STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00176261, NJ00176273, NJ00177933, NJ00178817, NJ00179250, & NJ00179283 Survey Date: 11/06/24 Census: 182 Sample: 9 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		12/3/24

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

Electronically Signed | 11/26/2024

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 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00179283 Based on observation, interviews, medical record review, and review of other pertinent facility documents on 11/01/24, 11/04/24, and 11/06/24, it was determined that the facility failed to develop a comprehensive person-centered care plan (CP) for a resident that included action taken by staff to educate the resident regarding alternatives and consequences. The facility also failed to follow its "Care Plans - Comprehensive" policy.	F 656	Resident #9's care plans were updated to reflect education and [redacted] violations suspensions. All residents that smoke have the potential to be affected by this deficient practice. All care plans for smoking were reviewed by nursing administration to ensure interventions related to smoking violations were indicated under interventions	

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F 656	Continued From page 2 The deficient practice was identified for 1 of 9 residents (Resident #9) reviewed for CP and was evidenced by the following: On 11/06/24 Surveyor #2 observed Resident #9 seated in a wheelchair dressed in a sweatshirt and pants. The resident was NJ Exec Order 26.4b1 the wheelchair out of the elevator onto the first floor. The resident stated recalling a recent incident that involved him/her and another resident. Surveyor #2 reviewed Resident #9's Admission Record which revealed that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted] Surveyor #2 reviewed Resident #9's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b, which revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated that the resident's NJ Exec Order 26.4b1. Surveyor #2 reviewed Resident #9's progress notes which contained a social service note that revealed: NJ Exec Order 26.4b1 at 3:24 PM: "IDT met on this date ... NJ Exec Order 26.4b1 . [Resident #9] NJ Exec Order 26.4b1 [redacted] [He/She] is now NJ Exec Order 26.4b1 Surveyor #2 reviewed a NJ Exec Order 26.4b1 Notice" which was provided by the facility for Resident #9, dated NJ Exec Order 26.4b. Under the	F 656	including education. Identified deficient practice had immediate correction implemented. The Director of Nursing reviewed the facility's policy regarding Comprehensive Care Plans and noted the policy to follow state and federal guidelines. A new procedure was implemented in which the director of social work will communicate smoking violations in morning meeting. The interdisciplinary team will review and ensure the care plans are updated to reflect the residents current care needs and education provided to the resident. All clinical staff will receive in-service education by the In-Service Director regarding the development and review of comprehensive care plans. The lesson plan will concentrate on the following: Comprehensive person-centered care plans are to be developed and implemented for each resident to meet the residents' medical, nursing, and psychosocial needs that are identified in the comprehensive assessments. The in-service will include updating interventions with action taken by staff to educate the resident regarding alternatives and consequences. A copy of the lesson plan and attendance will be filed for reference and validation. The Director of Nursing/ Designee will	

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F 656	Continued From page 3 "Intervention(s)" section, two items were checked: Room search as needed, and Other 2 days. Surveyor #2 reviewed Resident #9's CP which revealed that the resident had a focus that indicated that the resident NJ Exec Order 26.4b1 that was NJ Exec Order 26.4b1. Under the "Interventions" section, revealed that staff were to, "Reeducate as needed to facility NJ Exec Order 26.4b1 rules/policy," which was initiated on NJ Exec Order 26.4b1 Further review of the CP showed no additional revision or updates. On 11/06/24, at 1:45 P.M., Surveyor #2 interviewed the U.S. FOIA (b)(6) who stated that she recalled catching Resident #9 NJ Exec Order 26.4b1. She stated that Resident #9 handed the item to her, which she destroyed. The U.S. FOIA (b) further added that the resident agreed to a room search and was NJ Exec Order 26.4b1, and that this was obtained in writing. The surveyor asked the U.S. FOIA (b) if she was responsible for updating care plans, to which she stated, "I do not update care plans and I have never been instructed to do so." On 11/06/24, at 2:47 PM, Surveyor #2 interviewed the U.S. FOIA (b)(6) who stated that Resident #9's care plan should have been updated to reflect the incident that occurred on U.S. FOIA (b)(6). Review of the facility's "Care Plans - Comprehensive" policy, reviewed 08/02/24, revealed a "Procedure" section that included, "8. The comprehensive, person-centered care plan will: ...f. Incorporate identified problem areas; g. Incorporate risk factors associated with identified problems ..."	F 656	complete weekly audits of 10% of all residents that smoke to ensure the comprehensive care plans were developed and interventions are implemented that represent the resident's current medical, nursing, and psychosocial needs. The results of these audits will be presented at monthly QA/PI. The Director of Nursing is responsible for oversight of this POC.	

