined tall gray garbage pail to the left of the sink. 6. In the clean laundry room, there was a small blue bin against a wall where three folded white blankets were in direct contact with a piece of sheet rock that was propped against the wall. 7. There was a rolling fabric covered office chair which had a personal coat draped over it and multiple unfolded hospital gowns directly on top of the seat and in direct contact with the personal jacket. 8. There was a personal olive-green nap sack style bag stored directly on top of a clean folding table which was in direct contact with four folded white towels. 9. There was a set of personal keys and a phone charger on the second rack of a three-tiered metal rack which had stored folded clean laundry. There was also a personal black headset stored on the bottom rack which was in direct contact with a folded beige blanket. 10. There was a long handled soiled duster, a folded light blue bed pad and a face shield stored directly on top of the dryers. On 1/11/23 at 12:20 PM, the surveyor interviewed the laundry aide (LA) in the presence of a second surveyor. She described the laundering processes and stated if there was laundry left in the washing machines from the night before she would put it in the dryers and that then she processed the "COVID laundry first." She stated that the washing machine to the right was for COVID-19 linens and blankets, the middle washing machine was for non-COVID-19 linens and blankets and the washing machine was to the left was for personal clothing. She stated that	F 880	https://www.train.org/main/course/10818l5/ provided to all All staff including topline staff and infection preventionist. ¿ CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://www.youtube.com/watch?v=7srwrF9MGdw Provided to Frontline Staff and Laundry Staff. ¿ CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces https://www.youtube.com/watch?v=t7OH8ORr5Ig Provided to Frontline Staff and Laundry Staff. ¿ Nursing Home Infection Preventionist Training Course Module 11D - Linen Management https://www.train.org/cdctrain/course/l08l8l8/ Provided to Frontline Staff and Laundry Staff ¿ Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Provided to Topline staff and infection preventionist. • Th Infection Preventionist/designee will conduct audits, of the laundry area and mop bucket system, 3 times a week for two weeks and then weekly for 6 weeks and then monthly for three months to ensure it is maintained and operated in a sanitary manner to prevent infection control breaches. The results of the audit will be reported to the facility monthly QAPI Committee for one quarter to determine if sufficient compliance has	

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F 880	Continued From page 11 she processed personal laundry throughout the day which included laundry for residents that had COVID-19. The LA further stated that when she processed laundry she applied gloves, a non disposable yellow gown and eye protection. She stated that when she removed her personal protective equipment (PPE) she put the yellow gown into a clear plastic bag and collected them to launder on Friday(s). The surveyors did not observe a designated bin for the soiled gowns, which the LA acknowledged. She also acknowledged that the hand washing sink was blocked, that there was no soap in the dispenser, that the towel dispenser was not working, and that the garbage had no liner and did not have a cover. She stated that the hand washing area had not been functional "in a long while" and that the garbage was "not covered at all." She stated that there was no alcohol-based hand rub (ABHR) available in the soiled laundry room to perform hand hygiene. The LA was unable to state what mechanism disinfected the laundry. She stated, "I don't know the settings or chemicals and I do not know the water temperature." She stated that there were no masks (surgical or N 95) available in the soiled or clean laundry rooms and could not speak to whether or not she should apply an N 95 mask when she processed COVID-19 laundry. On that same date and time, in the clean laundry room, the LA acknowledged that there was a soiled duster, a clean folded light blue bed pad and a face shield stored directly on top of the dryers. When she acknowledged the face shield she stated, "that's mine." She stated that items stored on top of the dryers were a fire hazard and could not speak to any infection control concerns. She acknowledged that the three clean folded blankets were in direct contact with a piece of	F 880	been met. Based on the results of the audit the QAPI committee will determine continued need for the audit. • Completion Date: 2/4/2023	

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	315519	A. BUILDING _____ B. WING _____	01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12	F 880		

sheet rock and stated that the "clean blankets should not be leaning against the wall." She acknowledged that the jacket that was observed on the chair and in direct contact with multiple hospital gowns was hers and should not have been stored there or touching the gowns. In reference to the hospital gowns on the chair, she then stated, "I place them there when I take them out of the dryer, so then I can fold them" and also stated, "when the cart is full, I place them on the chair," and later stated that they should not have been on the chair, but could not speak to why not. The LA acknowledged that the table was for folding clean laundry, that she stored her personal bag on the table and that it was in direct contact with four clean folded towels.

