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 07/31/2024

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
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 Standard Survey Census: 172 Sample Size: 36+1 closed record C/O # NJ 163266, 167686, 168187, 168188, 168193, 168250, 169138,169607, 169928, 172022, 172065,173786, 173896, The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		9/1/24

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

Electronically Signed | 08/19/2024

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
	315209	A. BUILDING _____ B. WING _____	C 07/31/2024

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 582	Continued From page 1 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents reviewed for Beneficiary	F 582	Element #1 Residents #140 and resident #160 are not known to have NJ Ex Order 26.4(b)(1) by the deficient practice. The beneficiary	

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 07/31/2024

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 582	Continued From page 2 Protection Notification (Resident # 140 and Resident # 162. This deficient practice was evidenced by the following: A review of a facility policy on 07/29/2024 at 8:32 AM, titled Notice-Advanced Beneficiary Notice (ABN) with a creation date of 7/2019, revealed under the Policy section; The Advanced Beneficiary Notice of non-coverage (ABN) is issued by the facility to original Medicare (fee for service-FFS) beneficiaries in situations where Medicare payment is expected to be denied. Medicare requires SNF's (Skilled Nursing Facilities) to issue SNFABN to Original Medicare, also called FFS beneficiaries prior to providing care that Medicare usually covers but may not pay for in this instance because the care is: not medically reasonable and necessary or considered custodial. On 07/23/2024 at 01:45 PM, the surveyor requested 3 random residents, 1 resident who went home and 2 residents who remained in the facility beneficiary notification forms from the U.S. FOIA (b)(6) On 07/24/2024 at 12:29 PM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility as follows: 1. A review of the SNFBPNR for Resident #140 indicated that the last covered NJ Ex Order 26.4(b)(1) Day was NJ Ex Order 26.4(b)(1) and the resident remained in the facility. The SNFBPNR further revealed that a "Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage Form CMS-10055" was not given to Resident #140. There was no documentation to indicate why the form was not	F 582	notices were provided to the resident #140 and resident#160. Element #2 All residents have the potential to be affected by the deficient practice. The following actions were and will be taken: Residents with indicated that the last covered Medicare Part A Day and remained in the facility were reviewed for 90 days. Any resident identified to have not received a beneficiary notice were issued the notification. Element #3 1) The Administrator reviewed the policy on beneficiary notices and found it to be in compliance with state and federal guidelines. 2) The Inservice coordinator will provide education to: the finance director and the MDS coordinator on issuing Advance Beneficiary Notices. The in-service will include the following information: The Advance Beneficiary Notice of Noncoverage (ABN), is issued by the facility to Original Medicare (fee for service - FFS) beneficiaries in situations where Medicare payment is expected to be denied. The ABN is issued in order to transfer potential financial liability to the Medicare beneficiary in certain instances Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:	

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 07/31/2024

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 582	Continued From page 3 given to Resident #140. 2. A review of the SNFBPNR form for Resident #162 completed by the facility indicated that the last covered NJ Ex Order 26.4(b)(1) Day was NJ Ex Order 26.4(b)(1). The SNFBPNR further revealed that a "Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage Form CMS-10055" was not given to Resident #162. There was no documentation to indicate why the form was not given to Resident #162. During an interview with the surveyor on 07/24/2024 at 12:42 PM, the U.S. FOIA (b)(6) said that U.S. FOIA (b)(6) and MDS (Minimum Data Set) helped out giving notifications to residents cut from NJ Ex Order 26.4(b)(1) During an interview with the surveyor on 07/24/2024 at 01:07 PM, the U.S. FOIA (b)(6) said "I give NJ Ex Order 26 cut letter and Social Service is responsible for NJ Ex Order 26 notifications. In recent months the U.S. FOIA (b) has helped out." During an interview with the surveyor on 07/24/2024 at 01:11 PM, the U.S. FOIA (b)(6) said I have not been giving them. They took them away from me few years ago. During a follow-up interview with the surveyor on 07/24/2024 at 01:15 PM, the surveyor reviewed that residents who remained in the facility should have received a SNFABN. The U.S. FO said I know the form and will follow up. On 07/25/2024 at 09:21 AM, the surveyor confirmed with the U.S. FO that "100% the SNFABN	F 582	" not medically reasonable and necessary; or " considered custodial. PROCEDURE: Notice must be provided: " Prior to providing an item or service that is usually paid for by Medicare under Part B (or under Part A for hospice, HHA, and RNHCI providers only) but may not be paid for in this particular case because it is not considered medically reasonable and necessary " Prior to providing custodial care Timing " Prior to delivery of the item or service in question. Provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability " Prior to providing an item or service that is never covered by Medicare (not a Medicare benefit). Element #4 The Administrator developed an audit tool on issuance of beneficiary notices. Administrator/Designee will audit 20% of residents discharged from Medicare A coverage for issuance of advance beneficiary notices. The audits will be completed weekly for 4 weeks and then monthly util compliance is met. Findings of the audits will be presented and discussed at the facility□s QAPI meetings monthly, and further systematic changes will be implemented, if needed. Element #5	

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 07/31/2024

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 582	Continued From page 4 was not given to the residents." NJAC 8:39-4.1(a)(7)	F 582	Responsible Party: Administrator	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		9/1/24

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 07/31/2024

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 623	Continued From page 5 allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and	F 623		

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 07/31/2024

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 623	Continued From page 6 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Complaint #: NJ00173786 Based on interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to notify in writing, the representative of the New Jersey Long-Term Care U.S. FOIA (b) (6) office (NJ Ex Order 26.4 of resident emergency transfers to the hospital/discharges, when practicable, as mandated by Federal law. This deficient practice was identified for 2 of 37 sampled residents (Resident #54 and Resident # ADD NUMBER) and was evidenced by the following: On 07/25/2024 at 04:00 PM, a review of a facility policy titled NJ Ombudsman Mandatory Reporting	F 623	Element #1 Residents #56 and resident #516 are not known to have NJ Ex Order 26.4(b)(1) by the deficient practice. The transfer/discharge notices were provided to the U.S. FOIA (b) (6) Resident #56 and #516 were discharged from the facility with no return anticipated. Element #2 All residents have the potential to be affected by the deficient practice. The following actions were and will be taken: Residents with transfer and/or discharges	

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 07/31/2024

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 623	Continued From page 7 with last revised date of 2/2023 under procedure section Transfer/Discharge, Copies of all facility-initiated (non-resident-driven) discharge notices shall be provided to the U.S. FOIA (b) (6) 1. On 07/22/2024 at 01:29 PM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident # 54 which revealed the following: Resident # 54 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]. A review of the Discharge Return Anticipated Minimum Data Set (DRAMDS) revealed under the Entry/Discharge reporting section that Resident #54 was discharged with return anticipated on NJ Exec Order 26.4b1 [redacted]. 2. On 07/24/2024 at 10:20 AM, the surveyor reviewed the EMR for Resident #516 which revealed that the resident was admitted to the facility with diagnosis that included, but not limited to: NJ Exec Order 26.4b1 [redacted]. A review of the DRAMDS revealed under the Entry/Discharge reporting section that Resident #516 was discharged with return anticipated on NJ Exec Order 26 [redacted] During an interview with the surveyor on 07/24/2024 at 09:26 AM, the U.S. FOIA (b)(6) [redacted] said he has been here [redacted]	F 623	were reviewed for 90 days. Any resident identified to have not received a transfer/discharge notices were issued the notification retroactively. In addition, the ombudsman was sent notifications. Element #3 1) The Administrator reviewed the policy on transfer/ discharge notices and found it to be in compliance with state and federal guidelines. 2) The Inservice coordinator will provide education to: licensed nurses and the social workers on Transfer/Discharge Notices. The in-service will include the following information: Notice before transfer. Before a facility transfers or discharges a resident, the facility must- A. Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State LongTerm Care Ombudsman. B. Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; C. the notice of transfer or discharge required under this section must be made by the facility at least 30 days	

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 07/31/2024

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 623	Continued From page 8 months. When asked if he was responsible to send resident discharges to the hospital to the [U.S. FOIA (b)] the DSW replied since he has been here, he has not sent any notifications to the [U.S. FOIA (b)] of resident discharges to the hospital. He said "I wasn't told I had to do that here. I am familiar with the process." During a follow-up interview with the surveyor on 07/24/2024 at 09:28 AM, the [U.S. FOIA (b)] said I don't send [NJ Ex Order 26.4(b)(1)]) notifications. During an interview with the surveyor on 07/24/2024 at 09:31 AM the [U.S. FOIA (b)(6)] said the [U.S. FOIA (b)(6)] is responsible to send notification to the [U.S. FOIA (b)] office when residents are discharged to the hospital as well as send a monthly list. On 07/24/2024 at 10:25 AM, the [U.S. FO] told the surveyor he found the binder in the [U.S. FOIA] office, and it has not been done since the new [U.S. FOIA] started. On 07/24/2024 at 10:33 AM, a review of the binder provided by the facility contained a form titled "Discharge Log" by each Month. The form indicated resident name, discharge date, columns for Home, SNF (Skilled Nursing Facility), ALP (Assisted Living), AMA (Against Medical Advice), other as well as Home Care and DME company used. There was no column that indicated a discharge to the hospital. There was no documentation regarding the [U.S. FOIA (b)] being notified of hospitalizations. During a follow-up interview with the surveyor on 07/24/2024 at 11:56 AM, the [U.S. FOIA] said "It doesn't look like they were sending notifications of the	F 623	before the resident is transferred or discharged. Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered. (B) The health of individuals in the facility would be endangered, (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, (D) An immediate transfer or discharge is required by the resident's urgent medical needs, (E) A resident has not resided in the facility for 30 days. Element #4 The Administrator developed an audit tool on issuance of transfer/discharge notices and ombudsman notifications. Administrator/Designee will audit 20% of residents discharged from the facility and the issuance of transfer/discharge notices including ombudsman notification. The audits will be completed weekly for 4 weeks and then monthly util compliance is met. Findings of the audits will be presented and discussed at the facility□s QAPI meetings monthly, and further systematic changes will be implemented, if needed. A copy of the transfer discharge notices must be submitted to the office of the ombudsman	

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 07/31/2024

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 623	Continued From page 9 discharged residents to the hospital, just AMA and discharged to home. We will now be notifying the [U.S. FOIA (b)] of residents discharged to the hospital." On 07/25/2024 at 04:00 PM, a review of a facility policy titled NJ Ombudsman Mandatory Reporting with last revised date of 2/2023 under procedure section Transfer/Discharge, Copies of all facility-initiated (non-resident-driven) discharge notices shall be provided to the LTCO. NJAC 8:39-4.1(a) 32	F 623	Element #5 Responsible Party: Administrator	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: NJ COMPLAINT #: 169607 Based on interview and review of pertinent facility documents, it was determined that the facility failed to complete a significant change in status assessment using the Resident Assessment Instrument (RAI) process for a resident who elected [NJ Ex Order 26.4(b)] services. This deficient practice	F 637	Element #1 Resident #565 [NJ Exec Order 26.4b1] and is a closed chart therefor, a significant change MDS cannot be completed. Element #2	9/1/24

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 07/31/2024

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 637	Continued From page 10 was identified for 1 of 6 residents reviewed for accidents (Resident #565), and was evidenced by the following: A review of facility's "Electronic Submission of MDS" policy dated revised August 2023, included that all MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data...a Significant Change in Status (SCSA) Comprehensive has a MDS Completion Date is the 14th calendar day after determination of significant change in status ... A review of the facility's "Centers Health Care MDS Coordinator Job Description" document dated 12/6/22, included... Complies with federal and state regulations regarding completion and coordination of the RAI process. Maintains the frequent and accurate data entry of resident information into appropriate computerized MDS programs. The surveyor reviewed the medical record for Resident #565. A review of the Admission Record Face Sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted]	F 637	All residents have the potential to be affected by this deficient practice. All residents were reviewed for 6 months prior to determine if palliative care, comfort care, or hospice was initiated and a significant change was completed in conjunction with the referral. Identified deficient practice was immediately corrected. Element #3 The facility policy on MDS Completion and submission was reviewed and determined to be in compliance with state and federal guidelines. A new procedure was implemented for review of significant changes. Unit managers will review residents with new orders for palliative care consult and/or hospice consults. The Interdisciplinary team will discuss and determine if a significant change MDS should be initiated. The in-service coordinator/ designee will educate all unit managers, nursing administration, and MDS -on significant change MDS with emphasis on competition of a significant change MDS when a comfort care, palliative care, or hospice evaluation is ordered. Element #4 The MDS coordinator will audit 20% of all residents for palliative care, comfort care, or hospice care evaluations to ensure a significant change MDS was completed. The audits will be completed weekly x 4 weeks and then monthly until compliance	