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F 656	Continued From page 4 NJAC: 8:39-11.2(i); 27.1(a)	F 656		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and review of other pertinent facility documents on 11/01/24, 11/04/24, and 11/06/24, it was determined that the facility failed to ensure that the U.S. FOIA (b)(6) ensured that two staff that were currently working as U.S. FOIA (b)(6) were licensed as NJ Exec Order 26.4b1 per the facility's "Job Description" for U.S. FOIA (b)(6) [redacted] On 11/01/24, at 10:20 AM, the surveyor completed the entrance conference with Assistant Administrator (AA) #1, who stated that he had worked at the facility for 2.5 months. On 11/01/24, at 2:20 PM, Surveyor #1 requested a copy of Nursing Home license from AA #1 and AA #2. AA #1 stated that he was licensed in New York and not in New Jersey. AA #2 stated that he did not have a Nursing Home Administrator License. Both AA #1 and AA #2 stated that their job titles at the facility were U.S. FOIA (b)(6) [redacted] On 11/01/24, at 2:43 PM, AA #1 verified that he is	F 835	All residents have the potential to be affected by this cited deficient practice. All residents have the potential to be affected by this cited deficient practice, however no resident has been identified to be affected. The job description for Assistant Administrator #1 and Assistant Administrator #2 will be revised, to reflect their roles more accurately. The job description for Assistant Administrator will be reviewed and revised to reflect that a license is not needed in the job description. Both Assistant Administrators have been educated on the Assistant Administrator job description by the Regional director of operations. Any time there is a new hire as Assistant Administrator they will be given the updated job description. The Job Description for Assistant Administrators	12/3/24

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F 835	Continued From page 5 a licensed U.S. FOIA (b)(6) in New York, and not in New Jersey. A copy of the license was provided for review. Surveyor #2 reviewed the undated, "Hammonton Center Job Description" for an U.S. FOIA (b)(6) which revealed the following under the "Minimum Requirements" section, "This position requires the incumbent to be licensed as a U.S. FOIA (b)(6) ... The license must be in good standing ..." On 11/04/24 at 1:35 P.M., Surveyor #2 interviewed the U.S. FOIA (b)(6) who stated that he was aware that AA #1 and AA #2 were not licensed in the State of New Jersey as U.S. FOIA (b)(6). In the presence of the surveyor, the U.S. FOIA (b)(6) reviewed the "Hammonton Center Job Description" for U.S. FOIA (b)(6) and stated, "Oh I see it." The U.S. FOIA (b)(6) did not add any additional information. N.J.A.C.: 8:39-9.3(a), (4)	F 835	will be reviewed monthly for 3 months, and then quarterly for 3 months. The results of these audits will be presented at monthly QA/PI. The Regional Director of Operations/ Designee is responsible for the correction.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060113	A. BUILDING: _____ B. WING _____	C 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

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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 deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations. Complaint #: NJ00176261, NJ00176273, NJ00177933, NJ00178817, & NJ00179283 Survey Date: 11/06/24 Census: 182 Sample: 9	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 11 day shifts. The deficient practice was	S 560	The facility schedules were reviewed and agency staffing was added to meet the minimum requirement of direct care staff to resident requirement. All residents have potential to be affected	12/3/24

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

Electronically Signed | 11/26/24

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S 560	Continued From page 1 evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 08/11/2024 to 08/17/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -08/11/24 had 19 CNAs for 173 residents on the day shift, required at least 22 CNAs. 2. For the week of Complaint staffing from 09/29/2024 to 10/05/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows:	S 560	by this deficient practice. The facility schedules were reviewed and additional staff was added to meet the requirements for direct care staff to resident ratio. The US FOIA (b)(6) was educated by the administrator on ensuring that adequate staffing levels are reached to comply with the New Jersey state requirement for direct care staff to resident ratio. A meeting was held with administration and Nursing administration to review and discuss staffing levels. Advertisements for open CNA positions have been reviewed and updated to attract new potential employees. The administrator will audit schedules to ensure direct care staff to resident ratio requirement is met. Audits will be completed weekly x 4 weeks and monthly until compliance is met. The results of these audits will be presented at monthly QA/PI. The Administrator is responsible for execution and monitoring of this POC.	

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S 560	Continued From page 2 -09/29/24 had 20 CNAs for 182 residents on the day shift, required at least 23 CNAs. -09/30/24 had 22 CNAs for 181 residents on the day shift, required at least 23 CNAs. -10/02/24 had 20 CNAs for 180 residents on the day shift, required at least 22 CNAs. -10/04/24 had 18 CNAs for 180 residents on the day shift, required at least 22 CNAs. 3. For the 2 weeks of staffing prior to survey from 10/13/2024 to 10/26/2024, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -10/14/24 had 20 CNAs for 180 residents on the day shift, required at least 22 CNAs. -10/21/24 had 18 CNAs for 180 residents on the day shift, required at least 22 CNAs. -10/23/24 had 20 CNAs for 180 residents on the day shift, required at least 22 CNAs. -10/24/24 had 21 CNAs for 180 residents on the day shift, required at least 22 CNAs. -10/25/24 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs. -10/26/24 had 22 CNAs for 181 residents on the day shift, required at least 23 CNAs.	S 560		
S 775	8:39-9.2(a)(2) Mandatory Administration 2. In a facility with 100 beds or more, the administrator shall serve full-time in an administrative capacity within the facility. This REQUIREMENT is not met as evidenced	S 775		12/3/24

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S 775	Continued From page 3 by: Based on facility staff interview conducted during a complaint survey on 11/01/24, 11/04/24, and 11/06/24, it was determined that the facility failed to provide a full-time administrator within the facility. The deficient practice is evidenced by the following: The facility was licensed for 240 beds and the census on Friday 11/01/24 was 182. On 11/04/24, at 1:35 P.M., the Surveyor interviewed the U.S. FOIA (b)(6) who stated that he had worked at the facility full-time as the U.S. FOIA (b)(6) for approximately one year. The surveyor then asked if the U.S. FOIA (b)(6) was off on NJ Exec Order 26 Ab, since he was not present at the start of the survey. The U.S. FOIA (b)(6) stated, "I work remotely on Fridays." The U.S. FOIA (b)(6) further stated that he is in the facility for 4 days Monday to Thursday and worked remotely on Fridays and this has been his schedule while in this active role as an U.S. FOIA (b)(6).	S 775	The Administrator will serve full-time in an administrative capacity for Hammonton Center. No specific resident was identified as affected by this cited deficient practice. All residents have the potential to be affected by this. No specific resident was identified as affected by this cited practice. An Administrator should serve in a full-time capacity for the facility. This includes, but is not limited to, full time hours and as needed by the facility. US FOIA (b)(6) will be educated by the Regional Administrator about serving at the facility on a full-time basis. US FOIA (b)(6) was educated by the Regional Director of Operations on state and federal regulations requiring a full-time administrator to be employed by the facility. The regional administrator will monitor the weekly attendance of the administrator to ensure he is there in a full-time capacity. The findings will be reported to the QAPI committee monthly for 3 months, and then quarterly for 3 months. The Regional Director of Operations/ Designee is responsible for the correction.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315209	A. Building B. Wing	12/6/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 12/03/2024	ID Prefix F0835 Reg. # 483.70 LSC	Correction Completed 12/03/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO