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 09/12/2024

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 #: NJ:00164772 Census: 177 Sample Size: 3 THE FACILITY IS 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		

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

Electronically Signed | 09/27/2024

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.

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 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	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) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ 00164772 Census: 177 Sample Size: #3 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: 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 3 of 14-day shifts. The deficient practice was evidenced by the following:	S 560	Element #1 The facility schedules were reviewed and agency staffing was added to meet the minimum requirement of direct care staff to resident requirement. Element #2 All residents have potential to be affected by this deficient practice.	9/27/24

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

Electronically Signed | 09/27/24

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 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	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) COMPLETE DATE
S 560	Continued From page 1 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. The surveyor requested staffing for the weeks of 05/14/2023 to 05/27/2023, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts and deficient in total staff for residents on 8 of 14 overnight shifts as follow: -05/14/23 had 13 CNAs for 184 residents on the day shift, required at least 23 CNAs. -05/14/23 had 10 total staff for 184 residents on the overnight shift, required at least 13 total staff. -05/15/23 had 18 CNAs for 182 residents on the day shift, required at least 23 CNAs. -05/15/23 had 10 total staff for 182 residents on the overnight shift, required at least 13 total staff. -05/16/23 had 18 CNAs for 182 residents on the	S 560	The facility schedules were reviewed and additional staff was added to meet the requirements for direct care staff to resident ratio. Element #3 The staffing coordinator was educated on ensuring that adequate staffing levels are reached to comply with the NJ state requirement for direct care staff to resident ratio. Element #4 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 QAPI. The Administrator is responsible for execution and monitoring of this POC. Element #5 9/27/2024	

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 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	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) COMPLETE DATE
S 560	Continued From page 2	S 560		

day shift, required at least 23 CNAs.
-05/17/23 had 20 CNAs for 182 residents on the day shift, required at least 23 CNAs.
-05/17/23 had 12 total staff for 182 residents on the overnight shift, required at least 13 total staff.
-05/18/23 had 22 CNAs for 182 residents on the day shift, required at least 23 CNAs.
-05/19/23 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-05/20/23 had 18 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-05/21/23 had 11 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-05/21/23 had 9.5 total staff for 183 residents on the overnight shift, required at least 13 total staff.
-05/22/23 had 17.5 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-05/22/23 had 9.5 total staff for 181 residents on the overnight shift, required at least 13 total staff.
-05/23/23 had 20 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-05/24/23 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-05/25/23 had 20.5 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-05/25/23 had 9 total staff for 180 residents on the overnight shift, required at least 13 total staff.
-05/26/23 had 16.5 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-05/26/23 had 9.5 total staff for 180 residents on the overnight shift, required at least 13 total staff.
-05/27/23 had 19 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-05/27/23 had 11 total staff for 177 residents on the overnight shift, required at least 13 total staff.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060113 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/27/2024	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
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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 9/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			