On that same day at 12:50 PM, she removed the bag off the table and placed it directly on top of the hospital gowns on the chair, then removed and held it. She acknowledged that her personal keys and phone charger were on the middle tier of the metal rack and that the rack contained clean laundry and stated, "that's where I store it." She also acknowledged that a personal black headset was stored on the bottom shelf and was in direct contact with a clean folded beige blanket. She further stated that it belonged to the laundry aide that worked the evening shift. The surveyors had multiple observations of the LA touching clean laundry with her bare hands. She stated that she only wore gloves when she put wet laundry into the dryer not when folding clean laundry. She further acknowledged that there was no ABHR available in the clean laundry room to perform hand hygiene.

On 1/11/23 at 1:00 PM, the surveyor interviewed the Housekeeping Director (HD) in the presence

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F 880	Continued From page 13	F 880		

of a second surveyor. She acknowledged that there was a yellow mop bucket in the hallway with soiled standing water and a mop with a soiled mop head. She stated that her department had not used yellow mop buckets in two months and that "the bucket has been there two months." The HD stated that the department switched to the black mop bucket system which had a removable mop head that could be laundered. She acknowledged that there was a black mop bucket in the hallway as well which had soiled standing water and the mop head was stored directly in the water. She stated that her staff should have emptied and rinsed the bucket and removed the mop head for laundering prior to going on a break. She acknowledged that there were two yellow mop buckets in the soiled laundry room which had soiled standing water and that there was a disinfectant dispenser nozzle that was stored directly in the soiled water. The HD stated that maintenance should have discarded the yellow mop buckets. She acknowledged that the hand washing sink was not set up for use and there was no ABHR available for hand hygiene. She stated, "I have been getting on them about that for a long time." The Maintenance Director (MD) entered the soiled laundry room and stated that it was his responsibility to ensure that the sink area was functional. He further stated that the yellow mop bucket in the hallway with the soiled standing water and soiled mop head was used by his staff and stated, "probably my staff used last night" and they "should have emptied the bucket." The MD then stated that he cleaned the mop buckets once a week.

On 1/12/23 at 11:48 AM, the survey team met with the facility's administrative team. At that time, they acknowledged the surveyor's infection

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F 880	Continued From page 14	F 880		

control concerns in the laundry area.

Review of the undated facility policy "Laundry and Bedding, Soiled", reflected that "Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control." It also reflected that "Hand hygiene products, as well as appropriate PPE (i.e., gloves and gowns) are available and used while sorting and handling contaminated linens." It further reflected that "Damp laundry is not left in machines overnight."

Review of the undated facility policy "Cleaning and Disinfection of Environmental Surfaces", reflected that "Mop heads ... will be decontaminated regularly ..."

Review of the facility policy "Handwashing/Hand Hygiene" with a revised date of August 2019, reflected that "This facility considers hand hygiene the primary means to prevent the spread of infections." It also reflected that "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors." It further reflected that "Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies." It also indicated to "7. Use an alcohol-based hand rub ... or, alternatively, soap ... and water for the following situations: a.) Before and after coming on duty ... m.) After removing gloves; ... 8. Hand hygiene is the final step after removing and disposing of personal protective equipment."