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 07/31/2024

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 637	Continued From page 11 [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted] revealed the resident had a brief interview for mental status (BIMS) score of [redacted], which indicated NJ Ex Order 26.4b1 [redacted]. Section I - Active Diagnoses of the MDS revealed Resident #565 had an active diagnosis of [redacted] [redacted] According to section O - Special Treatments, Procedures, and Programs revealed Resident #565 received NJ Exec Order 26.4b1 [redacted] A review of the current physician's order sheet (POS) included a physician's order (PO) dated NJ Exec Order 26.4b1 [redacted]. The POS reflected a physician's order dated [redacted], for NJ Exec Order 26.4b1 related to [redacted] A review of the Progress Notes dated [redacted], included documentation that the resident was admitted to NJ Exec Order 26.4b1 [redacted], with a diagnosis of NJ Exec Order 26.4b1. A further review of the MDS assessments revealed Resident #565 had a quarterly MDS completed on [redacted]. There was no documentation that the facility completed a significant change in status assessment (SCSA) within 14 days after the resident was admitted to NJ Exec Order 26.4b1 [redacted]. During an interview with the surveyor on 7/29/24 at 1:40 PM, the US FOIA (b)(6) [redacted] stated that she was made aware of significant changes with a	F 637	is met, for a minimum of 6 months. The results of these audits will be submitted at monthly QAPI. Element #5 The MDS Coordinator is responsible for execution and monitoring of this POC.	

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 07/31/2024

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 637	Continued From page 12 resident during morning meetings or the unit manager informed her verbally. The [US FOIA (b)] [redacted] stated that a significant change in status was completed when there was a decline in the resident's status that was permanent or if a resident was NJ Exec Order 26.4b1. She also stated it should be completed within 14 days from discovery of the significant change in status. The U.S. FOIA (b)(6) confirmed that Resident #565 was admitted to NJ Exec Order 26.4b1, and that a SCSA MDS was not completed. During an interview on 7/30/34 at 1:38 PM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) and the survey team, stated when the resident was placed on hospice care, a SCSA MDS should have been completed within 14 days of the change. The surveyor reviewed the "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual", Version 1.18.11, updated October 2023, which revealed a SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). NJAC 8:39-11.2(i)	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		9/1/24

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 07/31/2024

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 656	Continued From page 13 §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 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	F 656		

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 07/31/2024

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 656	Continued From page 14 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: Based on observation, interview, review of the medical record, and review of pertinent facility documents, it was determined that the facility failed to consistently implement and revise a care planned intervention [redacted]) for 1 of 2 residents (Resident #78) reviewed for NJ Ex Order 26.4(b)(1) This deficient practice was evidenced by the following: The surveyor reviewed the facility policy titled Care Plans - Comprehensive, Last Date Revised: 10/2019. The following was revealed at POLICY: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." The following was revealed under PROCEDURE: 8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. c. Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights to refuse. i. Reflect the resident's expressed wishes	F 656	Element #1 Resident #78 care plans were updated to ensure care plan intervention o[redacted] were removed and was initiated with NJ Ex Order 26.4(b)(1) [redacted]. Element #2 All residents requiring heel bootie interventions have the potential to be affected by this deficient practice. The care plan intervention report will be reviewed for residents with heel booties. The need for this intervention was reviewed and compliance with the I tervention was addressed for identified resident without heel booties and the plan of care demonstrated the necessity for heel booties. In the case of refusals, alternative interventions were implemented to meet the resident's preference. interventions will be initiated. Element #3 The policy on comprehensive care plans was reviewed by the administrator and	

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 07/31/2024

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 656	Continued From page 15 regarding care and treatment goals. 13. Assessments of resident's are ongoing and care plans are revised as information about the residents and the residents' conditions change. On 07/22/2024 at 11:05 AM, during the initial tour of the facility the surveyor observed Resident #78 lying in bed. Resident #78 had their [redacted] and the surveyor observed Resident #78 with [redacted] The [redacted] was contracted against the [redacted], and they were in contact. The surveyor asked Resident #78 if the facility provided any intervention to help with his/her [redacted] Resident #78 [redacted] but not all the time." There was [redacted] on this observation and Resident #78 had [redacted]. On 07/23/2024 at 12:53 PM Resident #78 was observed lying in bed. Resident #78 gave the surveyor permission to lift the bed sheet to observe the resident's [redacted] Upon permission, the surveyor lifted the sheet and observed Resident #78's [redacted]. There were [redacted] in place [redacted], as described in the care plan. [redacted] were observed in the room. On 07/24/2024 at 12:00 PM Resident #78 was observed seated in a [redacted] in his/her room. Resident #78's [redacted] were observed to have [redacted] on [redacted] while in the [redacted] No [redacted] were present on this observation.	F 656	nursing administration. The policy was determined to follow state and federal guidelines. The staff educator will conduct education with Licensed nursing staff on comprehensive care plan development with emphasis on at risk for pressure ulcer development care plans specifically focusing on patient centered interventions. Element #4 The ADON/ designee will audit 10% of care plans for pressure injury risk to ensure all indicated interventions were initiated and meets the resident's preference weekly X 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI monthly. The Director of Nursing is responsible for execution and monitoring of this POC. Element #5 The Director of Nursing is responsible for execution and monitoring of this POC. This concern will be completed September 1, 2024	

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 07/31/2024

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 656	Continued From page 16	F 656		

On 07/25/2024 at 09:15 AM Resident #78 was observed lying in bed. Resident #78 permitted surveyor permission to observe resident's [redacted] under the bed covers. Upon lifting the top sheet, the surveyor observed Resident #78's [redacted] t covered with NJ Ex Order 26.4(b)(1). There were NJ Exec Order 26.4b1 present, as indicated on Resident #78's care plan. NJ Exec Order 26.4b1 were visible in the room.

On 07/30/2024 at 09:01 AM Resident #78 was observed lying in bed and watching television. Resident #78 allowed the surveyor permission to observe [redacted] under the bed sheet. Upon lifting the sheet, the surveyor observed Resident #78's feet had NJ Exec Order 26.4b1 in place and [redacted].

According to the Transfer/Discharge Report, Resident #78 was admitted to the facility with the following but not limited to diagnoses: [redacted].

A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] Resident #78 had a Brief Interview for Mental Status score of [redacted], which indicated [redacted]. Section E revealed that Resident #78 did not reject care. Section GG revealed that Resident #78 had [redacted] in NJ Ex Order 26.4(b)(1) on both sides of the NJ Exec Order 26.4b1. Resident #78 also was [redacted] on staff for [redacted] to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). Section GG further indicated Resident #78 required NJ Ex Order 26.4(b)(1) [redacted] to [redacted], and NJ Ex Order 26.4(b)(1). Section M indicated that Resident #78 was at risk

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 07/31/2024

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 656	Continued From page 17 for developing NJ Exec Order 26.4b1 but had no NJ Exec Order 26.4b1 at time of assessment. Section O revealed that Resident #78 was not currently receiving NJ Exec Order 26.4b1 . A review of the NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) Treatment Administration Record for Resident #78 did not include any reference to NJ Exec Order 26.4b1 . A review of the individualized comprehensive care plan for Resident #78 reviewed a care plan Focus of: "Resident is at risk for NJ Ex Order 26.4(b)(1) r/t (related to) NJ Exec Order 26.4b1) of NJ Ex Order 26.4(b) Date Initiated: NJ Ex Order 26.4(b)(1) ." The following was care planned as an intervention for the NJ Ex Order 26.4(b)(1) r/t NJ Ex Order 26.4(b)(1) of NJ Ex Order "NJ Exec Order 26.4b1 to be worn when in bed/remove for NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) . Date Initiated: NJ Ex Order 26.4(b)(1) ." On 07/30/2024 at 09:07 AM, the surveyor conducted an interview with the Certified Nursing Assistant (CNA #1) assigned to Resident #78 on that shift. The surveyor asked CNA #1 if f she provided Resident #78 with any special interventions, specifically NJ Exec Order 26.4b1 when caring for the resident. CNA #1 replied, "I'm not sure if the resident is to have NJ Ex Order 26.4(b)(1) or not, I'm agency. You should ask the nurse because they are more familiar with the resident." The surveyor then proceeded to interview the nurse assigned to Resident #78 on that shift. On 07/30/2024 at 09:09 AM, Registered Nurse (RN #1) stated that he regularly provided care to Resident #78. The surveyor asked RN #1 if any interventions were in place for NJ Ex Order 26.4(b)(1) . RN #1 said, "Did he/she have a NJ Ex Order 26.4(b)(1) " The surveyor stated that resident #78 did not have a NJ Exec Order 26.4b1 on surveyor	F 656		

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 07/31/2024

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 656	Continued From page 18	F 656		

observations. RN #1 then stated, "Let me check [name of electronic medical record] and see if there is an order. RN #1 told the surveyor he did not see an order for NJ Exec Order 26.4b1. He further stated, "If he/she already has an NJ Exec Order 26.4b1 they might not need them, but it would be helpful. Let me check and see if there is an NJ Exec Order 26.4b1." After going into Resident #78's room RN #1 told the surveyor, "No, he/she does not have an NJ Ex[redacted]

On 07/30/2024 at 10:45 AM, the surveyor asked Registered Nurse/Unit Manager (RN/UM #1) to assess Resident #78 to see if NJ Exec Order 26.4b1 were in place. When the surveyor and RN/UM #1 went to Resident #78's room and observed his/her NJ Ex Or after gaining permission Resident #78 was observed to have a NJ Exec Order 26.4b1 on this observation. The surveyor asked the RN/UM #1 to locate the NJ Exec Order 26.4b1. RN/UM #1 was able to find one NJ Exec Order 26.4b1 in the bottom of Resident #78's closet/cabinet next to the head of the bed. RN/UM #1 could not locate a NJ Ex Order 26.4([redacted]. RN/UM #1 then told the surveyor, "It's not an order it's a NJ Ex Order 26.4(b thing. They need to be discontinued because the resident NJ Ex Order 26.4(b)([redacted]." Resident #78 verbalized that he/she would prefer a NJ Exec Orde and did not want the NJ Exec Order 26.4b1. At that time Resident #78 told the surveyor that the last time he/she wore the NJ Exec O [redacted] was approximately 3 years ago and said, "I just want to NJ Ex Order 26.4(b)(1)."

