STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT HAMILTON	**1501 STATE HWY 33 HAMILTON SQUARE, NJ 08690**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint # : NJ00149893 Census: 92 Sample : 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		11/30/21

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

Electronically Signed | 11/26/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: C# : NJ00149893 Based on observation, interviews, and medical record review, as well as review of pertinent facility documents, it was determined that the facility failed to maintain a safe environment for 2 of 3 residents (Resident #1 and Resident #2) observed during Environmental tour. This deficient practice is evidenced by the following: 1. According to the "Admission Record (AR)", Resident #1 was admitted to the facility on [redacted] with diagnoses that included but were not limited to the following: [redacted] The Minimum Data Set (MDS), an assessment tool dated [redacted] showed that Resident #1 was [redacted] and [redacted]	F 584	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. F584 1. On 11/10/21, the portable heater that was found in the room of resident #1 and resident #2 was removed immediately and taken out of the facility. 2. All residents have the potential to be	

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F 584	Continued From page 2 NJAC 8:43E-2.1 and Exec from the staff with NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1 2. According to the AR, Resident #2 was initially admitted to the facility on NJAC 8:43E-2.1 an and readmitted on NJAC 8:43E-2.1 , with diagnosis that included but was not limited to the following: NJAC 8:43E-2.1 and Exec Order 26 The MDS, an assessment tool dated NJAC 8:43E-2.1 a showed that Resident #2's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. and required NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. from the staff with NJAC 8:43E The medical records for Resident #1 and Resident #2 showed that they were both transferred to room NJAC 8:43E-2.1 and Exec Order 26, 4 During the tour on 11/10/21 at 9:44 am, the surveyor observed a portable electric heater (PEH) inside room NJAC 8:43 (room of Resident #1 and Resident #2). The PEH (warmwave model) was plugged into the electric wall and in use. The PEH was at low setting heat during the tour. The surveyor did not observe any flammable material/substance inside room NJAC 8:43 . The Housekeeping Director (HD, also overseeing maintenance department) entered the room and checked the room temperature which was at 76.6 degrees Fahrenheit. The surveyor conducted an interview with Resident #2 on 11/10/21 from 9:44 am to 9:50 am. Resident #2 stated that when they moved them in room NJAC 8:43E the room was cold and it feels uncomfortable. Resident #2 reported it to the staff (unable to recall the name) and he brought in the PEH and plugged it into the electric wall. Resident #2 revealed that staff (nurses, CNAs,	F 584	affected by this practice. The Administrator and the Housekeeping Director made rounds in each of the resident rooms in the facility and did not find any other portable heater in any of the rooms. 3. To ensure that the no portable heating device/appliance, i.e. space heater, is used in the facility, the staff in the facility were inserviced on 11/10/21, that no portable heaters are allowed in all areas of the facility. 4. The Maintenance Director, or designee, will conduct environmental rounds, every two weeks x 6 (3 months), paying strict attention to presence of portable heaters, to make sure that there are no portable heaters in the facility. Staff were instructed to report to the Administrator, or designee, any heaters that is found in the facility. Results will be reviewed by the Quality Assurance Committee which meets quarterly, until such a time consistent substantial compliance has been achieved as determined by the committee. Findings of this audit will be discussed with the Resident Council. Corrective action completion date: November 30, 2021	

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F 584	Continued From page 3 housekeeping) knew about it because they come in and out of room [NJAC 8:43] The surveyor conducted an interview with the multiple staff (including Administrator and HD) on 11/10/21 from 9:50 am to 12:45 pm. The staff could not explain who brought in the PEH in room [NJAC 8:43E] The Administrator stated that portable electric heaters are not allowed in the facility especially in resident/s rooms. The [NJAC 8:43E-2.1 and Exec Order 26, 4. b, 1.], 1500-Watt Electric Portable Heater under product overview showed "...Ceramic Heater spreads heat for maximum heating comfort..." The facility's policy titled "Space Heaters" revised on 8/2021, under "Protocol: 1.) Portable Heaters are not allowed in all areas of the facility. Maintenance, Housekeeping and Administration will monitor during daily rounds to ensure that there are no portable heaters in the facility. 2.) Staff will report any heaters found in the facility to administration". NJAC 8:39-31.7 (f)	F 584		

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
315111 Y1	A. Building B. Wing Y2	12/6/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT HAMILTON	1501 STATE HWY 33 HAMILTON SQUARE, NJ 08690

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/10/2021	☐ YES ☐ NO