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

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315209	B. WING			C		
NAME OF PROVIDER OR SUPPLIER			D. WING	STREET ADDRESS, CITY, STATE, ZIP CO	NDE	09/	12/2024	
INAME OF PI	ROVIDER OR SUPPLIER			43 N WHITE HORSE PIKE	יטב			
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037				
()(1)	STIMMADA ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF C	ODDECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F	000				
	Complaint #: NJ:001	64772						
	Census: 177							
	Sample Size: 3							
	42 CFR PART 483, S	SUBSTANTIAL I THE REQUIREMENTS OF SUBPART B, FOR LONG TIES BASED ON THIS						
L ABORATORY	 DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATUR	 RE	TITLE			(X6) DATE	

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

Electronically Signed

program participation.

09/27/2024

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	060113 B. WING				C 09/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE	
HAMMON	TON CENTER FOR REHA	ABILITATION AND H	TE HORSE PIK		
		НАММО	ITON, NJ 0803	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
S 000	Initial Comments		S 000		
	Complaint #: NJ 0016	4772			
	Census: 177				
	Sample Size: #3				
	Code, Chapter 8:39, \$ Long-Term Care Facil submit a plan of corre completion date, for e that the plan is impler deficiencies may resu	Jersey Administrative Standards for Licensure of lities. The facility must ection, including a each deficiency and ensure nented. Failure to correct lit in enforcement action in Provisions of the New Jersey Title 8, Chapter 43E,			
S 560	8:39-5.1(a) Mandator	y Access to Care	S 560		9/27/24
	(a) The facility shall confederal, State, and longer regulations.				
	by: Based on review of perdocumentation, it was failed to ensure staffir maintain the required ratios as mandated by	determined that the facility ong ratios were met to minimum staff-to-resident y the state of New Jersey for e deficient practice was		Element #1 The facility schedules were reviewed agency staffing was added to meet the minimum requirement of direct care st to resident requirement. Element #2 All residents have potential to be affect by this deficient practice.	e aff

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

(X6) DATE 09/27/24

STATE FORM 6899 FAWE11 If continuation sheet 1 of 3

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
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		060113		B. WING	09/12/2024				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS CITY STA	TE ZIP CODE				
TO WILL OF T	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 43 N WHITE HORSE PIKE								
HAMMON	TON CENTER FOR REHA	ABILITATION AND H		ON, NJ 08037					
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)		
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETE DATE		
S 560	Continued From page	: 1		S 560					
	(NJDOH) memo, date with N.J.S.A. (New Je 30:13-18, new minimunursing homes," indic Governor signed into codified as N.J.S.A. 3	law P.L. 2020 c 112, 0:13-18 (the Act), which staffing requirements in ollowing ratio (s) were	ance d) s for		The facility schedules were reviewed a additional staff was added to meet the requirements for direct care staff to resident ratio. Element #3 The staffing coordinator was educated ensuring that adequate staffing levels reached to comply with the NJ state	i on are			
	residents for the day s member to every 10 r shift, provided that no shall be CNAs and ea be signed into work a shall perform nurse a care staff member to night shift, provided the	Aide (CNA) to every eightshift. One direct care stesidents for the evening fewer of all staff members a certified nurse aide ide duties: and one direct every 14 residents for that each direct care staft to work as a CNA and	aff G eers shall and ct he		requirement for direct care staff to resiratio. Element #4 The administrator will audit schedules ensure direct care staff to resident ratirequirement is met. Audits will be completed weekly x 4 weeks and monuntil compliance is met. The results of these audits will be presented at monthly QAPI.	to o			
	05/14/2023 to 05/27/2 deficient in CNA staffi 14-day shifts and defi residents on 8 of 14 of -05/14/23 had 13 CN/day shift, required at 1-05/14/23 had 10 total the overnight shift, required at 1-05/15/23 had 10 total the overnight shift, required at 1-05/15/23 had 10 total the overnight shift, reduced at 1-05/15/23 had 10 total the overnight shift.	ng for residents on 14 or cient in total staff for overnight shifts as follow As for 184 residents on least 23 CNAs. I staff for 184 residents quired at least 13 total s As for 182 residents on	of the on staff. the on		The Administrator is responsible for execution and monitoring of this POC. Element #5 9/27/2024				

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New Jersey Department of Health

NAME OF PROVIDER OR SUPPLIER HAMMONTON CENTER FOR REHABILITATION AND H SUMMARY STATEMENT OF DEPOSITIONS AND HAMMONTON, NJ. 08037 TAG SUMMARY STATEMENT OF DEPOSITIONS AND HAMMONTON, NJ. 08037 TAG SORO Continued From page 2 day shift, required at least 23 CNAs05/17/23 had 20 CNAs for 182 residents on the day shift, required at least 23 CNAs05/19/23 had 22 CNAs for 182 residents on the day shift, required at least 23 CNAs05/19/23 had 22 CNAs for 182 residents on the day shift, required at least 23 CNAs05/19/23 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs05/19/23 had 12 Colast staff for 182 residents on the day shift, required at least 23 CNAs05/19/23 had 12 CNAs for 184 residents on the day shift, required at least 23 CNAs05/19/23 had 12 CNAs for 184 residents on the day shift, required at least 23 CNAs05/19/23 had 12 CNAs for 184 residents on the day shift, required at least 23 CNAs05/22/23 had 12 CNAs for 184 residents on the day shift, required at least 23 CNAs05/22/23 had 12 CNAs for 184 residents on the day shift, required at least 23 CNAs05/22/23 had 19 CNAs for 187 residents on the day shift, required at least 13 total staff05/22/23 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs05/22/23 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs05/22/23 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs05/26/23 had 15 CNAs for 180 residents on the day shift, required at least 22 CNAs05/26/23 had 15 CNAs for 180 residents on the day shift, required at least 22 CNAs05/27/23 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs05/27/23 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs05/27/23 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs05/27/23 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs05/27/23 had 19 CNAs for 180 residents on the day shift, requi	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ### STREET ADDRESS, CITY, STATE, ZIP CODE ### NAMITE HORSE PIKE HAMMONTON CENTER FOR REHABILITATION AND H ### NAMITE HORSE PIKE HAMMONTON, NJ 98037 ### PROVIDERS PLAN OF CORRECTION [EMAIL DESCRIPTION MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTFYING INFORMATION) S 560 Continued From page 2						_ c	<u>`</u>
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STATE FORM: REVISIT REPORT

	51/X121 51XIII. 1X21	NOT REPORT		
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
	A. Building			
060113 _{Y1}	B. Wing	Y2	9/30/2024	Y3
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 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).

report form).							
ITEM	DATE	ITEM		DATE	ITEM	D	ATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix S0560	Correction	ID Prefix		Correction	ID Prefix	Co	rrection
8:39-5.1(a) Reg. #	Completed	Reg. #		 Completed	Reg. #	Co	mpleted
LSC	09/27/2024	LSC		<u> </u>	LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix	Co	rrection
Reg. #	Completed	Reg. #		Completed	Reg. #	Со	mpleted
LSC		LSC			LSC		
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LSC		LSC		_	LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	BURVEYOR		DATE	
REVIEWED BY REVIEWED BY (INITIALS)		DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/12/2024			OR ANY UNCORRECT		S. WAS A SUMMARY OF T TO THE FACILITY?		□ NO

Page 1 of 1 EVENT ID: FAWE12