On 07/30/2024 at 02:02 PM, the surveyors interviewed the facility U.S. FOIA (b)(6) [redacted]). The surveyor asked the U.S. FOIA (b) when are care plans updated for residents. The U.S. FOIA (b) responded, "Care plans are reviewed quarterly, when a significant event occurs, annually, and as

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 07/31/2024

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 656	Continued From page 19 needed." On 07/31/2024 at 12:34 PM, the facility U.S. FOIA (b)(6) [redacted] told the survey team that "when care plans are updated all disciplines are involved in care plan development and the unit manager is ultimately responsible for resident care plans." The facility U.S. FOIA (b) had provided the surveyor with a schedule of care plan updates for Resident #78 dating back to NJ Ex Order 26.4(b)(1) [redacted]. The review history provided revealed that Resident #78 last had their care plan updated on NJ Ex Order 26.4(b)(1) [redacted] The surveyor reviewed the facility policy titled Care Plans - Comprehensive, Last Date Revised: 10/2019. The following was revealed at POLICY: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."	F 656		
F 657 SS=D	NJAC 8:39-11.2(3)(h) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		9/1/24

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 07/31/2024

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 657	Continued From page 20 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172065 and NJ00169138 Based on interview and review of pertinent facility documents, it was determined that the facility failed to revise comprehensive care plans in a timely manner following an allegation of [redacted] This deficient practice was identified for 2 of 36 residents (Resident #515 and #265) reviewed for care plans. A review of the facility's "Care Plan" policy, last revised 10/2019, included ...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. A review of the facility's undated "Job Description Licensed Practical Nurse" document included...Participate in the development of a plan of care for each resident.	F 657	Element #1 Residents #515 and #265 are [redacted] Element #2 All residents with any allegation of abuse, care plans were reviewed for complete and timely revisions. Identified deficient practice were immediately corrected. Element #3 The Director of Nursing and Administrator reviewed the facility's policy regarding Comprehensive Care Plans and noted the policy to be compliant with state and	

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 07/31/2024

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 657	Continued From page 21 A review of the facility's undated "Job Description Registered Nurse" document included...Reviews and regularly evaluates resident care plans to meet nursing goals. A review of the facility's undated "Job Description Unit Manager" document included...Responsible for the evaluation and monitoring of all levels of resident care through on-site observations and audits, including the monitoring and the evaluation of Care Plans for quality, appropriateness and effectiveness of their unit. A review of the facility's undated "Job Description Assistant Director of Nursing" document included...Ensure resident assessments, care plan development and updates are completed within the required time frames on admission, quarterly, and with change in condition. This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical record for Resident #265. A review of the Admission Record Face sheet (an admission summary) reflected that Resident #265 was admitted to the facility with diagnosis that included, but not limited to NJ Exec Order 26.4b1 [redacted] A review of the Facility Reportable Event (FRE) dated NJ Ex Order 26.4(b)([redacted], included Resident #265 was	F 657	federal guidelines. The facility educator will provide education to licensed nurses on the review and revision of comprehensive care plans to ensure they accurately represent the resident's current medical, nursing, and psychosocial needs. The lesson plan will concentrate on the following: All comprehensive care plans should be reviewed and revised when a change in the resident's status occurs. A comprehensive care plan must be-Reviewed and revised with each event including allegations of abuse. A copy of the lesson plan and attendance will be filed for reference and validation. The lesson plan will concentrate on the following: All comprehensive care plans should be reviewed and revised when a change in the residents status occurs. A comprehensive care plan must be-Reviewed and revised with each event including allegations of abuse. A copy of the lesson plan and attendance will be filed for reference and validation. Element #4 The Director of Nursing/ Designee will complete weekly audits of 10% of all	

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 07/31/2024

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 657	Continued From page 22 involved in a NJ Ex Order 26.4(b)(1) NJ Exec Order2 [redacted] A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ Exec Order 26.4b, that [Resident #265] is at risk for NJ Exec Order 26.4b1 [redacted] The ICCP did not include an update that the resident had an allegation of NJ Ex Order 26.4(b) and what interventions were put into place after the incident. There was no evidence of an updated focus area and interventions related to the NJ Ex Order 26.4(b)(1) allegation after the incident. 2. The surveyor reviewed the medical record for Resident #515. A review of the Admission Record face sheet (an admission summary) reflected that Resident #515 was admitted to the facility with diagnosis that included, but not limited to; NJ Exec Order 26.4b1 [redacted]). A review of the Facility Reportable Event (FRE) dated NJ Ex Order 26.4(, included Resident #515 was involved in a NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ Exec Order 26.4b1 that [Resident #515] was at risk for [redacted]. The ICCP did not include an update that the resident	F 657	residents to ensure the comprehensive care plans for abuse were reviewed and revised when an allegation of abuse, neglect, mistreatment, or misappropriation has occurred to ensure the care plans accurately represent the resident's current medical, nursing, and psychosocial needs. The results of these audits will be presented at QAPI. The Director of Nursing is responsible for oversight of this POC. Element #5 The Director of Nursing is responsible for oversight of this POC.	

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 07/31/2024

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 657	Continued From page 23 had an allegation of NJ Ex Order 26.4(b)(1) with any interventions put into place after the incident. During an interview with the surveyor on 7/29/24 at 10:42 AM, the Licensed Practical Nurse (LPN #6) stated that the ICCP should have included any allegation of [redacted] because it summed up how to directly care for the resident from [redacted] to the medical need. LPN #6 further indicated that the ICCP should have been updated by the U.S. FOIA (b) (6) with any change to the resident needs. During an interview with the surveyor on 7/29/24 at 11:01 AM, the NJ Exec Order 26.4b1 [redacted] confirmed that unit managers, or Supervisors resumed the responsibility for updating the ICCP. The [redacted] described an ICCP was a way to track interventions to determine what made an impact on the resident's care. The [redacted] further explained that the ICCP was updated based on clinical meetings, chart reviews, and nurse input. The [redacted] confirmed that [redacted] allegations were to be included on the resident's ICCP. During an interview with the surveyor on 7/30/24 at 11:18 AM, the U.S. FOIA (b)(6) [redacted] identified that a ICCP should be updated with interventions following any allegation of [redacted] regardless if the [redacted] was substantiated or unsubstantiated. The [redacted] explained that the ICCP was important to update because it was to display what did and did not work with the resident, and what should be implemented to prevent another allegation of [redacted] During an interview with the surveyor on 7/31/24 at 11:18 AM, the U.S. FOIA (b)(6) [redacted]	F 657		

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 07/31/2024

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 657	Continued From page 24 U.S. FOIA (b)(6), in the presence of the U.S. FOIA (b)(6) confirmed that the ICCP was updated with any/all allegations (substantiated or unsubstantiated) of NJ Ex Order 26 with interventions.	F 657		
F 658 SS=D	NJAC 8:39-27.1(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to follow hold parameters for administration of NJ Ex Order 26.4(b)(1)) in accordance with the resident's physician's orders and in accordance with professional standards of practice. This deficient practice was identified for 1 of 36 residents reviewed for professional standards of practice (Resident #39). A review of the facility's "Medication Administration" policy dated revised 12/2023, included medications must be administered in accordance with orders, including any required time frame... Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states:	F 658	Element #1 The NP evaluated resident #39 with NJ Ex O from the omission of scheduled NJ Ex Order 26.4 The physician reviewed the NJ Ex Order 26 order and subsequently changed the order to a sliding scale with hold parameters NJ Ex Order 26. Medication error reports were completed for the resident and identified nurses were remediated on medication administration with hold parameters specifically focusing on Insulin administration. Element #2 All diabetic residents with insulin	9/1/24

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 07/31/2024

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 658	Continued From page 25 "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The evidence was as follows: On 7/22/2024 at 12:32 PM, the surveyor observed Resident #39 seated at a dining room table with another resident drinking a diet ginger ale. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1 [redacted] A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated U.S. FOIA (b)(6), reflected the resident had a brief interview for mental status score of U.S. FOIA (b)(6), which indicated a NJ Exec Order 26.4b1. A review of the Order Summary Report, included the following medication: NJ Exec Order 26.4b1 [redacted] Doses were scheduled at 8:00 AM, 12:00 PM, and 5:30 PM	F 658	administration have the potential to be affected by this deficient practice. The medication administration audit report was reviewed for residents with insulin orders with indicated holds. Holds were reviewed to ensure insulin was held in compliance with the physician order. negative outcome was noted for any identified resident. Medication errors were completed for each resident. Element #3 The Director of Nursing reviewed the policy on medication administration and determined it was in compliance with state and federal regulations. The staff educator will educate licensed nurses on professional standards with emphasis on medication administration. Course content will include ensuring insulin orders are adhered to and hold parameters are followed. Element #4 The Director of Nursing / designee will audit medication administration weekly for held administration of insulin x 4 weeks, then monthly x 6 months or until compliance is met.	

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 07/31/2024

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 658	Continued From page 26 A review of the July 2024 Medication Administration Record (MAR) revealed on five occasions the resident had [redacted] and the nurse documented "[redacted] which according to the key indicated NJ Exec Order 26.4b1". The dates were as follows: NJ Exec Order 26.4b1 [redacted] During an interview with the surveyor on 7/30/24 at 11:45 AM, the assigned Licensed Practical Nurse (LPN #1) for Resident # 39 who stated a [redacted] on the MAR indicated "NJ Exec Order 26.4b1". At that time the surveyor and [redacted] #1 reviewed the [redacted] MAR. LPN #1 acknowledged the nurse recorded the resident's [redacted] on the above referenced dates and times and confirmed the nurse should have administered the [redacted] according to the physician's orders. During an ointerview with the surveyor on 7/30/2024 at 11:58 AM, the Licensed Practical Nurse Unit Manager (LPN/UM #1) who confirmed after reviewing the [redacted] that on the above referenced dates the [redacted] was documented as [redacted] and the nurse should have administered the [redacted] as ordered according to the physician's orders. On 7/30/2024 the Survey team met with the facility Administration. The surveyor and the U.S. FOIA (b)(6) [redacted]) reviewed Resident #39's [redacted] MAR. The [redacted] confirmed the nurse indicated on the above referenced dates and	F 658	The results of these audits will be submitted at monthly QAPI x 6 months or until compliance is met. The Director of Nursing is responsible for execution and monitoring of this POC. Element #5 The Director of Nursing is responsible for execution and monitoring of this POC.	

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 07/31/2024

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 658	Continued From page 27 times the resident's [NJ Ex Order 26.4(b)(1)] and the nurse should have administered the resident's [NJ Ex Order 26.4(b)] in accordance with the physician's orders.	F 658		
F 689 SS=D	NJAC 8:39-11.2(b); 27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: NJ Complaint #:163266 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who [NJ Exec Order 26.4b1] was assessed for safety; educated on facility rules and safety for [NJ Exec Order 26.4b1]; and care planned for [NJ Ex Order 26.4(b)(] to ensure resident safety. The deficient practice was identified for 1 of 7 residents reviewed for accidents (Resident #266), and was evidenced by the following: A review of the facility's "Smoking Program" dated revised October 2022, included a [NJ Ex Order 26.4(b)(1] Assessment will be completed by the nurse for all new admissions who are identified as patients [NJ Ex Order 26.4(b)(1)]. If a resident previously identified as a	F 689	Element #1 Resident #266 is [NJ Exec Order 26.4b1] Element #2 All residents were reviewed to determine if a revision is required to the smoking care plan. Assessment will be complete on admission, quarterly and as needed to ensure smoking assessments reflected the resident's accurate smoking status and that smoking care plans with resident specific interventions in place. Identified deficient practice will have immediate corrective action.	9/1/24

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 07/31/2024

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 689	Continued From page 28 NJ Ex Order 26.4(b)(1) expresses the desire to NJ Ex Order 2 , the NJ Ex Order 26.4(b)(1 Assessment will be completed at that time...An individualized plan of care will be developed for the resident to ensure his/her NJ Ex Order 26.4(b)(safety based on the outcome of the NJ Ex Order 26.4(b)(1 Assessment... On 7/25/24 at 8:45 AM, the surveyor requested from the U.S. FOIA (b)(6) to provide a copy of Resident #266's Facility Report Event (FRE) that was reported to the New Jersey Department of Health (NJDOH). On 7/25/24 at 11:18 AM, the surveyor reviewed the closed medical Record for Resident #266. A review of the FRE dated NJ Ex Order 26.4 , which indicated Resident #266 reported that they provided NJ Exec O to the U.S. FOIA (b) (6)) to NJ Exec Order 26.4b1 . The investigation concluded that the U.S. FOI used NJ Ex Order 26.4(b)(1) to NJ Exec Order 26.4b1 for Resident #266, and that the resident had NJ Exec Order 26.4b1 Resident #266 stated that they had not seen the U.S. FO in a while and hoped that the U.S. FOIA (b)(6) would provide the resident with money. A review of the Transfer/Discharge Report face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but not limited to; NJ Exec Order 26.4b1 A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b indicated the resident had a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1 , which	F 689	Element #3 The facility policy on smoking was reviewed by administration and it was determined to be incompliance with state and federal guidelines. The staff educator gave in-service to the smoke aids and licensed nurses that smoking assessments must accurately reflect the residents current smoking status and to report any resident smoking that was previously a nonsmoker. Care plans must be reviewed and revised with targeted interventions based on the resident's smoking status. A lesson plan and sign in sheet will be kept on file for validation. Element #4 The Director of Nursing developed an audit toll for smoking assessments. The Director of nursing/ designee will audit 20% of smokers weekly x 4 weeks, then monthly x 6 months or until compliance is met of all smokers to ensure smoking assessments accurately and efficiently. The results of these audits will be presented at monthly QAPI. The Director of Nursing is responsible for the execution of this plan of correction.	