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F 880	Continued From page 15 NJAC 8:39-21.1(a,d,f,g,h,j); 21.2	F 880		

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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: Part A Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was identified, and the findings were as follows: Reference: New Jersey Department of Health (DOH) 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,	S 560	No residents were identified in the SOD. Residents of the facility have the potential to be affected by the deficient practice noted in the SOD. A staffing and culture committee including Director of Nursing, Staffing Coordinator, and Administrator/designees has been convened on 1/20/2023 and will meet four 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 multiple staffing agencies as an effort to provide additional staff when needed.	2/10/23

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

Electronically Signed | 01/27/23

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 12/18/22 through 12/24/22 and 2/25/22 through 12/31/22, Revealed the staffing to residents ratios did not meet the minimum requirement f one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -12/19/22 had 4 CNAs for 41 residents on the day shift, required 5 CNAs. -12/20/22 had 4 CNAs for 41 residents on the day shift, required 5 CNAs. -12/21/22 had 4 CNAs for 41 residents on the day shift, required 5 CNAs. -12/22/22 had 4 CNAs for 39 residents on the day shift, required 5 CNAs. -12/25/22 had 4 CNAs for 37 residents on the	S 560	The facility has secured an outside recruitment company to oversee recruitment 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. Part B No residents were identified in the SOD. Residents had the potential to be affected by the lack of training of the staff. The facility designated on 1/22, two representatives: one from the	

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S 560	Continued From page 2 day shift, required 5 CNAs. -12/26/22 had 3 CNAs for 34 residents on the day shift, required 4 CNAs. -12/30/22 had 4 CNAs for 37 residents on the day shift, required 5 CNAs. -12/31/22 had 4 CNAs for 37 residents on the day shift, required 5 CNAs. On 1/11/23 at 10:04 AM, the surveyor interviewed the Staffing Coordinator (SC) who acknowledged the new minimum staffing requirements for nursing homes. She stated she tries to meet the minimum staffing ratio of one to eight to meet the needs of each resident. There was no additional information provided. Part B: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to train the two (2) appointed designated staff members and the facility staff within the required time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program. This deficient practice was evidenced by the following: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+	S 560	Management and one front-line staff member who will be the designated staff members for LGBTGI+ education and training. Education has been initiated and will be provided by a contracted organization to all the staff in the facility. Educated will be completed by or before by 2/10/2023. The NHA/designee will ensure the facility is in compliance with monthly audits and in-services and will report to the monthly quality assurance committee for follow up.	

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and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking.

Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities").

The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status.

Prohibited Actions
The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status:
1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility;
2. Denying a request by residents to share a room;
3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5);
4. Forbidding a resident from, or harassing a

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S 560	Continued From page 4 resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.	S 560		

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S 560	Continued From page 5 Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject	S 560		

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S 560	Continued From page 6 to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+	S 560		

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S 560	Continued From page 7 Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. On 1/11/23 at 9:50 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who acknowledged that he was familiar with the LGBTQI+ Law and stated he had two (2) designated staff members certificate of completion; one from administrative staff and one from direct care staff and all facility staff training, but he cannot find the binder of the trainings or the two (2) designated staff members certificates. He stated he will continue to look for the binder. He further stated that the previous admissions director who was no longer employed at the facility was the designated staff member from administrative staff with a certificate and she trained the entire facility staff. He then stated, "currently, I only have one certificate." On 1/12/23 at 11:43 AM, the LNHA stated he could not find the in-service binder and provided a copy of one certificate of completion for the LGBTQI+ Residents' Right: Designated Representative who was the previous admissions director and was no longer employed at the facility. The LNHA further stated he is enrolling two staff members; one from administration and one front line staff member for a class scheduled on 1/18/23 and "in the works" to have a company come and train all facility staff. There was no evidence of a confirmation for any staff member(s) enrolled in a class. There was no additional information provided.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
11014 Y1	A. Building B. Wing Y2	2/23/2023 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	02/10/2023	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	
1/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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	2/23/2023 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 F0732	Correction	ID Prefix F0836	Correction	ID Prefix F0880	Correction
Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.70(a)-(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	02/03/2023	LSC	02/03/2023	LSC	02/03/2023
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	

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FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/12/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING **01** B. WING _____	**01/12/2023**

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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 1/06/2023 and Atrium Post Acute Hamilton was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Atrium Post Acute Hamilton is a Single-story, Type II Protected building that was built in February 2015. The facility is divided into 4 smoke zones.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 1/06/2023, in the presence of facility management it was determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps for two (2) of six (6) exit discharge doors. This deficient practice was evidenced by the following:	K 281	" No residents were identified nor immediately affected by the lack of not having two sources of light by the two exits paths. There were no instances where the facility needed to be evacuated or use these exits identified in the SOD. All residents had the same potential to be affected by the same deficient practice. " The areas identified in the SOD was repaired/resolved on 1/25/2023 by the	2/1/23

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

Electronically Signed | 01/27/2023

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
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K 281	Continued From page 1 On 1/06/2023, during the survey entrance at 9:13 AM, a request was made to the Senior Maintenance Director (SMD) and Maintenance Director (MD), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are six (6) designated exit (Illuminated exit sign above door) discharge doors in the facility. Starting at approximately 9:40 AM, a tour of the building with the SMD and MD was conducted. During the tour, the surveyor inspected outside of 6 exit discharge door and observed the following, 1. At approximately 10:55 AM, the surveyor observed outside of exit discharge door D-4 one light bulb fixture. 2. At approximately 11:30 AM, the surveyor observed outside of exit discharge door D-6 a two light bulb fixture. The two light bulbs were not illuminated and had signs of being burnt out, the two bulbs were black. The SMD and MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 1/06/2023 at approximately 2:20 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281	maintenance director. Both exterior light fixtures over the emergency exit doors will be replaced by a licensed electrical contractor on 2/1. " All other exit paths were audited to ensure that that they have at least two sources of illumination. " The Maintenance Director/designee will audit all exit paths weekly to ensure that they have at least two sources of illumination. " Inservice education was provided the NHA to the maintenance team regarding ensuring that the exit lighting includes two sources of illumination. " The NHA/designee will conduct weekly audits to ensure there is two functioning sources of illumination and in working order for one year. Results of the audits will be presented during the Quarterly Quality assurance committee meetings.	
K 291 SS=E	Emergency Lighting	K 291		2/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING **01** B. WING _____	**01/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 291	Continued From page 2 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/06/2023, in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above one (1) of one (1) emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 1/06/2023, during the survey entrance at 9:13 AM, a request was made to the Senior Maintenance Director (SMD) and Maintenance Director (MD), if the facility had an emergency generator. The MD told the surveyor yes we have a 500 KW generator. Starting at approximately 9:40 AM, a tour of the building with the SMD and MD was conducted. During the tour at 11:14 AM, an inspection outside of the building where the emergency generator and generator's transfer switch was located was performed. The surveyor observed that the emergency generator transfer switch was located next to the generator.	K 291	" All the residents had the potential to be affected by the deficient practice. " The maintenance director or designee will ensure that the proper emergency battery backup light will be installed above the generator transfer switch and tested on a regular basis. A licensed electrician will install this by 2/1/2023 " Inservice education was provided the NHA to the maintenance team regarding ensuring that the emergency lighting is maintained in good working order. " The NHA/designee will conduct monthly checks for 3 months to ensure that it is functioning correctly. Findings will be brought to the quarterly Quality Assurance committee.	

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	315519	A. BUILDING **01** B. WING _____	**01/12/2023**

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K 291	Continued From page 3 The surveyor observed no evidence of a battery back up emergency light in the area for the generator transfer switch. At this time the surveyor asked the SMD and MD, "Do you have a battery back up emergency light out here for the transfer switch." The MD told the surveyor, "no we don't." The SMD and MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 1/06/2023 at approximately 2:20 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 1/06/2023, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being	K 521	" On 1/6/2023 immediately after we were made aware of the exhaust system not functioning properly for the residents in the rooms identified on the SOD. The	2/1/23

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K 521	Continued From page 4 properly maintained for three (3) of five (5) resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90 A. This deficient practice was evidenced by the following: On 1/06/2023, during the survey entrance at 9:13 AM, a request was made to the Senior Maintenance Director (SMD) and Maintenance Director (MD), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. The surveyor also requested, "How many Resident sleeping rooms are in the facility." The MD told the surveyor there are 35 Resident rooms. Starting at approximately 9:40 AM, in the presence of the facility's SMD and MD a tour of the building tour was performed. Along the tour the surveyor inspected five (5) resident sleeping rooms and one (1) unisex bathroom. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in three (3) of five (5) resident bathrooms in the following locations: 1. At approximately 10:16 AM, inside Resident room #101 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the SMD and MD that the exhaust system did not function properly. 2. At approximately 10:23 AM, inside Resident	K 521	NHA offered the residents a room change. Residents declined. The Director of Nursing/Designee checked the residents to ensure they were not effected and there were no negative outcomes due to the exhaust not working properly and continued until the vendor fixed the system. The Maintenance Director/Designee checked the rooms identified and no foul odor or air issues was identified. The NHA reviewed the grievance binder and interviewed staff: there wasn't any instances noted of resident complaints about the ventilation system. All residents had the potential to be affected if the proper ventilation system were not functioning properly. " The administration hired a contractor who will be replacing the system Completion Date 2/1/23 " Inservice education was provided the NHA to the maintenance team regarding ensuring that the ventilation system is kept in good working order. " The Maintenance Director or designee will conduct weekly checks for 3 months to ensure the system is working properly. The findings will be brought to the quarterly quality assurance committee.	

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	315519	A. BUILDING **01** B. WING _____	**01/12/2023**

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K 521	Continued From page 5 room #109 bathroom, when tested the exhaust system did not function properly. At this time the surveyor asked the MD how many exhaust fans do you have for the bathrooms. The MD told the surveyor that there are two (2) exhaust systems on the roof of the facility. A request was made to go onto the roof of the building to inspect the exhaust systems. At 10:28 AM, an inspection on the roof of the building was performed. This inspection identified that Unit #1 Exhaust System was not running. The MD turned off the breaker and reset the unit to the on position. The system did not function. 3. At approximately 10:58 AM, inside resident room #132 bathroom, when tested the exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The SMD and MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 1/06/2023 at approximately 2:20 PM. This was a repeat deficiency from 10/28/2020 Re-Certification survey. NFPA 90 A. NJAC 8:39- 31.2 (e).	K 521		

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	315519	A. BUILDING **01** B. WING _____	**01/12/2023**

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K 918	Continued From page 6	K 918		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		1/27/23

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K 918	Continued From page 7 Based on observation and interview on 1/06/2023, in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for one (1) of one (1) emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 1/06/2023 during the survey entrance at 9:13 AM, a request was made to the Senior Maintenance Director (SMD) and Maintenance Director (MD), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and if the facility had an emergency generator. The MD told the surveyor yes we have a 500 KW generator. Starting at approximately 9:40 AM, a tour of the building with the SMD and MD was conducted. During the tour at 11:14 AM, an inspection outside of the building where the emergency generator was located was performed. The surveyor observed that the emergency shut off was located on the generator's metal housing. At this time the surveyor requested if the facility had a Remote emergency stop button that was not on the housing of the generator. The MD told the surveyor, "no." The SMD and MD confirmed the findings at the time of observations.	K 918	" No residents were identified nor immediately affected by the lack of having a remote emergency stop button. The remote button was not used or needed to be used. " All the residents had the potential to be affected by the deficient practice if the switch needed to be used. " NHA educated maintenance team regarding the placement of the emergency stop button " The stop button was moved on 1/9/2023 to a remote location not attached to the housing of the generator. " The maintenance director or designee will conduct monthly checks for 3 months to ensure that it is functioning correctly. Findings will be brought to the quarterly Quality Assurance committee.	

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K 918	Continued From page 8 The Administrator was informed of the deficiency at the Life Safety Code exit conference on 1/06/2023 at approximately 2:20 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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 01 - MAIN BUILDING B. Wing Y2	2/23/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	02/01/2023	LSC K0291	02/01/2023	LSC K0521	02/01/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	01/27/2023	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	

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FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/12/2023	☐ YES ☐ NO