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 07/31/2024

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 689	Continued From page 29 indicated a NJ Exec Order 26.4b1. A further review in Section J "Health Conditions" reflected the resident did not use tobacco. A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ Ex Order 26.4(b) that the resident was a U.S. FOIA (b)(6) Interventions included to educate on benefits of NJ Ex Order 26.4(b)(program; educate resident on NJ Ex Order 26.4(b)(rules/policy, designated NJ Ex Order 26.4(b)(1), and that they will be regularly assessed for safety; and have all NJ Ex Order 26.4(b)(1) individually labeled and kept in secure location. The ICCP was initiated over thirty days after the resident reported the NJ Exec was purchasing them NJ Exec Order 26.4b1. A review of the Admission/Readmission Evaluation dated NJ Exec Order 26.4b, did not include the resident was a NJ Exec Order 26.4b A review of the Quarterly Evaluation dated NJ Ex Order 26.4(b, indicated the resident was a U.S. FOIA (b)(6) and could NJ Exec Order 26. safely. A review of the resident's "Smoking Rules and Safety Agreement" was signed by Resident #266 on NJ Exec Order 26.4b1 which was over thirty days after they reported the U.S. FO was purchasing the NJ Exec Order 26.4b1. During an interview with the surveyor on 7/30/24 at 10:34 AM, the U.S. FOIA (b)(6) stated that residents were assessed upon admission and quarterly for smoking which included safety; if they were able to hold their own NJ Exec Order 26.4b1. The U.S. FOIA continued that the ICCP was initiated for NJ Ex Order 26.4(b)(including interventions for safety, and residents were not permitted to NJ Ex Order 26.4(b)(1) . The U.S. FOIA stated that Resident #266 was a NJ Exec Order 26.4, and could not speak to why there was no	F 689	Element #5 The Director of Nursing is responsible for the execution of this plan of correction.	

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 07/31/2024

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 689	Continued From page 30 [redacted] assessment until [redacted] During an interview with the surveyor on 7/30/24 at 11:18 AM, the US FOIA (b)(6) stated that smoking assessments were completed upon admission and quarterly. The [redacted] stated that [redacted] was self reported by the resident, and Resident #266 NJ Exec Order 26.4b1. The [redacted] stated when the facility observed the resident ask another resident for [redacted], the facility initiated the [redacted] contract. During an interview with the surveyor on 7/31/24 at 9:16 AM, the US FOIA (b)(6) [redacted]) stated that Resident #266 initially denied NJ Exec Order 26.4b1 so that was why the [redacted] assessment and ICCP were not initiated until [redacted]. At that time, the surveyor reviewed the FRE dated [redacted], with the [redacted] that indicated Resident #266 had [redacted] at that time. The surveyor asked the [redacted] that if the facility was aware on [redacted], that the resident had [redacted] should the facility have completed a smoking contract, assessment, and ICCP at that time, and the [redacted] confirmed yes. During an interview the surveyor on 7/31/24 at 12:30 PM, the [redacted] confirmed that Resident #266 was not found smoking in areas that were prohibited.	F 689		
F 693 SS=D	NJAC 8:39-27.1(a) Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 693		9/1/24

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 07/31/2024

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 693	Continued From page 31 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to follow physician orders specifically to change the [NJ Ex Order 26.4(b)(1)] every 24 hours for 1 of 2 residents reviewed for [NJ Exec Order 26.4b1], (Resident #37.). This deficient practice was evidenced by the following: A review of facility policy on 07/24/2024 at 12:08 PM, titled Enteral Feedings with last revised date of 4/2023, did not include documentation of the care and changing of the [NJ Ex Order 26.4(b)(1)]. On 07/31/2024 at 10:26 AM, the [U.S. FOIA (b)] provided the surveyor the same policy titled Enteral Feedings. The following was highlighted under	F 693	Element #1 Resident #37 was evaluated by the physician with [NJ Ex Order 26.4(b)(1)] from this deficient practice. The resident□s [NJ Ex Order 26.4(b)(1)] was immediately replaced. Element #2 This had the potential to affect all tube fed residents. All tube fed residents were reviewed piston syringe sets that were replaced daily. No other resident was identified to be affected by this deficient practice. Element #3	

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 07/31/2024

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 693	Continued From page 32 the Procedure section: 4. Ensure that equipment and devices are working properly by performing any calibrations or checks as instructed by manufacturer. 12. Administration and feeding sets. a. Feeding may be reused for next scheduled feed as long as it is free from contamination, however; b. Replace tubing and feeding sets every 24 hours or if contamination has occurred before that time c. store in designated, clean location until next use. During the initial tour of the unit on 07/22/2024 at 11:06 AM, the surveyor observed the [NJ Ex Order 26.4] in a clear plastic bag hanging from the NJ Ex Order 26.4(b)(1) that was dated [NJ Ex Order 26.4(b)]. On 07/23/2024 at 11:58 AM, the surveyor observed the NJ Ex Order 26.4(b)(1) in a plastic bag hanging on the [NJ Ex Order 26.4] and it was dated [NJ Ex Order 26.4(b)]. A review of the Electronic Medical Record on 07/23/2024 at 11:15 AM, revealed the following: Resident #37 was admitted with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted].)	F 693	The facility policy on Tube Feeding was reviewed by the Dietician and the Director of Nursing and determined to be in compliance with state and federal guidelines. The staff educator/ designee completed in-service to all Licensed Nurses Tube feedings specifically focusing on providing a resident with a new piston and syringe daily. The lesson plan and attendance record will be kept on file for validation. Element #4 The Director of Nursing developed an audit tool. The Director of Nursing/ Designee will complete an audit of 20% of all residents with orders for tube feedings and piston syringe sets to ensure the intervention is provided to the resident daily. Audits will be completed weekly x 4 weeks and then monthly for a minimum of 6 months or until compliance is met. The results of these audits will be presented at monthly QAPI. Element #5 The Director of Nursing is responsible for the execution and monitoring of this plan of correction.	

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 07/31/2024

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 693	Continued From page 33	F 693		

A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated [redacted], revealed Resident #37 had [redacted]. The MDS further indicated that Resident #37 had a [redacted], and [redacted] were received through [redacted].

A review of the Order Summary Report with Active Orders as of [redacted] revealed a physician order to" [redacted] administration setup ([redacted]) every 24 hours every night shift for [redacted] care AND as needed when compromised."

A review of the Treatment Administration Record TAR) for [redacted] had signatures in the box for the order and was timed at 11pm for [redacted] and [redacted]

On 07/23/2024 at 11:59 AM, the surveyor accompanied by Licensed Practical Nurse/Unit Manager (LPN/UM #1) went to Resident #37's room. LPN/UM #1 confirmed the date of [redacted] on the bag and [redacted] on the [redacted]. During an interview with the surveyor at that time, LPN/UM #1 said it should be changed daily. When asked should this have been changed, she replied "yes should have been changed on the [redacted]" LPN/UM #1 discarded the set dated [redacted]

During a follow up interview with the surveyor on 07/24/2024 at 10:02 AM, LPN/UM #1 was asked to review the TAR for [redacted]. LPN/UM #1 confirmed the [redacted] was dated [redacted] and should have been changed on [redacted] and [redacted]. LPN/UM #1 said "Yes there are initials there

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 07/31/2024

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 693	Continued From page 34 (in the blocks of the TAR) and that is the user. LPN/UM #1 explained that means they signed it out on the TAR as completed." LPN/UM #1 confirmed it (NJ Ex Order 26.4b1) wasn't changed according to what we saw yesterday. During an interview with the surveyor on 07/29/2024 at 08:52 AM, the surveyor questioned as to what the facility practice was regarding use of NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) residents? The U.S. FOIA (b)(6) replied, "We change it every 24 -48 hours and label it with pt (patient) room number/or name and date. If there is a physician order to change the NJ Ex Order 26.4(b)(1) , then we will go by the physician order, and it will be documented on the TAR." The surveyor asked why it was important to change them (NJ Ex Order 26.4(b)(1)) every day? The U.S. FOIA (b) said it is part of infection control to prevent infection and NJ Ex Order 26.4(b)(1).	F 693		
F 695 SS=D	NJAC 8:39-27.1(a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the	F 695	Element #1	9/1/24

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 07/31/2024

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 695	Continued From page 35 medical record, and review of other pertinent facility records, it was determined that the facility failed to implement infection control measures for the handling and storage of [redacted] equipment for 2 of 4 residents reviewed for [redacted] care (Resident #22 and Resident #63). This deficient practice was identified by the following: The surveyor reviewed the facility policy titled Nebulizer Medication/COVID 19, Last Revised Date: 1/2023. The following was revealed under the heading POLICY: "Nebulization is used to deliver medications along the respiratory tract and is indicated for various respiratory problems and diseases. The therapy must be prescribed by a properly licensed physician or physician extender. The purpose of the procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Nebulizer treatments will be given by licensed nursing staff or respiratory therapists as directed, using proper technique and universal precautions." The following was revealed under the heading PROCEDURE: 21. "Rinse and disinfect the [redacted] equipment a. Wash pieces with warm soapy water b. Allow to air dry on a paper towel 23. "When equipment is completely dry, store in a plastic bag with resident's name and date on it. 1. On 07/22/2024 at 10:36 AM, during the initial tour of the facility the surveyor observed Resident #22 lying in bed and asleep. The surveyor observed the [redacted] placed on the top of the over bed table. The [redacted] was	F 695	1.1. Resident #22 was evaluated. The [redacted] was replaced, dated and secured at bedside 2. Resident #63 was [redacted] Element #2 All residents on nebulizer treatments have potential to be affected by this deficient practice. All residents on Nebulizer treatments were evaluated to ensure nebulizer masks and tubing were changed weekly and cleaned to manufacturer instructions with each use. Element #3 The facilities policy on Nebulizer Treatments was reviewed by the Director of Nursing and determined to be in compliance with state and federal guidelines. The staff educator completed education to all nursing staffing on Respiratory Care specifically focusing on nebulizer equipment, changing, dating, and sanitation with each use. The lesson plan and attendance record have been completed for validation.	

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 07/31/2024

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 695	Continued From page 36 undated, uncovered, and exposed while not in use. On 07/24/2024 at 12:12 PM, Resident #22 was observed lying in bed with NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was observed on the over the bed table. The NJ Exec Order 26.4b1 was not currently in use and the mask was resting on top of the bed side table. The NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 had no dates on observation. Resident #22 said "Yes" when the surveyor asked if he/she had a NJ Exec Order 26.4b1 today. Review of Resident #22's NJ Ex Order 26.4(b)(1)NJ Ex Order 26.4(b)(1) Medication Administration Record (MAR) revealed that Resident #22 received a NJ Exec Order 26.4b1 at 0900 (9:00 AM) on 7/24/2024 and the next scheduled NJ Exec Order 26.4b1 was 1300 (1:00 PM). On 07/30/2024 at 08:55 AM Resident #22 was observed lying in bed with NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 was observed on the over the bed table next to bed, as seen previously. A plastic NJ Ex Order 26.4(b)(1) NJ Exec Order 26 was on top of the table. The NJ Ex Order 26.4(b)(1) NJ Exec Order 26 was not covered and was exposed while not in use. The NJ Exec Order 26.4b1 was undated. Review of Resident #22's MAR revealed Resident #22 received a NJ Exec Order 26.4b1 at 2100 (9:00 PM) on 7/29/2024 and received a NJ Exec Order 26.4b1 According to the facility provided Transfer/Discharge Report Resident #22 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1	F 695	Element #4 The Director of Nursing developed an audit tool. The Director of Nursing/ designee will audit 20% of resident's nebulizer treatments to evaluate that: the tubing is dated and bagged when not in use; nebulizer masks are changed at a minimum of weekly; and the nebulizer mask is sanitized with each use. The audit reports will be completed weekly x 4 weeks; then monthly at a minimum of 6 months or until compliance is met. The results of these audits will be submitted at monthly QAPI. The Director of Nursing is responsible for the execution and monitoring of this plan of correction. Element #5 The Director of Nursing is responsible for the execution and monitoring of this plan of correction. The concern completion date will be September 1, 2024	

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 07/31/2024

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 695	Continued From page 37	F 695		

NJ Exec Order 26.4b1 [redacted]

A review of the Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26.4(b)(1), revealed Resident #22 had a Brief Interview for Mental Status score of NJ Exec Orde which indicated NJ Exec Order 26.4b1 [redacted]. Section O of the MDS revealed that Resident #22 received NJ Exec Order 26 [redacted] while a resident at the facility.

A review of the Order Summary Report, dated NJ Ex Order 26.4(b)(1) revealed the following physician orders for Resident #22:

'NJ Exec Order 26.4b1 [redacted]"

'NJ Exec Order 26.4b1 [redacted]

A review of Resident #22's MAR (Medication Administration Record) revealed that Resident #22 had received a NJ Exec Order 26.4b1 [redacted] and the next treatment was scheduled for 1300.

A review of Resident #22's individualized comprehensive care plan revealed a Focus of NJ Exec Order 26.4b1 [redacted]

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 07/31/2024

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 695	Continued From page 38	F 695		

failure Date Initiated: [NJ Exec Order 26.4b1]." The following intervention was included in the care plan under Interventions/Tasks: '[NJ Exec Order 26.4b1] Commonly used for the [NJ Exec Order 26.4b1] & medications per MD orders. Date Initiated: [NJ Ex Order 26.4(b)(1)]."

On 07/25/2024 at 09:50 AM, Resident #22 was observed on the [NJ Exec] hallway speaking with the nurse at the medication cart between room [NJ Exec O]. Resident #22 had [NJ Exec Order 26.4b1]. After gaining permission to enter Room [NJ Exec Order] from Resident #22's roommate, the surveyor observed Resident #22's [NJ Exec Order 26.4b1] on top of the over the bed table. The [NJ Exec Order 26.4b1] was not in use and was observed to be lying on top of a sheet of paper that appeared to be a word search puzzle. The [NJ Ex Order 2] was [NJ Ex O] and was exposed while not in use. The nurse asked the resident if he/she had a [redacted] this AM and the resident stated, "Yes."
The surveyor then interviewed the Licensed Practical Nurse (LPN #2) previously observed speaking with Resident #22. The surveyor asked what the facility practice was for [NJ Exec Order 26.4b1] maintenance between treatments. LPN #2 stated, '[NJ Exec Order 26.4b1] should be covered when not in use because of germs" LPN #3 further stated that both nursing and [NJ Exec Order 26.4b1] staff were responsible for maintaining the protection of [NJ Exec Order 26] equipment when not in use, specifically keeping the [NJ Exec Order 26.4b1] covered when not in use."

2. On 07/22/2024 at 11:20 AM, the surveyor

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 07/31/2024

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 695	Continued From page 39 observed Resident #63 in their room during the initial tour of the facility. Resident #63 was [NJ Ex Order 26.] and [NJ Ex Order] The surveyor observed a [NJ Exec Order 26.4b1] on top of bedside table. The [NJ Exec Order 26.4b1] was dated [NJ Exec Order 26.4b]." The [NJ Exec Order 26.4b1] was lying on top of the bedside table and was exposed while not in use. Resident #63 stated that he/she had received [NJ Exec Order 26.4b1] treatments twice a day when asked by the surveyor. On 07/23/2024 at 08:50 AM the surveyor observed that Resident #63 was out of the room at this time. The surveyor observed a [NJ Exec Order 26.4b1] on top of the bedside table. The mask was resting on top of a plastic bag and was not in use. The [NJ Exec Order 26.4b1] was exposed while not in use. On 07/24/2024 at 12:28 PM Resident #63 was observed lying in bed. Resident #63 stated that they are to [NJ Ex Order 26.4(b)(1)]. The surveyor observed a [NJ Exec Order 26.4b1] on the bedside table as seen on previous observations. The [NJ Exec Order 26.4b1] was not in use and was not bagged and was exposed while not in use. A review of Resident #63's Transfer/Discharge Report revealed that Resident #63 was admitted to the facility with the following but limited diagnoses: [NJ Exec Order 26.4b1] A review of Resident #63's comprehensive MDS, dated 6/28/2024, revealed that Resident #63 had a BIMS score of [NJ Exec Order 2] indicating [NJ Exec Order 26.4b1]. Review of section J indicated Resident #63 had [NJ Exec Order 26.4b1] and while [NJ Ex Orde]. Section O indicated Resident #63 was	F 695		

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 07/31/2024

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 695	Continued From page 40 receiving [redacted] while a resident in the facility. A review of Resident #63's Order Recap Report with Order Date: [redacted] indicated Resident #63 had the following physician orders: "Change and date [redacted] and storage bag once weekly on Sunday every night shift every Sun for [redacted]. Order Date: [redacted]" "Rinse and disinfect [redacted] equipment after each use Wash pieces with warm soapy water. Allow to air dry on a paper towel. Store only when completely dry every shift for [redacted] maintenance Order Date: [redacted]" [redacted] four times a day for [redacted] A review of the [redacted] MAR revealed that Resident #63 received a [redacted] treatment on [redacted]. A review of Resident #63's individualized comprehensive care plan revealed a care plan Focus of "Resident has an alteration in respiratory system r/t [redacted]) Date Initiated: [redacted]" The following was a care planned Intervention: "Administer treatments [redacted] & medications per MD orders. Date Initiated: [redacted]" On 07/25/2024 at 09:40 AM, the surveyor observed a [redacted] placed on top of	F 695		

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 07/31/2024

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 695	Continued From page 41 bedside table in Resident #63's room. The [redacted] was not in use and was not covered. The [redacted] was exposed on the bedside table. The surveyor then conducted an interview with the nurse assigned to Resident #63 on that shift. The surveyor asked LPN #3 while in Resident #63's room if the [redacted] should be protected when not in use. LPN #3 stated, "Well, it's not being used right now but it should be covered when it's not being used." The surveyor asked LPN #3 why the [redacted] should be covered when not in use. "It's an [redacted] issue." The surveyor then asked LPN #3 who was responsible for making sure the [redacted] equipment is stored properly when not in use? LPN #3 responded, "It could be anybody but usually the CNA's or nurses who are responsible for maintaining the [redacted] equipment." On 07/30/2024 at 01:34 PM, the surveyor conducted an interview with facility administration, which included the [redacted]. The surveyor asked what the facility expectation was for [redacted] when they are not in use by a resident receiving treatment. The [redacted] told the surveyor, "The expectation is that the machine is cleaned, and the [redacted] and [redacted] are to be cleaned, air dried, and bagged between use once dried. It is important to bag between uses for sanitation and infection control."	F 695		
F 755 SS=D	N.J.A.C. 8:39- 27.1 (a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		9/1/24

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 07/31/2024

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 755	Continued From page 42 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 forms) were completed with sufficient detail	F 755	Element #1 No resident was negatively affected by this deficient practice. Order form numbers 221690894;	

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 07/31/2024

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 755	Continued From page 43 to enable accurate reconciliation for 3 of 3 forms provided. The evidence was as follows: A review of the facility's provided "Medication-Narcotic Management" policy with a revised date of 4/2023 did not include information related to the completion of the DEA 222 forms. On 7/30/2024 at 10:15 AM, the surveyor reviewed the facility provided DEA 222 forms which revealed on three of the three provided forms Part 5, had not been completed upon receipt of the medications from the provider pharmacy as instructed on the reverse of the ordering form. The forms were as follows: Order form number: 221690894; 221690895; and 221690896. On 7/30/2024 at 1:39 PM, the surveyor and U.S. FOIA (b)(6) reviewed the provided DEA 222 forms. The [redacted] acknowledged she should have completed the Part 5 as instructed on the reverse of the DEA 222 form as required. A review of the Instructions for DEA Form 222, under Part 5. Controlled Substance Receipt, 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item... NJAC 8:39-29.7(c)	F 755	21690895; and 221690896 Part 5 were updated in compliance with DEA guidelines. Element #2 All DEA 222 forms were reviewed for omission of Part 5 on the form. Immediate corrective action was initiated for deficient practice. Element #3 The facility policy on medication administration and Controlled Drugs were reviewed by the Director of Nursing and determined to be in compliance with state and federal guidelines. The staff educator/ designee educated licensed nurses on pharmacy services ensuring that the designated licensed nursing staff follows the established Instructions for DEA Form 222, under Part 1. Including but not limited to: Controlled Substance Receipt, 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item Element #4 The Director of Nursing/designee will audit DEA form 222 upon receipt of	

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 07/31/2024

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 755	Continued From page 44	F 755	narcotics orders to ensure all sections are fully completed appropriately according to DEA requirements. The audit will be completed weekly x 4 weeks; then monthly x 6 months or until compliance is met. The results of these audits will be submitted at QAPI monthly. Element #5 The Director Of Nursing is responsible for the execution and monitoring of this POC.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 812	Element #1	9/1/24

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 07/31/2024

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 812	Continued From page 45 other faciloirty documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: A review of the facility policy titled Food Storage, Last Date Revised 7/19/2023, revealed the following under the heading POLICY: "Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination." The following was revealed under the PROCEDURE section: 10. "Food will be stored a minimum of 6 inches above the floor, 18 inches from the ceiling and 2 inches from the wall on clean racks or other clean surfaces, and is protected from splashes, overhead pipes, or other contamination (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.). 12. "Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 24-72 hrs (hours). Check state regulations as state regulations may allow shorter time frames for use of leftovers." 13. Refrigerated food storage:	F 812	1. The sausage and zucchini were discarded. 2. The lettuce, carrots, and coleslaw were discarded from the freezer. 3. The wall mounted paper towel holder had paper towels placed in them. 4. A thermometer was placed in the white refrigerator/freezer in front of the dietary office. The unknown food in the Styrofoam container was discarded. 5. The thickened water identified was discarded. 6. The identified nested pots were re-washed and allowed to dried prior to storing. 7. The dishwasher was serviced and paper plates, plastic utensils were used until corrected. 8. The reach-in refrigerator was serviced and repaired. . Element #2 All residents have the potential to be affected by this deficient practice. Based on resident record review, there was no signs or symptoms of food borne illness therefore there was no identified resident affected by this deficient practice.	

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 07/31/2024

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 812	Continued From page 46 a. "All refrigerator units will be clean and in good working condition at all times." b. "TCS (temperature control for safety) foods must be maintained at or below 41 degrees F unless otherwise specified by law. Periodically take temperatures of refrigerated foods to assure temperatures are maintained at or below 41 F. Temperatures for refrigerators should be between 35 to 39 F. Thermometers should be checked at least two times each day." c. "Every refrigerator must be equipped with an internal thermometer." f. "All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded." 14. Frozen Foods: c. "All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. All frozen leftovers must be used within 30 days." The surveyor reviewed the facility provided copy of the Daily Cleaning Schedule for the facility kitchen, undated. Review of the schedule did not include cleaning of the reach-in refrigerator daily. The surveyor reviewed the facility policy titled Dish Washing and Storage Policy, Last Date Revised: 01/17/2024. The following was revealed under POLICY: "Dishes, pot and pans will be washed and dried using procedures, chemicals and equipment that result in clean, sanitized dishes, pans, flatware, and utensils."	F 812	Element #3 The facility administrator reviewed policy on Food Procurement and determined to be compliant with state and federal regulations. The staff educator will give an in-service to all dietary staff on food procurement, prepare and serve sanitary food. The in-service will specifically focus on: 1.Dating all open packages 2.Ensuring the paper towel holder is full next to the sink. 3. All refrigerators and freezers have thermometers placed in them. 4. Undated food is not placed in the refrigerator, freezers. 5. Food is not kept past the expiration date. 6. Pots and pans are dried and not nested. 7. Ensuring the dishwasher is functioning with appropriate dispensing of the cleaning agent. 8. Refrigerators are free from standing water and identified leaks are serviced immediately. Pooled water should be cleaned up and the area should be	

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 07/31/2024

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 812	Continued From page 47 The policy revealed the following under the heading PROCEDURE: Dish Machine Washing: 3. "Dish machine temperatures are logged at each meal on the Dish Machine Temperature log." 4. Staff will monitor dish machine temperatures throughout the dishwashing process b. Low Temperature Dishwasher: Spray Type Dish Machine Using Chemicals to Sanitize Minimum Wash Temperature: 120 F Final Rinse Temperature 120 F and sanitization 50 ppm Hypochlorite (chlorine). "Dishes, pots, pans, utensils and flatware must be air dried before being stored, Do not dry with towels." 7/ "Employees are trained in proper dishwashing and drying procedures. Staff will be trained to report any problem with the dish machine to the director of food and nutrition services as soon as they occur." The surveyor reviewed the facility policy titled FOOD FROM OUTSIDE-SAFETY, Last Date Revised: 5/2019. The following was revealed under the Monitor section: "Facility staff will be appointed to check resident refrigerators for proper temperatures, food containment and quality, and disposal of items per facility policy." On 7/22/2024 from 9:17 to 9:50 AM, the surveyor in the presence of the facility U.S. FOIA (b)(6)	F 812	sanitized. 1.Dating all open packages 2.Ensuring the paper towel holder is full next to the sink. 3. All refrigerators and freezers have thermometers placed in them. 4. Undated food is not placed in the refrigerator, freezers. 5. Food is not kept past the expiration date. 6. Pots and pans are dried and not nested. 7. Ensuring the dishwasher is functioning with appropriate dispensing of the cleaning agent. 8. Refrigerators are free from standing water and identified leaks are serviced immediately. Pooled water should be cleaned up and the area should be sanitized. Element #4 The administrator developed an audit tool. The administrator/ Designee will complete audits of the kitchen to ensure the kitchen operates in a safe and sanitary manner to prevent food born illness. The audits will review: Dating on packages; Discarding of expired food/ beverage; paper towel holders; thermometer placement; dish machine functioning including sanitizer distribution and temperature; presence of unidentified containers; nested pots and pans; Presence of pooled water in refrigerators and timely servicing of kitchen equipment.	

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 07/31/2024

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 812	Continued From page 48 U.S. FOIA (b)(6) observed the following in the kitchen: 1. On an upper shelf/rack in the walk-in freezer a package of frozen sausage was removed from its original container and had no dates. In addition, a clear garbage size bag contained what appeared to be frozen zucchini slices. The bag had no dates. 2. In the walk-in refrigerator a previously opened clear plastic bag on a middle shelf contained chopped lettuce. The bag had a manufacturer's "best if used by" date of "07-19-24." On the same shelf, a clear plastic bag contained chopped lettuce and carrots. The lettuce appeared slimy, and the bag had a manufacturer's "best if used by date" of "06/27/24." On an upper shelf a 10 pound container of cole slaw had been previously opened. The cole slaw had a manufacturer's "Best If Used By" date of "07/20/24." 3. The surveyor approached the designated hand washing sink to get a paper towel to perform hand hygiene. There were no paper towels in the wall mounted paper towel dispenser. 4. A white refrigerator/freezer in front of the dietary office had no internal thermometer in the freezer to monitor freezer temperatures. In addition, styrofoam take-out style container in the refrigerator that contained unknown food contents had no dates. A(U.S. FOIA (b) (6)) threw the container in the trash. On 07/25/2024 at 08:46 AM, on the 2nd Floor Pantry (NJ Exec Order 26.4b) the surveyor, accompanied by the facility U.S. FOIA (b)(6) observed the following:	F 812	The audits will be completed weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be presented at QAPI monthly. Element #5 Responsible Party: Facility Administrator The concern completion date will be September 1, 2024	

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 07/31/2024

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 812	Continued From page 49	F 812		

1. In the bottom left drawer of the pantry refrigerator, used to store resident food and beverage, (19) 4oz containers of "Thick & Easy moderately thick/honey consistency" thickened waters used for residents had a "Use by Jun 22, 24" manufacturer's label. In addition, four (4) more containers of the same product were observed on the lower shelf of the refrigerator door and had "Use By Jun 22, 24" manufacturer's date. According to the [redacted] on interview it (thickened beverages) was normally kept in the nutrition closet on the unit and then the nurses would stock the fridge as needed. The surveyor asked the [redacted] who was responsible for ensuring the use by dates of products in the pantry refrigerator. The [redacted] replied, "The nurse is absolutely responsible for checking the use by date when stocking the fridge." The [redacted] removed the expired thickened waters to the trash.

On 07/30/2024 from 09:53 to 10:23 AM the surveyor, accompanied by the U.S. FOIA (b)(6) [redacted], observed by the following in the kitchen:

1. In the three compartment sink/manual dish washing area a [redacted] was actively washing pots and pans. Observation of the pot/pan drying rack revealed (4) quarter pans stacked on top of each other. The surveyor lifted the top pan and observed a wet/watery, clear substance on the bottom of the pan below (wet nesting, occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow). The [redacted] agreed the pans were not air dried prior to stacking and instructed the [redacted] to rewash and air dry the quarter pans before

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 07/31/2024

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 812	Continued From page 50 stacking. 2. At approximately 10:00 AM, kitchen staff were actively using the low temperature dish machine after the breakfast meal. When asked to see the dish machine temperature log the [redacted] stated, "It's hanging on the wall." (opposite wall of dish machine). Observation of the temperature log revealed that no wash/rinse or sanitizer ppm levels (parts per million) had been recorded for the breakfast on 7/30/2024. The kitchen had a low temperature dish machine, according to the [redacted] and it had a minimum wash and final rinse temperature of 120 Fahrenheit (F). The [redacted] told the surveyor that they used chlorine as the sanitizing agent. At that time the facility had cleaned several racks of pellet bottoms and lids and several racks of hard plastic trays used to serve resident food. Upon observation of the sanitizer container mounted on the wall (a sanitizing agent that utilizes sodium hypochlorite to sanitize dishware) the [redacted] stated that "it was empty." The [redacted] then went to the [redacted] at the three compartment sink and asked for another bottle of sanitizer. The [redacted] handed the [redacted] an approximate half bottle of sanitizer from the designated chemical closet and stated that he had more down stairs. After replacing the empty bottle of sanitizer, the [redacted] restarted the dish machine, and a [redacted] assisted the surveyor in putting an empty plastic pellet lid in the plastic dish rack and the [redacted] then proceeded to run the rack through the wash and rinse cycle which was observed at 120 F. The rack that contained the pellet lid exited the dish machine after going through a full wash and rinse cycle. The [redacted] obtained a white chlorine test strip and dipped the test strip into the dishwater that had collected in the pellet lid from the wash and rinse cycle. The	F 812		

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 07/31/2024

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 812	Continued From page 51	F 812		

test strip remained white after dipping it into the collected dish machine water, indicating that no chlorine was present or 0 ppm. The surveyor then requested the [U.S. FOIA] to attempt a second test of the sanitizer by passing the pellet lid in the dish rack through the machine a second time. The [U.S. FOIA] dumped the previous dish water from the pellet lid. Upon placing the rack in the machine, the surveyor and [U.S. FOIA] observed that the pump for the chlorine sanitizer was not pulling the sanitizer completely through the wall mounted pump and the chlorine sanitizer remained in the pump tubing, which was visible through the clear tubing and was unable to enter the dishwater to sanitize dishes. The [U.S. FOIA] shut down the dishwasher at this point and told the surveyor they would contact the foodservice contract company to do necessary repairs. The surveyor told the [U.S. FOIA] that all trays and pellet lids that had been washed would have to be rewashed and sanitized. The [U.S. FOIA] agreed. The surveyor re-visited the kitchen at approximately 11:30 AM and the repair service had not arrived at that time. The surveyor observed the kitchen dish room, and all dish washing could be confirmed as stopped when the [U.S. FOIA] shut down the dish machine. The [U.S. FOIA (b)] stated that paper products will be used for the lunch meal and until the machine is repaired. A review of the service invoice dated 2024-07-30T16:03:00, revealed the following: "Final rinse sanitizer not working. Replaced a bad injector fitting and chemical line. Issue resolved. The sanitizer was test (sic) and adjusted to 50-100 ppm."

2. Observation of the floor of the reach-in refrigerator revealed an approximate 1/4 to 1/2 inch level of clear liquid fluid on the floor of the refrigerator. When asked what the fluid was the

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 07/31/2024

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 812	Continued From page 52 [redacted] stated, "The line is leaking. We need to get a new refrigerator, but we have been using a shop type vacuum to remove the water. It just really started to leak." Beverages (iced tea containers) were observed to be above the level of the water on the bottom of the fridge. No active leakage was observed by the surveyor. NJAC 18:39-17.2(g)	F 812		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 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: 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 as mandated by the state of New Jersey. This was evident for 7 of 14-day shifts and Certified Nursing Assistants (CNAs) to total staff on 2 of 14 evening shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	Element #1 The facility schedules were reviewed and staffing was added to meet the minimum requirement of direct care staff to resident requirement. All allegations of abuse for the past 90 days were reviewed to determine if clearing house reporting was required. CN A#2, LPN#4, LPN#5 and RN#2 were reported to the NJ clearing house to meet state guidelines. LPN#4, LPN#5, RN#2 and CN A#2 are no longer an employee at Hammonton	9/1/24

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

Electronically Signed | 08/19/24

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 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 a facility provided policy, titled, "Staffing Hours," with a revised date of 4/2019; under #2 The facility strives to meet New Jersey state requirements for minimum staffing: A) One certified nurse aide to every eight residents for the day shift. B) 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 certified nurse's aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and C) 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 certified nurse aide and perform certified nurse aide duties.	S 560	Center. Element #2 All residents have potential to be affected 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. No resident was affected by LPN#4, LPN#5, RN#2 and CN A#2 not being reported to the clearing house. Element #3 The staff educator in-serviced the staffing coordinator and the administrator on: 1. Ensuring that adequate staffing levels are reached to comply with the NJ state requirement for direct care staff to resident ratio. 2. The process to report a nurse for substantiated narcotic diversion. 3. Reporting to appropriate agencies such as Clearing House Element #4 The administrator will audit schedules to ensure direct care staff to resident ratio requirement is met. The administrator will audit all allegations of staff to resident abuse reports weekly x4 weeks then monthly x 4 months to	

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 1. For the week of Complaint staffing from 04/02/2023 to 04/08/2023, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts and deficient in total staff for residents on 7 of 7 overnight shifts as follows: -04/02/23 had 12 CNAs for 179 residents on the day shift, required at least 22 CNAs. -04/02/23 had 10 total staff for 179 residents on the overnight shift, required at least 13 total staff. -04/03/23 had 17 CNAs for 179 residents on the day shift, required at least 22 CNAs. -04/03/23 had 11 total staff for 179 residents on the overnight shift, required at least 13 total staff. -04/04/23 had 16 CNAs for 179 residents on the day shift, required at least 22 CNAs. -04/04/23 had 11 total staff for 179 residents on the overnight shift, required at least 13 total staff. -04/05/23 had 19 CNAs for 179 residents on the day shift, required at least 22 CNAs. -04/05/23 had 12 total staff for 179 residents on the overnight shift, required at least 13 total staff. -04/06/23 had 18 CNAs for 185 residents on the day shift, required at least 23 CNAs. -04/06/23 had 10 total staff for 185 residents on the overnight shift, required at least 13 total staff. -04/07/23 had 15 CNAs for 185 residents on the day shift, required at least 23 CNAs. -04/07/23 had 11 total staff for 185 residents on the overnight shift, required at least 13 total staff. -04/08/23 had 13 CNAs for 185 residents on the day shift, required at least 23 CNAs. -04/08/23 had 7 total staff for 185 residents on the overnight shift, required at least 13 total staff. 2. For the week of Complaint staffing from 09/17/2023 to 09/23/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows:	S 560	ensure the clearing house and all other agencies were notified. Audits will be completed weekly x 4 weeks and monthly x6 months until compliance is met. The results of these audits will be presented at monthly QAPI. Element #5 The Administrator is responsible for execution and monitoring of this POC.	

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 3 -09/22/23 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. -09/23/23 had 17 CNAs for 150 residents on the day shift, required at least 19 CNAs. 3. For the week of Complaint staffing from 10/01/2023 to 10/07/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -10/06/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. 4. For the 3 weeks of Complaint staffing from 10/29/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 5 of 21 day shifts as follows: -10/31/23 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/02/23 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/06/23 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/10/23 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -11/11/23 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. 5. For the week of Complaint staffing from 01/28/2024 to 02/03/2024, there were no deficient practices identified for staffing as submitted. 6. For the 2 weeks of Complaint staffing from 03/03/2024 to 03/16/2024, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -03/03/24 had 17 CNAs for 163 residents on the	S 560		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 4 day shift, required at least 20 CNAs. -03/04/24 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -03/10/24 had 19 CNAs for 158 residents on the day shift, required at least 20 CNAs. -03/11/24 had 19 CNAs for 158 residents on the day shift, required at least 20 CNAs. -03/15/24 had 19 CNAs for 162 residents on the day shift, required at least 20 CNAs. 7. For the week of Complaint staffing from 05/12/2024 to 05/18/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -05/12/24 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -05/13/24 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. 8. For the 2 weeks of staffing prior to survey from 06/30/2024 to 07/13/2024, the facility was deficient in CNA staffing for residents on 1 of 14-day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -07/04/24 had 11 CNAs to 34 total staff on the evening shift, required at least 17 CNAs. 07/10/24 had 19 CNAs for 166 residents on the day shift, required at least 21 CNAs. During an interview with the surveyor on 07/29/24 at 10:12 AM, the Assistant Director of Nursing (ADON) acknowledged that they do not always meet the staffing criteria despite over staffing for each shift due to last minute call outs. The ADON indicated that the state regulations for staffing are: Day shift 1 CNA to every 8 residents;	S 560		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 5 Evening shift, 1 CNA to every 10 residents, and Night shift 1 CNA to every 14 residents. Part B NJ Complaint #: 167686; 168188; 173896 Based on interview and review of pertinent facility documents, it was determined that the facility failed to notify the Clearing House Coordinator of a.) a Certified Nursing Aide (CNA #2) who NJ Ex Order 26.4(b)(1) a resident's (Resident #265); b.)a Registered Nurse (RN #2) and a Licensed Practical Nurse (LPN #4) who NJ Ex Order 26.4(b)(1) a Resident (Resident #122) without a physician's order; and c.) LPN #5 who diverted a resident's (Resident #61) NJ Ex Order 26.4(b)(1) medication as mandated by the State of New Jersey. This deficient practice was identified for 3 of 13 investigations reviewed and the findings were as followed: Reference: New Jersey Administrative Code Title 13 Law and Public Safety Chapter 45E Health Care Professional Reporting Responsibility. Subchapter 3: 13:45E-3.1 Notification to the Clearing House Coordinator by a Health Care Entity a) Except as provided in (c) below, a health care entity shall file a report with the Clearing House Coordinator concerning a health care professional who is employed by, under contract	S 560		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 6 to render professional services to, has clinical privileges granted by that health care entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry if: 1) For reasons relating to health care professional's impairment, incompetency or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety, the health care entity: i) Summarily or temporarily revokes or suspends or permanently reduces, suspends or revokes the health care professional's full or partial clinical privileges or practice; ii) Removes the health care professional from the list of eligible employees of health services firm or staffing registry; iii) Discharges the health care professional from the staff of the health care entity; or iv) Terminates or rescinds a contract with the health care professional to render professional services: A review of the facility's "Abuse" policy dated reviewed 6/1/24, included the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility...The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect,	S 560		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 7 mistreatment, and/or misappropriation of property...Reporting [...] notify the local law enforcement and appropriate State Agency (s) immediately (no later than two hours after allegation/identification of allegation) by Agency's designated process after identification of alleged/suspected incident... The policy did not include to report to the Clearing House Coordinator. 1. On 7/25/24 at 9:33 AM, the surveyor reviewed the closed medical record for Resident #265. A review of the Transfer/Discharge Report face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but not limited to; [redacted] A review of the Investigation form dated [redacted] indicated that on [redacted], the resident reported funds o[redacted] were missing from their [redacted] The conclusion of the investigation revealed that Certified Nursing Aide (CNA #2) made [redacted] from the resident's [redacted] to the CNA's [redacted] using a [redacted] application. CNA #2 was terminated from the facility. During an interview with the surveyor on 7/29/24 at 11:01 AM, the Registered Nurse/Unit Manager (RN/UM) stated that if a resident reported an allegation of [redacted] it was reported to the Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON) who investigated the allegation. The RN/UM stated that a full investigation was completed including gathering witness statement and notifying the	S 560		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 8 New Jersey Department of Health (NJDOH). During an interview with the surveyor on 7/30/24 at 11:18 AM, the Director of Nursing (DON) stated that the facility investigated all allegations of [NJ Ex Order 26] by first sending the suspected staff member home pending the allegation, then gathering statements from staff, the resident and any witnesses. The DON stated that if an allegation of [NJ Ex Order 26] was substantiated against a CNA, then the facility notified the NJDOH and the NJDOH Licensing Department. The surveyor asked what the purpose of the Clearing House Coordinator was for, and the DON stated to allow facilities to know if a staff member had a pending allegation of [NJ Ex Order 26] or substantiated allegation of [NJ Ex Order 26] The surveyor asked if the facility reported CNAs to the Clearing House, and the DON stated that she had never reported a CNA, but she thought the facility would. The DON stated that the ADON reported any CNAs to licensing. On 7/30/24 at 11:41 AM, the surveyor requested from the DON confirmation that CNA #2 was reported to the Clearing House Coordinator. During an interview with the surveyor on 7/30/24 at 11:47 AM, the ADON stated she was responsible for reporting allegations of [NJ Ex Order 26] to the NJDOH. The ADON stated if the allegation of [NJ Ex Order 26] was substantiated for a CNA, she completed the state required "FRIDAY" form to the NJDOH Licensing Department. The ADON stated she was not familiar with the Clearing House Coordinator, and she had never reported a staff member to it. During an interview with the survey team on 7/30/24 at 1:31 PM, in the LNHA in the presence of the Assistant Administrator (AA), DON, and	S 560		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 9 Senior Resource Director stated they were not familiar with reporting to the State Clearing House Coordinator. No additional information was provided. 2. On 7/25/24 at 9:24 AM, the surveyor conducted a record review for Resident #122 which revealed the following: A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but was not limited [redacted] A review of the significant change Minimum Data Set (MDS), an assessment tool, dated [redacted] reflected a brief interview for mental status score (BIMS) of [redacted] which indicated [redacted] A review of a Clinical Note dated NJ Exec Order 26.4b1 [redacted], indicated that the interdisciplinary team (IDT) had a high-risk meeting regarding the resident's care, which included the social worker following up with the resident regarding the NJ Exec Order 26.4b1 [redacted] A review of the facility's reportable event investigation submitted to the New Jersey Department of Health (NJDOH) on NJ Exec Order 26.4b1 [redacted] indicated Resident #122 was reported to have been NJ Exec Order 26.4b1 by certain members of the nursing staff on or about the NJ Exec Order 26.4b1 Review of the facility's investigation form dated NJ Ex Order 26.4(b [redacted] for incident dated NJ Ex Order 26.4(b [redacted] concluded that Resident #122 had been NJ Exec Order 26.4b1	S 560		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 10 [redacted] by RN #2 and LPN #4. The conclusion further included that "a reasonable person would conclude that [redacted] and [redacted] did occur." 3. On 7/25/24 at 11:32 AM, the surveyor conducted a record review for Resident #61 which revealed the following: A review of the Face Sheet reflected that the resident was admitted to the facility with diagnoses that included but was no [redacted] A review of the quarterly MDS dated [redacted] reflected a BIMS of [redacted] which indicated [redacted]. A review of the resident's physician order summary report included an order with start date [redacted] tablet [redacted] to give [redacted] A review of the facility's reportable event investigation submitted to the New Jersey Department of Health (NJDOH) on [redacted] at 1:39 PM, indicated Resident #61's [redacted] medication blister pack was reported to have been missing with investigation and LPN #5 was suspended. Review of the facility's investigation form dated [redacted] with incident date [redacted] concluded that LPN #5 was responsible for the drug diversion and had been terminated following the investigation.	S 560		

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 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION	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 11 During an interview on 7/30/24 at 1:31 PM, in the presence of the survey team, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), Director of Nursing (DON), and Senior Resource Director (Administration team) who stated they were not familiar with reporting to the State Clearing House Coordinator, and the DON was unable to provide documentation to support having reported LPN #4 and RN #2 to the state nursing board. NJAC 8:39-5.1(a)	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315209 Y1	A. Building B. Wing Y2	9/3/2024 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 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 F0582	Correction	ID Prefix F0623	Correction	ID Prefix F0637	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(b)(2)(ii)	Completed
LSC	09/01/2024	LSC	09/01/2024	LSC	09/01/2024
ID Prefix F0656	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	09/01/2024	LSC	09/01/2024	LSC	09/01/2024
ID Prefix F0689	Correction	ID Prefix F0693	Correction	ID Prefix F0695	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(4)(5)	Completed	Reg. # 483.25(i)	Completed
LSC	09/01/2024	LSC	09/01/2024	LSC	09/01/2024
ID Prefix F0755	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	09/01/2024	LSC	09/01/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
7/31/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060113	A. Building B. Wing	9/3/2024

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 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 09/01/2024	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	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

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	
7/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
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 07/29/2024 and 07/30/2024 and Hammonton Center For Rehabilitation and Healthcare 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. Hammonton Center For Rehabilitation and Healthcare is a two-story, Type I Fire Resistant building that was built in January 1984. The facility is divided into 13 smoke zones. The facility has one 180 KW Diesel Emergency Generator that supplies about 60% of the buildngs electrical power in the event of electric power loss to the building.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/30/2024 in the presence of the Maintenance Assistant 1 (MA1), Maintenance Assistant 2 (MA2) and Environmental Services (EVS), it was	K 211	Element #1 All stored items in the basement corridor that were restricting access removed.	9/1/24

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

Electronically Signed | 08/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 211	Continued From page 1 determined that the facility failed to ensure that the means of egress was maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101: 2012 Edition, Sections 19.2.1, and 7.1.10.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:33 PM, revealed that the exit access corridor in the basement was being used to store items on both sides of the hallway restricting usage and limiting usable space to 37-inches. In an interview at the time of observation, the MA1, MA2 and EVS confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2(e)	K 211	Element #2 All residents had the potential to be affected. Element #3 Maintenance director will conduct audits of all exit corridors to ensure they are not restricted. The audits will be weekly x4 and monthly until compliance is met. Education was provided to the U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. These audits will be documented in a new audit sheet that was created on 8/11/2024. Element #4 The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the	K 222		9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 222	Continued From page 2 clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 222	Continued From page 3 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 7/30/24 in the presence of the Maintenance Assistant 1 (MA1), Maintenance Assistant 2 (MA2) , and Environmental Services (EVS), it was determined that the facility failed to ensure that doors with installed delayed-egress systems were properly labeled and functioning in accordance with NFPA 101:2012 edition, Sections 19.2.2.5 and 7.2.1.6. This deficient practice was observed for 2 of 16 tested doors, had the potential to affect all residents and was evidenced by the following: An observation at 9:35 AM, revealed that the "Front Stairwell" delayed-egress door on the first floor was not provided with a readily visible sign that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". In an interview at the time of observation, the MA1, MA2 and EVS confirmed the observation. An observation at 10:15 AM, revealed that the "A Back" egress door was provided with a delayed-egress locking system that did not release the lock in the direction of egress within 15 seconds when tested by the MA1. The lock did release with the door access code.	K 222	Element #1 A new sign was placed on the "Front Stairwell" that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". Element 2 - All residents had the potential to be affected. Element 3 □ Maintenance director will conduct monthly checks of all doors with delayed egress to ensure they have a readily visible sign. Education was provided to the U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. These audits will be documented in a new audit sheet that was created on 8/11/2024. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 222	Continued From page 4 In an interview at the time of observation, the MA1 and MA2 confirmed the observation. The facility's U.S. FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference at 3:00 PM.	K 222	Administrator/Maintenance Director	
K 300 SS=F	N.J.A.C 8:39-31.2 (e) Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/29/24 and 7/30/24 in the presence of the Maintenance Assistant 1 (MM1), Maintenance Assistant 2 (MM2) and Environmental Services (EVS), it was determined that the facility failed to maintain a complete membrane of the ceiling in a room where sprinklers, smoke, or heat detectors are installed in the room or area served by the ceiling in accordance with NFPA 101:2012 sections 8.4.4.1, 4.6.1.2 and NFPA 13 Installation of Sprinkler Systems . The ceiling acts to trap the heat and smoke and allows the sprinklers or	K 300	Element 1 □ New celling tiles were placed in the 2nd floor Air Exchange room. The missing 24-inch x 48-inch ceiling tile in the Social Worker/Maintenance Director's office was replaced. The missing ceiling tiles of various shapes and sizes in the Air Exchange room on the first floor were replaced. Element 2 - All residents had the potential to be affected.	9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING 01 B. WING _____	07/31/2024

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
K 300	Continued From page 5 detectors to operate. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 7/29/24 at 12:52 PM, revealed approximately 3 missing ceiling tiles of various shapes and sizes were missing in the Air Exchange room on the second floor. In an interview at the time of observation,, the MM1 confirmed the observation. An observation on 7/30/24 at 10:17 AM revealed a missing 24-inch x 48-inch ceiling tile in the U.S. FOIA (b)(6) office. In an interview at the time of observation, the MM1 and MM2 confirmed the observation. An observation on 7/30/24 at 10:30 AM, revealed approximately 4 missing ceiling tiles of various shapes and sizes were missing in the Air Exchange room on the first floor. In an interview at the time of observation, the MM1, MM2, and EVS confirmed the observation. The facility's U.S. FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 7/30/24 at 3:00 PM N.J.A.C 8:39-31.2(e) NFPA 13	K 300	Element 3 □ Maintenance director will conduct monthly audits of all rooms that require ceiling tiles to ensure there are none missing. Education was provided to the U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. These audits will be documented in a new audit sheet that was created on 8/11/2024. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 321	Continued From page 6 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/30/24 in the presence of the Maintenance Assistant 1 (MA1), Maintenance Assistant 2 (MA2), and Environmental Services (EVS), it was determined that the facility failed to protect hazardous area enclosures in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 19.3.5.9, 19.7.5.7, 8.4, and 7.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 321	Element 1 □ A automatic door closer was placed on the soiled linen room doors. The laundry room doors were adjusted to ensure that the doors close into the frame and have to gap wich is not in compliance. Element 2 - All residents had the potential to be affected. Element 3 □ Maintenance director will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 321	Continued From page 7 An observation at 12:55 PM, revealed that the soiled linen room (over 50 sq. ft.) in the basement contained soiled linens exceeding 64 gallons. The door was not self-closing or automatic closing. In an interview at the time of observation, the MA1, MA2, and EVS confirmed the observation. An observation at 1:05 PM, revealed that the laundry room (larger than 100 sq.ft.) was not separated from other spaces by smoke resisting doors. The doors were self closing or automatic closing, but when tested by the MA1 one of the doors did not close into its frame leaving a 1 and 1/4 inch space at the meeting edges of the doors. In an interview at the time of observation, the MA1, MA2 and EVS confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2(e)	K 321	conduct monthly audits off all doors that are required to be self-closing and not have a gap to ensure they are in compliance. Education was provided to the U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. These audits will be documented in a new audit sheet that was created on 8/11/2024. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director	
K 344 SS=F	Fire Alarm - Control Functions CFR(s): NFPA 101 Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/29/24 in the presence of the Maintenance Assistant 1	K 344	Element 1 □ The plastic electrical box which was jammed into the smoke	9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING 01 B. WING	07/31/2024

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
K 344	Continued From page 8 (MA1), it was determined that the facility failed to ensure that the fire alarm would automatically activate required control functions in accordance with NFPA 101:2012 Edition, Sections 8.5.5.7.3, 9.6.5.2, 19.3.4.4 and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice had the potential to affect all residents and was evidenced by the following An observation at 12:52 PM in the second floor air exchange room, revealed that a plastic electrical box was jammed into the smoke damper controlled louvers that would prevent closure upon activation of the fire alarm system. In an interview at the time of the observation, the MA1 confirmed the observation, removed the plastic electrical box and stated that they were not sure how it got in there. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 7/30/24 at 3:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 72	K 344	damper-controlled louvers, was removed. Element 2 - All residents had the potential to be affected. Element 3 □ Maintenance director will conduct monthly audits of all smoke dampers to ensure there is nothing in the way preventing the automatic closer upon activation of the fire alarm system. Education was provided to the U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. These audits will be documented in a new audit sheet that was created on 8/11/2024. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director	
K 361 SS=F	Corridors - Areas Open to Corridor CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by:	K 361		9/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING 01 B. WING	07/31/2024

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
K 361	Continued From page 9 Based on observation and interview on 7/29/24 in the presence of the Maintenance Assistant 1 (MM1) and Maintenance Assistant 2 (MM2), it was determined that the facility failed to ensure that spaces open to the corridor were in accordance with NFPA 101:2012 Edition, Sections 19.3.6.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:50 PM, revealed that the dining room on the second floor was 1 of 4 dining/ lounging spaces that were open to the corridor and not protected by an electrically supervised automatic smoke detection system. In an interview at the time of the observation, the MM1, MM2 and EVS confirmed the observation The facility's NJ Exec Order 26.4b1 was notified of the deficient practice during the Life Safety Code exit conference on 7/30/24 at 3:30 PM.	K 361	Element 1 □ The facility's fire safety will install a new electrically supervised automatic smoke detector in the second-floor dining room. Element 2 - All residents had the potential to be affected. Element 3 □ Maintenance director will conduct monthly audits of all open areas to ensure they are in accordance with NFPA regulation. Education was provided to the U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. These audits will be documented in a new audit sheet that was created on 8/11/2024. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director. Documentation of completed work will be uploaded as soon as it is available.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that	K 374		9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING 01 B. WING _____	07/31/2024

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
K 374	Continued From page 10 resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observationss and interview on 7/29/24 and 7/30/24 in the presence of the Maintenance Assistant 1 (MA1), Maintenance Assistant 2 (MA2) and Environmental Services (EVS), it was determined that the facility failed to ensure that smoke barriers were provided with doors that were self-closing or automatic-closing and restricted the passage of smoke in accordance with NFPA 101:2012 Edition, Sections 19.3.7.6 and NFPA 105, Standard for Smoke Door Assemblies and other opening protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 7/29/24 at 12:30 PM on the 2nd floor near the salon, revealed that upon testing of the smoke barrier doors conducted by the MM1 and MM2, the doors did not close into the frame leaving a 1.5-inch gap at the meeting edges of the doors. An observation at 1:00 PM on B-Wing, revealed that the smoke barrier doors did not close into the frame leaving a 1-inch gap at the meeting edges of the doors. An observation at 1:22 PM on C-Wing, revealed	K 374	Element 1 □ The doors 2nd floor near the salon, B-Wing, C Wing, 1st floor A, C, D wing was all repaired and there is no gap between or under the doors. Element 2 - All residents had the potential to be affected. Element 3 □ Maintenance director will conduct monthly audits of all smoke barriers to ensure there are no gaps. These monthly audits will be documented in a new audit sheet that was created on 8/10/2024. Education was provided to the U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 374	Continued From page 11 that the smoke barrier doors did not close into the frame leaving a 1-inch gap at the meeting edges of the doors. Additionally, there was a 1-inch space under the door. An observation on 7/30/24 at 10:10 AM on the first floor, revealed that upon testing of the A-Wing smoke barrier doors conducted by MA1 and MA2 , there was a 1-inch space under the door when tested An observation at 10:50 AM on C-Wing, revealed that smoke barrier doors did not close into the frame leaving a 1-inch gap at the meeting edges of the doors. An observation at 11:10 AM on D-Wing, revealed that the door closer did not function to prevent the door from closing, leaving a 24-inch gap between the doors when tested. In interviews at the time of tests and observations, the MA1 and MA2 confirmed the observations. The facility's U.S. FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 7/30/24 at 3:00 PM N.J.A.C 8:39-31.2 (e) NFPA 105	K 374		
K 521 SS=E	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	K 521		9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING 01 B. WING _____	07/31/2024

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
K 521	Continued From page 12 specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 7/29/24 and 7/30/24 in the presence of the Maintenance Assistant 1 (MA1) , it was determined that the facility failed to maintain ventilation and related equipment in resident bathrooms in accordance with NFPA 101:2012 Edition, Sections 19.5.2.1, 9.2.1 and NFPA 90A. This deficient practice had the potential to affect various residents on multiple units and floors and was evidenced by the following: An observation on 7/29/24 at 1:00 PM, revealed that the bathroom ventilation in room B215 was not functioning when tested by the MA1. An observation at 1:08 PM, revealed that the bathroom ventilation in room B204 was not functioning when tested by the MA1. An observation on 7/30/24 at 10:10 AM, revealed that the bathroom ventilation in room A106 was not functioning when tested by the MA1. An observation at 10:26 AM, revealed that the bathroom ventilation in room B102 was not functioning when tested by the MA1. In interviews at the time of the observations, the MA1 confirmed the observations after each test. The facility's U.S. FOIA (b)(6) was notified of the	K 521	Element 1 □ The bathroom exhaust in room B215, B204, A106,B102 were repaired and are now functional. Element 2 - All residents had the potential to be affected. Element 3 □ Maintenance director will conduct monthly audits of all bathroom exhaust to ensure they are working correctly. Education was provided to the U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. These audits will be documented in a new audit sheet that was created on 8/11/2024. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 521	Continued From page 13 deficient practice during the Life Safety Code exit conference on 7/30/24 at 3:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 90A	K 521		
K 532 SS=F	Escalators, Dumbwaiters, and Moving Walks CFR(s): NFPA 101 Escalators, Dumbwaiters, and Moving Walks 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and interview on 7/29/24 and 7/30/24 in the presence of Environmental Services (EVS), it was determined that the facility failed to maintain written records for elevators in accordance with NFPA 101:2012 Edition, Section 9.4.6, 9.4.6.1, 9.4.6.2, and ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice had the potential to affect all residents and was evidenced by the following: Documention review on 7/29/24 at 11:00 AM, revealed that the facility did not have a written record of the findings for the monthly fire fighters'	K 532	Element 1 □ Maintenance director tested and documented monthly fire recall testing of elevator car #1 & #2. Element 2 - All residents had the potential to be affected. Element 3 □ Maintenance director will conduct monthly testing of Fire Recall in elevator Car #1 & 2. Maintenance director will audit inspection books Quartey to ensure testing is being done and documented. Education was provided to the	9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 532	Continued From page 14 emergency operations in the provided inspection books. In an interview at 12:30 PM , a request to EVS was made for the documentation. EVS stated that they would get in contact with the elevator company if they could not find the documentation in the maintenance logs. Documentation was provided from the elevator servicing company stating that the Fire Recall testing for the elevators is performed at the premises during its regular maintenance service visits, but no indication on the frequency of the testing was provided. Monthly operations with a written records of the findings were not made and kept on the premises. The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code exit conference on 7/30/24 at 3:00 PM. N.J.A.C 8:39-31.2 (e) ASME A17.1/CSA B44	K 532	U.S. FOIA (b) (6) to ensure facility is incompliance with NFPA 101 code. These audits will be documented in a new audit sheet that was created on 8/11/2024. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is	K 741		9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING 01 B. WING _____	07/31/2024

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
K 741	Continued From page 15 prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/29/24 in the presence of the Maintenance Assistant 1 (MM1) , it was determined that the facility failed to ensure that ashtrays of noncombustible material and metal containers with self-closing cover devices were provided and readily available in all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:20 PM, revealed that 3 of the 4 smoking ashtrays provided in the smoking area were made of combustible material and a metal container with a self -closing cover device was not readily available. In an interview at the time of observation, the MA1 confirmed the observations. The facility's U.S. FOIA (b)(6) was notified of the	K 741	Element 1 □ On 8/1/2024 EVS replaced the Ashtrays with metal ones that are fire rated. Element 2 - All residents had the potential to be affected. Element 3 □ EVS director will conduct monthly audits of smoking area to ensure proper metal ashtrays are in place and in working order. These audits will be documented in a new audit sheet that was created on 8/11/2024. Education was provided to the U.S. FOIA [redacted] to ensure facility is using the correct Ashtrays. Element 4 - The maintenance Director/Designee will report any negative findings to the Administrator and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**07/31/2024**

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
K 741	Continued From page 16 deficient practice during the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2(e)	K 741	Quality Assurance Committee monthly x3 months for review and action as needed. Element 5 - Responsible Party Administrator/Maintenance Director	

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
315209 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/3/2024 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 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	09/01/2024	LSC K0222	09/01/2024	LSC K0300	09/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	09/01/2024	LSC K0344	09/01/2024	LSC K0361	09/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	09/01/2024	LSC K0521	09/01/2024	LSC K0532	09/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0741	09/01/2024	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 7/31/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO