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 02/03/2025

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 #: NJ 172211, #175979, #177635, #182108 Survey Date: 2/3/25 Census: 117 Sample: 28 + 3 Closed Records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		2/28/25

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

Electronically Signed | 02/28/2025

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
	315111	A. BUILDING _____ B. WING _____	C 02/03/2025

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 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to promote and maintain resident dignity a.) while providing NJ Ex Order 26.4(b)(1) and b.) for a resident with a NJ Ex Order 26.4(b)(1). This deficient practice was identified for 4 of 16 residents reviewed for dignified dining (Resident #11, #51, and #72) and 1 of 2 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #52). The evidence was as follows: 1. On 1/29/25 at 12:15 PM, the surveyor observed resident dining in the NJ Ex Order 2 Wing resident dining room. The surveyor observed a Licensed Practical Nurse (LPN) NJ Ex Order 26.4(b)(1) Resident #72, while standing alongside the resident at the resident's table. There were five empty and available chairs near the LPN while she remained standing over the resident who was	F 550	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident # 72 was NJ Ex Order 26.4(b)(1) by the nurse NJ Exec Order 26 the resident while standing. The nurse involved was provided with 1:1 re-education on 1/30/2025 by the nurse educator regarding resident dignity when providing feeding assistance. Resident #72, #51 and #11's tray slips were corrected. The new software being utilized in the kitchen has been updated on 1-30-2025 to remove the labeling of "feeder" on the meal tickets by the Regional Food Service Director. The urine drainage bag was immediately placed inside the privacy bag for resident	

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 02/03/2025

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 550	Continued From page 2 seated in a NJ Ex Order 26.4(b)(1) at the table. On 1/29/25 at 12:20 PM, the surveyor interviewed the Certified Nursing Aide (CNA) who was in the dining room, who stated that staff should have been seated alongside the resident while providing NJ Ex Order 26.4(b)(1). On 1/29/25 at 12:23 PM, the surveyor observed the CNA replace the LPN with assisting Resident #72 with NJ Ex Order 26.4(b). The LPN walked away from the table, and at that time the surveyor interviewed the LPN, who stated that the proper way to assist a resident with NJ Ex Order 26.4(was to sit alongside the resident to maintain eye contact and dignity. On 1/30/25 at 1:48 PM, the surveyor reviewed Resident #72's medical record. A review of the resident's Admission Record face sheet (an admission summary) indicated the resident was admitted to the facility with diagnosis which included but was not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the resident's physician's Order Summary Report indicated the resident had a NJ Ex Order 26.4(b)(1). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4 indicated that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated NJ Ex Order 26.4(b)(1). A further review of the MDS reflected the resident required NJ Ex Order 26 to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26. On 1/31/25 at 12:00 PM, the surveyor interviewed	F 550	# 52. The C.N.A. involved was provided with 1:1 re-education by the facility nurse educator on 1/30/2025 of the importance of maintaining resident dignity with emphasis on putting the NJ Ex Order 26.4(b)(1) inside the NJ Ex Order 26.4(b)(1). Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who require feeding assistance or have an indwelling urinary catheter have the potential to be affected by the cited practices An immediate audit was conducted of the meal tickets for the labeling of “feeder.” The tickets identified with the labeling of “feeder” were corrected. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The facility policy for Urinary Catheters has been reviewed and updated to include the use of privacy bags to provide for resident dignity. This was completed on 2/4/2025. The nursing staff were educated of the updated policy by the nurse educator, this was initiated on 2/4/2025 and ongoing. The nurse educator and designee have re-educated nursing staff on 2/7/2025 and its ongoing regarding promoting resident dignity when providing feeding assistance to the residents. The Dietary management team will maintain the software to assure the labeling of “feeders” does not appear on the meal tickets for residents. Dietary staff	

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 02/03/2025

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 550	Continued From page 3 the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), who both stated that when NJ Ex Order 26.4(b)(residents with NJ Ex Order 26.4(b)(1), staff should be seated alongside the resident and not have been standing over them for dignity concerns. On 2/3/25 at 10:13 AM, the U.S. FOIA (b) in the presence of the survey team acknowledged that staff should always be seated when assisting residents with NJ Ex Order 26.4 2. On 1/30/25 at 11:36 AM, during a follow-up kitchen inspection, the surveyor observed three meal trays being prepared by the kitchen staff with individual resident meal slips placed on them. Upon closer review of the meal slips, it was observed for each slip to have Resident #11, #51, and #72's names on each slip with the term 'NJ Ex Order 26.4(b)(1 printed below each resident's name. The surveyor continued to monitor and followed the meal trays which each still had the resident's meal slip on them as they were delivered to the main dining room. Staff then passed the trays out to the individual residents and the meal slips remained on the tray on the table in front of the residents. On 1/30/25 at 1:48 PM, the surveyor reviewed Resident #11's medical record. A review of the resident's Admission Record face sheet indicated the resident was admitted to the facility with diagnosis which included but was not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)). A review of the resident's quarterly MDS dated NJ Ex Order 26.4(, indicated that the resident had a BIMS	F 550	have been educated by the Food Service Director on 2/4/25 and ongoing on this aspect of resident dignity with dining related to meal tickets. These in-services will be given during the orientation for newly hired nursing and dietary staff, annually and as deemed necessary. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Nursing Unit Managers or designee will conduct weekly meal service observations for 10 residents who require feeding assistance, covering all meals to assure that staff are promoting dignity when providing assistance for 4 weeks and then monthly for 4 months. Negative findings will be addressed through one-on-one in-service, and progressive disciplinary actions as appropriate. The nurse Infection Preventionist will perform an audit for 5 residents with urinary catheters for 4 weeks and then monthly for 4 months to assure compliance with the Urinary Catheter policy specific in providing privacy bags. The Dietary management team will conduct audits for 10 meal tickets for residents who require feeding assistance weekly x 4 and monthly x 3. Negative findings will be addressed through education, and or progressive disciplinary measures as appropriate. The results of all audits will be submitted to the QAA committee, who meets quarterly for review and will determine the necessity for further audits and recommendations.	

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 02/03/2025

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 550	Continued From page 4 score of [NJ] out of 15, which indicated [NJ Ex Order 26.4] [redacted]. A further review of the MDS reflected the resident required [NJ Ex Order 26.4(b)(1)] to NJ Ex Order 26.4(b)(1) with [NJ Ex Order 26.4] On 1/30/25 at 1:48 PM, the surveyor reviewed Resident #51's medical record. A review of the resident's Admission Record face sheet indicated the resident was admitted to the facility with diagnosis which included but was not limited to; NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)(1)] A review of the resident's quarterly MDS dated [NJ Ex Order 26.4(b)(], indicated that the resident had a BIMS score of [NJ] out of 15, which indicated [NJ Ex Order 26.4] [redacted]. A further review reflected the resident was [NJ Ex Order 26.4(b)(1)] on staff for NJ Ex Order 26.4(b)(1). On 1/30/25 at 1:48 PM, the surveyor reviewed Resident #72's medical record. A review of the resident's Admission Record face sheet indicated the resident was admitted to the facility with diagnosis which included but was not limited to; [NJ Ex Order 26.4(b)(1)] and NJ Ex Order 26.4(b)(1). A review of the resident's quarterly MDS dated [NJ Ex Order 26], indicated that the resident had a BIMS score of [NJ] out of 15, which indicated [NJ Ex Order 26.4] [redacted]. A further review reflected that the resident required [NJ Ex Order 26] to [NJ Ex Order 26.4(b)(1)] [redacted] with [NJ Ex Order 26] On 1/31/25 at 9:35 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6) [redacted]), who stated that they were unsure as to how the term '[NJ Ex Order 26.4(b)]	F 550		

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 02/03/2025

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 550	Continued From page 5 was put on the meal slips. On 1/31/25 at 12:00 PM, the surveyor interviewed the [U.S. FOIA (b)] and the [U.S. F] who both stated that staff and the facility should not refer to residents or use terms such as '[NJ Ex Order 26.4(b)]' because that would be considered undignified. On 2/3/25 at 10:13 AM, the U.S. FOIA (b) (6) [redacted] in the presence of the survey team acknowledged that the meal slips containing the term '[NJ Ex Order 26.4(b)]' was an error and "should have been caught" by the facility. A review of the facility's "Dining and Meal Assistance" policy with a last revised date of 6/2024, included all residents will be encouraged to eat in the dining room. facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: not standing over residents while assisting them with meals... avoiding the use of labels when referring to residents (e.g., "feeders")... 3. On 1/28/25 at 10:30 AM, during the initial tour of the facility, the surveyor observed Resident #52 lying in their bed awake. The resident stated they had a NJ Ex Order 26.4(b)(1) [redacted]. The surveyor observed the [NJ Ex Order 26.4(b)(1)] [redacted] secured to the bed frame, not placed in a [NJ Ex Order 26.4(b)(1)] exposing the [NJ Ex Order 26.4(b)] [redacted] in the [NJ Ex Orde] The surveyor was able to	F 550		

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 02/03/2025

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 550		F 550		

Continued From page 6

observe the NJ Ex Order in the resident's NJ Ex Order 26.4(b)(1) from the hallway.

On 1/29/25 at 10:45 AM, the surveyor reviewed the medical record for Resident #52.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included but not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)).

A review of the most recent comprehensive MDS, an assessment tool dated NJ Ex Order 26.4(b), indicated the resident had a BIMS score of NJ Ex out of 15, indicating a NJ Ex Order 26.4(b)(1) .

A review of the Order Summary Report included a physician's order (PO) dated NJ Ex Order 26.4(b) for a NJ Ex Order 26.4(b)(1) maintain NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1)) for a diagnosis of NJ Ex Order 26.4(b)(1)) and attach NJ Ex Order 26.4(b)(1) and maintain it below the level of NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26.4(b) management.

A review of the individual comprehensive care plan (ICCP) included a focus area dated NJ Ex Order 26.4(b), that the resident had a NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1). Interventions included but not limited to; check and place NJ Ex Order 26.4(b) in NJ Ex Order 26.4(b) each shift and secure NJ Ex Order 26.4(b) per facility protocol.

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 02/03/2025

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 550	Continued From page 7 On 1/29/25 at 1:44 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that NJ Ex Order 26.4(b)(1) should be located below the resident's NJ Ex Order 26.4(b) hooked on the resident's bed frame, and placed in NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) further stated the importance of the NJ Ex Order 26.4(b)(1) to be in a NJ Ex Order 26.4(b)(1) was for the resident's dignity. On 1/30/25 at 1:04 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that NJ Ex Order 26.4(b)(1) should be placed in a NJ Ex Order 26.4(b)(1) positioned below NJ Ex Order 26.4(b)(1), and should not be touching the floor. The U.S. also stated that NJ Ex Order 26.4(b)(1) were used for the resident's dignity. On 1/31/25 at 10:30 AM, the surveyor presented the U.S. FOIA (b) (6)) and U.S. a picture of the resident's NJ Ex Order 26.4(b)(1) that was seen during initial tour. The U.S. FOIA (b and U.S. acknowledged that the NJ Ex Order 26.4(b)(1) was not in a NJ Ex Order 26.4(b)(1) at that time. The U.S. FOIA (b stated it should have been in a NJ Ex Order 26.4(b)(1) for dignity reasons. On 2/3/25 at 10:14 AM, the U.S. FOIA (b) in the presence of the U.S. FOIA (b) (6) U.S. FOIA (b) (6) , U.S. FOIA (b) (6)) and the survey team, confirmed that the catheter drainage bags should be maintained in a privacy bag for dignity reasons. A review of the facility's "Urinary Catheters" policy dated reviewed 11/1/24, did not include storing Foley catheter bags in a privacy bag. NJAC 8:39-4.1(a)(12)	F 550		

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 02/03/2025

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 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; §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	F 584		2/28/25

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 02/03/2025

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 584	Continued From page 9 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint # NJ 182108 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the resident's living environment in a clean, comfortable, homelike manner. This deficient practice was identified on 1 of 2 nursing units ([redacted]) reviewed for environmental concerns, and was evidenced by the following: On 1/28/25 at 10:30 AM, the surveyor observed the [redacted] nursing unit and identified the following concerns: In Resident Room #[redacted] had one bag of dirty linen on the floor near the resident's dresser. In Resident Room #[redacted] had a cracked trash can with no liner. In the bathroom the surveyor observed the toilet which had [redacted] splattered in the toilet and around the rim. The surveyor also observed a clear bag tied to the handrail filled with [redacted]. On 1/20/25 at 12:57 PM, the surveyor observed in Resident #1's bathroom a clear bag tied to the hand grab bar. The surveyor observed [redacted] in the clear bag. At that time, the surveyor asked Resident #1 if they tied the clear bag to the handrail. Resident #1 stated no, the [facility]; the resident does not use it. At that time, the [redacted] observed Resident #1's bathroom, and she acknowledged that the bag	F 584	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. The ADON immediately discarded the cracked trash can that was found in room [redacted] and was replaced with a new trash can with a liner upon notification by the surveyor on 1/28/25. The dirty linen bag was removed from the floor and was properly disposed in the Dirty utility room by the nurse unit manager. A one-on-one re-education of the CNA involved regarding proper handling of soiled linens by the nurse educator on 1/28/25. The [redacted] for resident #1 were discarded immediately by the nurse unit manager. One on re-education was provided to the CNA involved by the nurse educator on 1/28/25 regarding infection control practices related to proper handling of [redacted]. The housekeeping staff cleaned the toilet and rim of the toilet for room [redacted] on 1/28/25. Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the cited practices. All residents who have indwelling catheters have the potential to be affected	

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 02/03/2025

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 584	Continued From page 10 had NJ Ex Order 26.4(b)(1) in it. The U.S. FOIA (b) (6) stated it should not be hanging on the handrail for infection control reasons, and she was not sure who tied it to the handrail and removed the bag and discarded it. Resident #1 then stated, "It's just dirty." On 1/31/25 at 10:30 AM, the surveyor interviewed the U.S. FOIA (b) (6) in the presence of the U.S. FOIA (b) (6)), who stated that soiled linen should be bagged and taken to the soiled utility room immediately. The U.S. FOIA (b) further stated it should not be left on the resident's floor. The U.S. stated it should not be left in the resident's room for infection control purposes. The surveyor presented the photos of the soiled bagged linen, the trash can with no liner, and bathroom to the U.S. FOIA (b) and U.S. F The U.S. FOIA (b) and the U.S. acknowledged that the toilet should have been cleaned and the trash can should not be cracked and should have a liner in it. On 1/31/25 at 10:38 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that the housekeepers had a daily schedule that they followed. The U.S. FOIA further stated that if a resident had an accident, the U.S. FOIA (b) (6)) should have notified the housekeeping department so that the toilet seat could have been cleaned right away. The U.S. FOIA acknowledged the surveyor's concerns with the toilet seat, trash can, dirty linen, and the bag with NJ Ex Order 26.4(b)(1) . On 2/3/25 at 10:14 AM, the U.S. FOIA (b) in the presence of the U.S. F U.S. FOIA (b) (6) , U.S. FOIA (b) (6) , and survey team acknowledged the surveyor's environmental concerns.	F 584	by the cited practices Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Nursing staff were re-educated on proper handling of soiled linens and used indwelling catheters by the nurse educator on 2/5/2025 – 2/10/2025 and ongoing. Same in-service education will be given during orientation for newly hired nursing staff, annually and as deemed necessary. Housekeepers were given re-education on the proper cleaning of the toilet and discarding and replacing cracked trash can and placing plastic liner on the trash can. These in-services were initiated on 2/10/2025 by the Environmental Service Director and ongoing. Same In-services will be given during orientation for a newly hired housekeeper, annually and as deemed necessary. An audit tool was developed to be utilized by the Environmental Service Director to monitor and identify issues related to trash can condition, trash can liners, and soiled toilet bowls and rims. An audit tool was developed to be utilized in auditing soiled linens on the floor and used indwelling catheters to maintain a homelike environment for the residents. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Environmental Service Director will conduct weekly audits for 10 rooms x 4 then monthly x 4 to identify issues related to cracked or damaged trash cans, trash	

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 02/03/2025

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 584	Continued From page 11 A review of the facility's "Linen Handling" policy dated revised 6/2024, included...It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection...linen can become contaminated with pathogens from contact with intact skin or body surfaces, or from environmental contaminants or contaminated hands... A review of the facility's "Routine Cleaning and Disinfection" policy dated created 1/2025, included...routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge...routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to...toilet seats... NJAC 8:39-31.4(a)	F 584	cans without liners, and soiled toilet bowls and rims. Negative findings will be addressed through one on one re-education of the involved housekeeper staff, discarding and replacing cracked trash cans, placing plastic liners in the trash can, and cleaning soiled toilet etc. The IP nurse or designee will audit 10 rooms covering other shifts to ensure no soiled linens are found in the resident's room. Negative findings will be addressed through one on one re-education of staff involved and progressive disciplinary measures as appropriate. The IP nurse or designee will perform a weekly audit for 5 residents who have indwelling catheters to ensure that used indwelling catheters are not tied in the resident side rails. Negative findings will be addressed with involved staff through one on one re-education and discarding soiled indwelling catheter bags and progressive disciplinary measures as appropriate.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's	F 644		2/28/25

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 02/03/2025

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 644	Continued From page 12 assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to conduct a new NJ Exec Order 26.4b1 assessment after a resident was newly diagnosed with NJ Ex Order 26.4(b)(1). This deficient practice was identified in 1 of 2 residents reviewed for [redacted] (Resident #17) and was evidenced by the following: On 1/28/25 at 11:02 AM, during the initial tour the surveyor observed Resident #17 in bed with eyes closed. On 1/28/25 at 11:26 AM, the surveyor reviewed the medical Record for Resident #17. A review of the Admission Record face sheet (an admission summary) reflected the resident was initially admitted to the facility in [redacted] with diagnoses which included but not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), and [redacted]. Further review showed a new diagnosis of [redacted] in [redacted]. A review of Resident #17's NJ Exec Order 26.4b1 in the Electronic Medical Record (EMR) dated [redacted]. A review of section one of the [redacted] which asked if the resident had NJ Ex Order 26.4(b)(1)	F 644	Element #1 A new NJ Exec Order 26.4b1 was completed for Resident #17 reflecting all the current medical diagnosis for the Resident. The new NJ Exec Order 26.4b1 resulted in a [redacted] and therefore did not require [redacted] This was completed on 1/28/25. Immediate re-education was completed with the Social Worker on ensuring an accurate NJ Exec Order 26.4b1 is on file for each current Resident. Element #2 All residents with a newly diagnosed of mental illness have the potential to be affected by the cited practice. Element # 3 The U.S. FOIA (b) (6) was re-educated by the Administrator to ensure an accurate Level one PASSR is on file for each current Resident. Completed 2/25/25. This same in-service will be provided during orientation for a newly hired social worker, annually and as deemed necessary. The Social Worker will review new Psychiatric Consults to identify new diagnosis of mental illness. Element # 4 The Social Worker/Designee will audit	

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 02/03/2025

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 644	Continued From page 13 diagnosis, [redacted] was marked. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, meaning the resident had [redacted] A review of section I of the MDS titled active diagnoses revealed the resident had a diagnosis of [redacted] and [redacted]. On 1/29/25 at 8:50 AM, the surveyor interviewed the [redacted]) regarding the [redacted] for Resident #17. The [redacted] was able to provide the surveyor with the [redacted] completed prior to admission, but not a [redacted] The surveyor asked if a [redacted] was completed when the resident developed a [redacted] diagnoses, and the [redacted] stated she would complete it now because "it was missed." The surveyor asked how a new diagnosis would be communicated to her, and she said that the psychiatrist told the nurse of a new diagnosis, and the nurse let the [redacted] know. On 2/3/25 at 12:30 PM, during a meeting with the [redacted]), she acknowledged the [redacted] should have been completed and told the survey team the [redacted] was educated. A review of the facility's "Resident Assessment-Coordination with PASRR Program" policy dated 7/2024, included... any resident who exhibits a newly evident or possible serious mental disorder will be referred promptly to the state mental health or intellectual disability authority for a level two resident review...	F 644	weekly for 5 Residents' Level One PASARR's x 4 and then monthly x 4 to ensure that the PASARR is accurately reflected of a resident with a newly diagnosed with mental illness. Results of the audits will be submitted to the QAA committee who meets quarterly to review and determine necessity of future audits and recommendations.	

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 02/03/2025

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 644	Continued From page 14 NJAC 8:39-27.1(a)	F 644		
F 657 SS=D	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. (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: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to revise an individual comprehensive care plan for a resident with a history of [redacted] who used [redacted]. This deficient	F 657	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident #17 was NJ Ex Order 26.4(b)(1)	2/28/25

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 02/03/2025

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 657	Continued From page 15 practice was identified in 1 of 5 residents reviewed for [redacted] (Resident #17) and was evidenced by the following: On 1/28/25 at 11:02 AM, during the initial tour, the surveyor observed Resident #17 in bed with eyes closed. The resident had [redacted] on the floor next to the bed and the right side of the bed was pushed up against the wall. On 1/29/25 at 1:24 PM, the surveyor reviewed incidents and accidents for Resident #17. The report reflected that on [redacted], the resident was observed [redacted] with their back against [redacted]. It was documented that the resident [redacted] from [redacted] and on the following day an interdisciplinary team meeting was held. A review of the Admission Record face sheet (an admission summary) reflected Resident #17 was admitted to the facility with diagnoses which included but were not limited to: [redacted], and [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, meaning the resident had [redacted]. A review of the individualized comprehensive care plan (ICCP) included a focus area initiated on [redacted], that the resident was at risk for [redacted]. The care plan focus area was updated on [redacted], following [redacted]. Interventions included frequent room checks, [redacted], encourage resident to	F 657	by this finding. The resident was reassessed on 1/31/2025 and the care plan was updated to include the [redacted] and bed up against the wall as interventions. The U.S. FOIA (b) (6) involved was provided with one on one re-education on 2/11/2025 by the nurse educator regarding revisions of the Comprehensive care Plans processes to reflect appropriate interventions. Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents identified with the history of falls who used fall mats and bed against the wall have the potential to be affected by the cited practices. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Re- education was provided by the nurse educator on 2/12/2025_____for Nurse unit managers and the IDT members who have roles in updating care plans regarding Comprehensive Care Plan revision processes. This in-service will be given during orientation for a newly hired nurse unit manager, IDT members, annually and as deemed necessary. Residents who have experienced a fall incident will be reviewed in the clinical meeting to review and revise the resident comprehensive care plans to reflect the appropriate interventions Element 4: Indicate how the facility plans to monitor its performance to make sure	

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 02/03/2025

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 657	Continued From page 16 ask for [NJ Ex Order 26.4(b)(1)] call light within reach, bed in [NJ Ex Order 26.4(b)(1)], well lit room and a clutter free environment. Interventions did not include [NJ Ex O] and bed against the wall. On 1/30/25 at 9:15 AM, the resident was observed in bed with eyes closed. The bed was against the wall and [NJ Ex Order 26.4(b)(1)] on the floor next to the side of the bed. On 1/31/25 at 11:55 AM, the resident was observed in the bed. The bed was against the wall and [NJ Ex Order 26.4(b)(1)] in place. There was a [US FOIA (b)(6)] with the resident providing care. The surveyor asked the [US FOIA (b)] if the resident had history of [NJ Ex Orde] and she said yes and pointed to the [NJ Ex Order 26.4(b)] On 2/3/25 at 10:45 AM, during a meeting with the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)], and the [U.S. FOIA (b) (6)], the surveyor asked if the resident should have been care planned for [NJ Exec Order] and having the bed against the wall. The [U.S. FOIA (b)] replied yes, it should have been on the care plan. A review of the facility's "Fall Policy" dated 1/2024, included...the care plan would be reviewed and updated following a resident fall... A review of the "Care Plan Process" policy dated 9/2024, included the purpose was to ensure a care plan will be developed that is appropriate for each resident's needs and/or wishes based on the assessment and the reassessment process with required timeframes...	F 657	that solutions are sustained. The DON or nurse designee will perform weekly audit for 5 residents with fall incidents x 4, then monthly x 4 to ensure that the Comprehensive Care Plan is revised with the appropriate interventions. Negative findings will be addressed through one on one re-education of the involved staff, revision of the care plan to reflect the appropriate interventions, progressive disciplinary measures as appropriate. The results of the audits will be submitted to the facility QAA committee who meets quarterly for review, and determines the necessity for future audits and recommendations.	

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 02/03/2025

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 657	Continued From page 17 NJAC 8:39-27.1(a)	F 657		
F 658 SS=E	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 observation, interview, and record review, it was determined that the facility failed to ensure that a resident received care and services for the provision of dressing changes to a NJ Ex Order 26.4(b)(1) consistent with professional standards of practice. The deficient practice was identified for 1 of 24 residents reviewed for professional standard of practice (Resident #12). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident #12 was NJ Ex Order 26.4(b)(1) from this cited practice. The nurse obtained an order from the physician for dressing changes for the NJ Ex Order 26.4(b)(1) on 1/29/25. NJ Ex Order 26.4(b)(1) dressing was changed with proper labeling on 1/29/25 in accordance with the physician's order by the license nurse. Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Residents with a prescribed physician order for PICC line have the potential to be affected by the cited practice. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. License nurses were re-educated by the nurse educator on the facility's policy for PICC line, and other Intravenous infusion site dressing changes with emphasis in	2/28/25

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 02/03/2025

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 658	Continued From page 18 "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 1/28/25 at 10:26 AM, the surveyor observed that Resident #12 had a bag attached to NJ Ex Order 26.4(b)(1). The resident revealed a NJ Ex Order 26.4(b)(1) located in the NJ Ex Order 26.4(b)(1). The surveyor observed the NJ Ex Order 26.4(b)(was not labeled or dated. On 1/29/25 at 10:10 AM, the surveyor observed the undated and unlabeled NJ Ex Order 26.4(b)(on Resident #12. On 1/29/25 at 10:37 AM, the surveyor interviewed Resident #12, who stated that the NJ Ex Order 26.4(b)(had not been changed since it was NJ Ex Order 26.4(b)(The resident continued that the medication bag was changed every eight (8) hours. On 1/29/25 at 10:57 AM, the surveyor reviewed the medical record for Resident #12. A review of the Admission Resident face sheet (an admission summary) reflected Resident #12 was admitted to the facility with medical diagnoses which included but was not limited to; NJ Ex Order 2 and/or NJ Ex Order 26.4(b)(1) A review of the most recent comprehensive	F 658	obtaining physicians order and proper labelling. This in-service was initiated on 2/10/25 and will be ongoing. Same Inservice education will be given during orientation of a newly hired nurse, annually and as deemed necessary. An audit form was developed to be utilized to audit IV access dressing changes. During the clinical meeting, the 24-hour nursing progress note will be reviewed by nursing management to identify residents who have new PICC line to ensure a physician order is in place for dressing changes. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Unit Managers or nurse designee will perform a weekly audit x 4 weeks then monthly x 4 months for residents with PICC lines to ensure that dressing changes have physician orders and properly labeled. Negative findings will be addressed through one-on-one re-education of the involved nurses, obtaining physicians order for dressing changes, and progressive disciplinary measures as appropriate. The results of all audits will be submitted to the facility QAA committee who meets quarterly and will review and determine the necessity of further audits and recommendations.	

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 02/03/2025

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 658	Continued From page 19 Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated a [redacted]. A review of the Order Summary Report included physician's orders (PO) with a start date of [redacted], for [redacted]) every shift [redacted] for [redacted] The PO did not reflect any orders for [redacted] observation or [redacted] changes. A review of the corresponding Medication Administration Record (MAR) dated, [redacted], revealed the nurses were electronically for the [redacted] three times a day at [redacted], and [redacted]) since [redacted]. The Mar did not include orders for [redacted] observation or [redacted] changes. A review of the Treatment Administration Record (TAR) dated, [redacted] did not reflect any orders for [redacted] observation or [redacted] changes. A review of nursing progress notes from since the start of the [redacted] did not include any documentation for the [redacted] changes or measurements of the [redacted] of the [redacted] On 1/29/25 at 12:08 PM, the surveyor interviewed the [redacted]), who stated upon admission, the nurse conducted an initial assessment and contacted the physician for	F 658		

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 02/03/2025

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 658	Continued From page 20 orders. The U.S. stated a NJ Ex Order 26.4(b)(1) data set should have been discussed with the physician and the orders should be placed in the electronic medical record (eMR) that distributed the orders to the correct forms (MAR or TAR). The U.S. stated the forms allowed the nurse to acknowledge, perform, and document accordingly. The U.S. acknowledged that the facility process was not followed and since the NJ Ex Order 26.4(b)(was unlabeled and undated she could not tell me when it was last changed. On 1/31/25 at 12:35 PM, the surveyor interviewed the U.S. FOIA (b) (6), who acknowledged the facility process was not followed by staff. On 2/3/25 at 10:16 AM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) U.S. FO and the U.S. FOIA (b) (6), who all acknowledged the surveyor's concerns. A review of the facility's "PICC /Midline/CVAD Dressing Change" policy, dated 1/2025, which included a policy statement;...change peripherally inserted central catheter (PICC) ...dressing weekly or if soiled in a manner to decrease the potential for infection or cross contamination...measure external length of catheter from hub to skin entry to ensure that it has not migrated...secure the catheter with engineered stabilization device...label the dressing with date and time and your initials. A review of the facility's "Infection Control" IV policy, dated 1/3/2025, change IV site according to physician orders or facility policy... NJAC 8:39-27.1(a)	F 658		

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 02/03/2025

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 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint #175979 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) implement interventions to prevent the development of a NJ Ex Order 26.4(b)(1) ; b.) ensure individualized comprehensive care plan interventions were implemented to prevent a NJ Ex Order 26.4(b)(1) from worsening; c.) ensure daily observation during NJ Ex Order 26. care was documented according to professional standards of nursing practice to follow continuity of care; and d.) ensure that the physician evaluated and assessed the resident's medical issues related to NJ Ex Ord care. This deficient practice occurred for 1 of 2 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #167). Resident #167 was identified as having NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)	F 686	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident #167 is NJ Ex Order 26.4(b)(1) in the facility. The nurses, the U.S. FOIA (b) (6) ; the U.S. FOIA (b) (6)), physician that were involved in the resident care when the cited practices were identified were re-educated regarding the wound care treatment, and management and proper wound skin documentation, Individualized plan of care and implementations of interventions in accordance with the facility's policy and professional standards of practice. This was completed on 2/26/2025 by the facility RN nurse educator. Element 2: Address how the facility will identify other residents having the	2/28/25

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 02/03/2025

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 686	Continued From page 22 NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(, which progressed to a NJ Ex Order 26.4(b)(1) on NJ Ex Order 26, of the NJ Ex Ord and NJ Ex Order 26.4(b)(1) measuring NJ Ex Order 26.4(b)(1) The evidence was as follows: A review of the Admission Record face sheet (admission summary) indicated that Resident #167 was admitted to facility with the diagnoses that included but not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1 indicated that Resident #167 had NJ Ex Order 26.4(b)(1) and required NJ Ex Order 26 to NJ Ex Order 26.4(b)(1) with activities of daily living (ADLs). The MDS also indicated that the resident was at risk for developing NJ Ex Order 26.4(b)(1 A review of the "Resident Evaluation-V2" dated NJ Ex Order 26, reflected that Resident #167's NJ Ex Ord was NJ Ex Order 2 at the time of admission to the facility and the NJ Ex Order 26.4(b)(1) reflected that the resident's score was NJ Ex Ord which indicated that the resident was at risk for NJ Ex Order 26.4(b)(1). The surveyor was unable to interview or observe Resident #167 as the resident was NJ Ex Order 26.4(b) in the facility. A review of Resident #167's individual comprehensive Care Plan (ICCP) dated NJ Ex Order 26.4 reflected that the resident was at risk for NJ Ex Ord	F 686	potential to be affected by the same deficient practice. Residents who have documented at high risk for development of pressure ulcers, and residents with having pressure ulcers have the potential to be affected by the cited practices. Element 3: Address what measures will be put into place or systemic changes made to ensure that the 1. Re- education of NJ Ex Order 26.4, U.S. FOIA (b) (6) by the Nurse educator regarding wound treatment with emphasis on proper inputting of a new physician order for dressing changes in PCC to reflect timely initiation of treatment in the ETAR, wound observations and documentations in accordance with professional standard of nursing practice with emphasis of proper documentations of worsening wounds, notifications of physician , development of individualized care plan interventions and implementations . These in-services were initiated on 2/4/2025 and ongoing. Same In-services will be given during orientation for new hire nurses /nurse unit manager, annually and as deemed necessary. 2. The DON reviewed and revised the process of weekly skin checks, and a new skin checks form was developed and implemented on 02/04/2025 to reflect the results of the weekly skins checks. The nurses and CNAs were Inservice of the new form and revised skin checks process on 2/5/2025 – 2/10/2025 and ongoing by the nurse educator. Same In-services will be given during orientation for new hire nurses, CNA's, annually and	

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 02/03/2025

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 686	Continued From page 23 NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Interventions included to: NJ Ex Ord and NJ Ex Order 26.4(b)(1) every two to four hours; inspect NJ Ex Ord during provision of care and NJ Ex Order 26.4(activities; labs as ordered; limit out of bedtime to two hours per session; provide NJ Ex Order 26.4(b)(1) ; report any NJ Ex Order 26.4(b)(1) to the nurse; NJ Ex Order 26.4(b)(or NJ Ex Order 26.4(b)(1) as able; apply NJ Ex Order 26.4(b)(1) and needed for NJ Ex Order 26.4(b)(1) after each NJ Ex Order 26.4(b)(1). A review of the Treatment Administration Record (TAR) dated NJ Ex Order 26.4 , reflected a physician's order to apply NJ Ex Order 26.4(b)(1)) to the NJ Ex Order 26.4 every shift for NJ Ex Order 26.4(b)(1) and/or NJ Ex Order 26.4(b) The order was subsequently discontinued on NJ Ex Order 26.4(The ICCP was not updated to reflect that the resident was not receiving a NJ Ex Order 26.4(b)(1) for preventive NJ Ex Order 26.4(b)(1). On 1/29/25 at 10:34 AM, the surveyor interviewed the Licensed Practical/Nurse Unit Manager (LPN/UM #1), who stated that Resident #167's NJ Ex Ord was assessed on admission to the facility and was NJ Ex Order 2 LPN/UM #1 stated that NJ Ex Ord were ordered on admission and were scheduled to be conducted on the resident's NJ Ex Order 26.4(b)(1). LPN/UM #1 added that NJ Ex Order 26.4(b)(1) were documented on the Medication Administration Record (MAR) and the nurses assigned to the resident were required to sign that the NJ Ex Order 26.4(b)(1) was performed. LPN/UM #1 stated that he thought the condition of the resident's NJ Ex Ord was documented in the resident's progress notes but was not sure. A review of the MARs for NJ Ex Order NJ Ex Order and NJ Ex Order of	F 686	as deemed necessary. 3. Re- education of nurses and CNAs by nurse educator regarding proper documentation, prevention of pressure ulcers and management and implementations of interventions were initiated on 2/4/2025 and ongoing. This education will be given during orientation for new hire CNAS and nurses, annually and as deemed necessary. 4. Re- education of primary physicians/nurse practitioners by nurse educator regarding medical evaluation, assessment, and documentation of a resident with wound care. This was initiated on 02/14/2025 and is ongoing and will be given for a new primary physician/nurse practitioner, and as deemed necessary. 5. The facility appointed a new wound Nurse coordinator to oversee wound care management, these include weekly wound rounds, review of wound recommendations and coordination with the primary physicians regarding wound care recommendations and treatment to assure that wound treatments are started on a timely manner in accordance with the professional standard of nursing practice, development and update of individualized care plan and interventions. 6. The RN regional nurse will review the weekly pressure ulcer wound report from the wound consultant to oversee the facility compliance with wound care management, proper documentation and development and updating of	

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 02/03/2025

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 686	Continued From page 24 NJ Ex Order 2 included a physician's order dated NJ Ex Order 26, for NJ Ex Order 26.4(b)(1) to be done on NJ Ex Order 26.4(b)(1) every evening shift on Tuesday and Friday for monitoring. There was no weekly documentation of NJ Ex Order 26.4(b)(1) describing the resident's NJ Ex Ord condition until the resident developed NJ Ex Order 26.4(b)(on NJ Ex Order 26.4(. A review of the NJ Ex Order 26.4(b)(1)) dated NJ Ex Order 26.4(b) at 5:30 AM, indicated that the resident had developed a facility acquired NJ Ex Order 26.4(b)(1) . The NJ Ex Order 26.4 was described as NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) . A review of the resident's ICCP revealed that the ICCP was not updated to reflect that the resident had developed NJ Ex Order 26.4(b)(1), and no new interventions were initiated to prevent further NJ Ex Order 26.4(b)(1) of the NJ Ex Ord after the resident developed an NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b) . A review of the NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b), reflected that the resident developed NJ Ex Order 26. on the NJ Ex Order 26.4(b)(1). The NJ Ex Order 2 indicated that the NJ Ex Order 26.4(b)(1)) recommended NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26. as the treatment to the resident's NJ Ex Order 26.4(b)(1) According to the report, the NJ Ex Order 2 performed a treatment to NJ Ex Order 26.4(b)(1) using NJ Ex Order 26 with a NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(The NJ Ex Order 2 also recommended preventative interventions to promote NJ Ex Order 26.4(b)(1) such as: NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) a specific type of NJ Ex Order 26.4(b)(1) to be applied to the resident's wheelchair (to NJ Ex Order 26.4(b)(1)); and to encourage the resident	F 686	individualized plan of interventions. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON and or nurse designee will perform weekly audits for 10 residents with documented high risks for development of pressure ulcers to assure that individualized plan of care and interventions are completed and implemented, weekly skin checks and documentations. These audits will be done to cover off shifts for 3 months and then monthly x 3 months. Negative findings will be addressed through re-education of nursing staff involved, notifications of physician for wound care treatment order, updating care plans and interventions and others as appropriate based on the findings of the audit. The DON and or nurse designee will perform weekly audit for 5 residents with documented pressure ulcers to assure that wound care treatment is initiated on a timely manner, pressure ulcer that has worsened has proper nursing documentations and a revised plan of care and interventions are updated and implemented, and the physician/nurse practitioner evaluated and assessed the resident to reflect proper documentations of wounds. These weekly audits will be performed for 3 months and then monthly x 3 months. Negative findings will be addressed with the nursing staff involved through one on one re- education; notification of physician for wound care treatment; updating care plan and	

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 02/03/2025

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 686	Continued From page 25 to perform [NJ Ex Order 26.4(b)] every 15 minutes. The ICCP was not updated to reflect these interventions. A review of the Physician Order Report (POR) dated [NJ Ex Order 26.4(], reflected a [NJ Exec Order 26] treatment to start on [NJ Ex Order 26.4(], and to cleanse the area with NJ Ex Order 26.4(b)(1)), apply [NJ Ex Order 26.4(b)(1)]) to the NJ Ex Order 26.4(b)(1) everyday shift for [NJ Ex Order 26.] care and to cover with a [NJ Ex Order 26.4(b)(1] daily. The treatment was started two days after the [NJ Ex Order 2] recommended the treatment to start on [NJ Ex Order 26.4(b)] A review of the [NJ Ex Order 26.4(b)(1)] TAR revealed that Resident #167 did not have a treatment done on [NJ Ex Order 26.4(]. The TAR revealed that the treatment was not performed until [NJ Ex Order 26.4(]. A review of the MAR dated [NJ Ex Order 26.4(b)], had a nursing signature indicating that a [NJ Ex Order 26.4(b)(1)] was performed for Resident #167. There was no further documentation regarding the condition of the resident's [NJ Ex Orde] A review of the NJ Ex Order 26.4(b)(1) Note ([NJ Ex Order 2] dated [NJ Ex Order 26.4] indicated that the U.S. FOIA (b) (6) documented that the resident had no [NJ Ex Order 26.4(b)] [NJ Ex Order] or [NJ Ex Order 26.4] and that the [NJ Ex Ord] was within normal limits (wnl). A review of the [NJ Ex Orde] dated [NJ Ex Order 26], indicated that the [U.S. FO] documented that the resident had no [NJ Ex Order 26.4(b)] [NJ Ex Order] or [NJ Ex Order 26.4] and that [NJ Ex Ord] was wnl. A review of the U.S. FOIA (b) (6) notes dated [NJ Ex Order 26.4(] at 5:01 PM, [NJ Ex Order 26] at 10:12 PM, and [NJ Ex Order 26] at 10:29 PM, did not address the	F 686	interventions, addressing physician to document to reflect skin care needs as appropriate based on the result of the audit. The results of all audits will be submitted to the QAA committee, who meets quarterly for review and will determine the necessity for further audits and recommendations.	

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 02/03/2025

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 686	Continued From page 26 resident's [NJ Ex Order 26.] that developed on [NJ Ex Order 26.4(b)(1)] [redacted] A review of the TAR dated [NJ Ex Order 26], included a nursing signature that indicated a [NJ Ex Order 26.4(b)(1)] was performed for Resident #167. There was no further documentation regarding the condition of the resident's [NJ Ex Orde] A review of the [NJ Ex Order 26.4(] dated [NJ Ex Order 26] at 8:38 PM, reflected that Resident #167 had developed a NJ Ex Order 26.4(b)(1) of the [NJ Ex Order 26.4(b)(1)] [redacted] and [NJ Ex Order 26.] of the NJ Ex Order 26.4(b)(1) [redacted]. The resident had a weekly [NJ Ex Order 26.4(b)(1)] done on [NJ Ex Order 26], and there was no documentation regarding the resident's [NJ Ex Order 26.4(b)(1)]. A review of the [NJ Ex Order 2] dated [NJ Ex Order 26], indicated that the resident's [NJ Ex Order 26.4(b)(1)] had [NJ Ex Order 26.4(b)(1)] The documentation reflected that the resident's [NJ Ex Orde] [redacted] had [NJ Ex Order 26.4(b)(1)] to a [NJ Ex Order 26.4(b)(1)] [redacted] and developed NJ Ex Order 26.4(b)(1) [redacted]. The [NJ Ex Order 2] indicated that the resident had a [NJ Ex Order 26.4(b)(1)] [redacted]) of the NJ Ex Order 26.4(b)(1) and the resident [NJ Ex Order 26.4(b)(1] the procedure [NJ Ex Orde] The [NJ Ex Order 2] specified that the resident was to be NJ Ex Order 26.4(b)(1) [redacted] utilizing an [NJ Ex Order 26.4(b)(1)] [redacted]. The resident's ICCP did not reflect that the resident was utilizing the [NJ Ex Order 26.4(b)(1] as recommended by the [NJ Ex Order 26] A review of the subsequent PCP note dated [NJ Ex Order 26] at 4:30 PM, the physician did not address that the resident had a new NJ Ex Order 26.4(b)(1)	F 686		

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 02/03/2025

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 686	Continued From page 27 NJ Ex Order 2 on the NJ Ex Order 26.4(b)(1). The U.S. FO nor the U.S. FOIA (documented and addressed that the resident had developed a NJ Ex Order 26.4(b)(1) until NJ Ex Order 26.4(. On 1/29/25 at 11:27 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that weekly NJ Ex Ord assessments were ordered on admission and performed on the resident's NJ Ex Order 26.4(b)(1). The U.S. explained that NJ Ex Order 26.4(b)(1) were ordered weekly as a preventative measure to prevent NJ Ex Ord breakdown and the checks were documented on the MAR when it was completed. The U.S. stated that she was not sure where the actual NJ Ex Order 26.4(b)(1) was documented regarding the condition of the residents' NJ Ex Orde At that time, the U.S. reviewed the resident's medical record and stated that she could not locate where the nurses were writing what the resident's NJ Ex Ord actually looked like, but would find out where the information was located. The U.S. stated that the facility completed a RMS (Risk Management System-incident) report which was the NJ Ex Order 26.4(when a resident developed NJ Ex Order 26.4(b)(1. The U.S. reviewed the resident's ICCP with the surveyor and confirmed that the ICCP was not updated to include NJ Ex Order 26.4(b)(1) with interventions after the resident developed NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(. On 1/30/25 at 10:01 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that the nurses were required to sign the MAR after completing a weekly NJ Ex Order 26.4(b)(1). The U.S. FOIA (b stated that weekly NJ Ex Order 26.4(b)(1) were documented by exception, meaning that the nurses only documented if there was an issue with the resident's NJ Ex Orde The U.S. FOIA (b stated that she would	F 686		

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 02/03/2025

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 686	Continued From page 28	F 686		

have expected the nurses to write a description of the resident's [redacted] when they performed a weekly [redacted] after the resident had developed a [redacted] on [redacted]. The [redacted] did not have an explanation as to why the treatment order was not obtained when the resident developed [redacted] on [redacted]. The [redacted] reviewed the TAR in the presence of the surveyor and confirmed that the treatment order was not received until [redacted], but was not completed until [redacted]. The [redacted] did not have an explanation as to why Resident #167's ICCP was not updated to reflect the [redacted] recommendations for additional offloading interventions after the [redacted] development on [redacted]. The [redacted] explained that the facility did not need an order for [redacted] because the Certified Nursing Aide (CNA) [redacted] it to the resident's [redacted] during care for [redacted].

On 1/30/25 at 1:20 PM, the surveyor interviewed the [redacted] who stated that he saw Resident #167 on [redacted], and that treatment recommendations and [redacted] interventions were given to the nurse on the that day. The [redacted] stated that the nurses were responsible to get the treatment orders from the providing physician and to update the ICCP with the new offloading interventions to aid in [redacted].

On 2/3/25 11:44 AM, the surveyor conducted a telephone interview with the resident's [redacted] who stated that he left the recommendations for [redacted] care up to the [redacted] care team. The [redacted] stated that he did not write the notes on [redacted] or [redacted], that Resident #167's [redacted] was [redacted]. The [redacted] stated a US FOIA (b)(6) documented those notes, and that he did not work with the [redacted]. The [redacted] added that the [redacted]

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 02/03/2025

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 686	Continued From page 29	F 686		

was hired by the facility and he did not follow-up or supervise the [redacted]. The [redacted] did not have a response as to why there was no documentation from the [redacted] or NP that addressed that the resident developed a facility acquired [redacted] until [redacted].

On 2/3/25 at 12:01 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that there were two groups of NPs that came to the facility and saw the residents. The [redacted] stated that the [redacted] were contracted and they had their own physicians. The [redacted] also stated that the [redacted] should have been reporting to the attending physician ([redacted] and the NJ Ex Order 26.4(b)(1) should have been reported to and addressed by the physician. The [redacted] stated that the [redacted] who documented that the resident's [redacted] was [redacted] when in fact it was not, did not work at the facility anymore, but he would have to address with the [redacted] that it was not documented until [redacted] that the resident had a NJ Ex Order 26.4(b)(1).

A review of the facility's "Skin Assessment Policy" dated 1/3/25, included it was the policy to perform a full body assessment as part of our systematic approach to pressure injury prevention and management...documentation of skin assessments with any skin impairment will be noted in the patients' medical record...

A review of the facility's "Pressure Ulcer/Wound Treatment Management" policy dated 2/1/24, included that the facility was to provide evidence-based treatments in accordance with current standards of practice and physician's orders...wound treatments will be provided in accordance with physician's orders and in the absence of treatment orders, a licensed nurse will

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 02/03/2025

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 686	Continued From page 30 notify the physician to obtain treatment orders... A review of the facility's "Care Plan Process" policy dated September 2024, included that the resident's care plan (CP) will be developed was appropriate for each resident's needs and/or wishes based on the assessment and reassessment process with the required timeframes...the plans of care have key areas, may include but were not limited to health maintenance and daily care needs...the CP would include problem statements to include medical problems for which the resident was on significant medications (i.e., hypertension, diabetes etc.). The policy indicated that a CP would include: identified problem; onset date; related risk factors; build on the resident's strengths; reflect treatment goals and objectives; interventions and approaches. A review of the facility's "Pressure Ulcer/Wound Treatment Management" policy dated 2/1/24, included the facility was to provide evidence-based treatments in accordance with current standards of practice and physician's orders...wound treatments will be provided in accordance with physician's orders and in the absence of treatment orders, a licensed nurse will notify the physician to obtain treatment orders... A review of the facility's "Resident Care Consultants and Referrals" policy dated June 2024, included the nurse would inform the attending physician of the consulting physician recommendations for appropriate follow-up and physician orders if indicated... A review of the facility's "Service Agreement - Advance Practice Nursing" dated 6/5/18, included	F 686		

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 02/03/2025

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 686	Continued From page 31 the facility had a contract with [name redacted] to provide advanced practice nurses (APN). The APNs were expected to follow all facility policies and procedures. NJAC 8:39-27.1(a)	F 686		
F 695 SS=D	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, and review of pertinent facility documents, it was determined that the facility failed to a) label, date, and store respiratory equipment in a manner to prevent contamination for infection control and b) develop a individualized comprehensive care plan (ICCP) for use of [redacted] This deficient practice was identified for 2 of 3 residents reviewed for [redacted] care (Resident #45 and #85), and was evidenced by the following: 1. On 1/28/25 at 10:30 AM, during the initial tour of the facility, the surveyor observed Resident #45 lying in their bed watching television. The surveyor observed an [redacted] with [redacted] placed on the [redacted]	F 695	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident # 45 [redacted] was reviewed with the physician and the [redacted] was discontinued on [redacted] as the resident no longer require [redacted] Resident # 85 [redacted] and [redacted] were replaced with proper label and storage on 1/29/25 by nurse unit manager. The care plan was updated to reflect the need for [redacted] this was completed on 1/29/25 Element 2: Address how the facility will identify other residents having the potential to be affected by the same	2/28/25

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 02/03/2025

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 695	Continued From page 32 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). On 1/29/25 at 1:14 PM, the surveyor reviewed the medical record for Resident #45. A review of the Admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, indicating a NJ Ex Order 26.4(b)(1) . A review of the Order Summary Report included a physician's order (PO) dated NJ Ex Order 26.4(b, for NJ Ex Order 26.4(every shift. Further review revealed a physician's order for NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) as needed to maintain NJ Ex Order 26.4(b)(1) . A review of the ICCP did not include a focus area for NJ Ex Order 26.4(b)(1) The ICCP did not include interventions to administer NJ Ex Order 26.4(b On 1/29/25 at 1:44 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN #1), who stated that NJ Ex Order 26.4(b)(1) should be stored NJ Ex Order 26.4(b when not in use.	F 695	deficient practice. All residents with physician order for oxygen use has the potential to be affected by the cited practices. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The oxygen policy was revised to include the addition of dating the humidifier bottles and storage of oxygen tubing when not in use. This was completed on 02/4/2025. Nurses were in-service of the revised policy on 2/10/2025 – 2/15/2025 and ongoing. This in-service will be given during orientation for newly hired nurses, annually and as deemed necessary. Nurse unit managers were provided re-education on care planning process for residents who require oxygen administration therapy by the nurse educator. This in-service will be given during orientation for a newly hired nurse unit manager, annually and as deemed necessary. The IP nurse will generate a weekly report for residents who have an order for oxygen to identify residents who have an order for oxygen therapy to ensure that it is reflected in the resident care plan Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The IP nurse and or nurse designee will perform weekly audits for 10 residents who have an order for oxygen therapy x 4, then monthly x 4 to assure that oxygen humidifier is properly labeled, oxygen tubing is properly stored, labeled and	

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 02/03/2025

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 695	Continued From page 33 UM/LPN #1 further stated that the [NJ Ex Order 26] should be stored in a bag for [NJ Ex Order 26.4(b)] control purposes. On 1/30/25 at 1:04 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that NJ Ex Order 26.4(b)(1) was changed once a week and as needed. The [U.S.] further stated that NJ Ex Order 26.4(b)(1) should be stored in a bag when not in use to ensure it does not become NJ Ex Order 26.4(b)(1) On 1/31/25 at 10:30 AM, the surveyor presented the U.S. FOIA (b) (6)) and [U.S.] pictures of the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1 unbagged and exposed to air. The [U.S. FOIA (b)] and [U.S.] acknowledged that NJ Ex Order 26.4(b)(1) should be stored in a bag and not exposed to air when not in use for infection control purposes. On 2/3/25 at 10:14 AM, the [U.S. FOIA (b)] in the presence of the [U.S. FOIA (b)] U.S. FOIA (b) (6) , [U.S. FOIA (b) (6)]), and the survey team, confirmed that NJ Ex Order 26.4(b)(1) should be stored in a bag and not exposed to air when not in [NJ Ex] infection control purposes. The [U.S. FOIA (b)] also confirmed that Resident #45's ICCP did not include [NJ Ex Order 26.4] and it should have. 2. On 1/28/25 at 10:26 AM, during the initial tour, the surveyor observed Resident #85 sitting up in the wheelchair (w/c) with [NJ Ex Order 26.4(b)(1)]) being [NJ Ex Order 26.4] via a NJ Ex Order 26.4(b)(1). The [NJ Ex] and the NJ Ex Order 26.4(b)(1)) was not labeled or dated. The resident was	F 695	reflected in the resident's care plan. Negative outcome will be addressed though a one on one re-education with the nurse or nurse unit manager involved and progressive disciplinary measures as appropriate. The results of all audits will be submitted to the QAA committee who meets quarterly for review and will determine the necessity of future audits and recommendations.	

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 02/03/2025

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 695	Continued From page 34 NJ Ex Order 26.4(b)(and NJ Exec Order 26.4b1. Resident #85 when asked, was unsure when the NJ Ex Order 26.4(b)(1) was changed or when the NJ Ex Order 26.4(b)(1) was changed. On 1/29/25 at 10:00 AM, the surveyor reviewed the medical record for Resident #85. A review of the Admission Record face sheet reflected that Resident #85 was admitted to the facility with the diagnoses which included but not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)([redacted] A review of the most recent comprehensive MDS indicated that the resident had a BIMS score of NJ out of 15, which indicated NJ Ex Order 26.4(b)(1) [redacted]. The MDS also indicated that the resident received NJ Ex Or[redacted] A review of the physician Order Summary Sheet reflected a physician's order (PO) dated NJ Ex Order 26.4(b)(for the resident to be administrated NJ Ex Order 26.4(b)(1) [redacted] A review of Resident #85's ICCP did not include the administration of the resident's NJ Ex Order 26.4(b [redacted] On 1/29/25 at 12:49 PM, the surveyor observed Resident #85 sitting up in the w/c and NJ Ex O[redacted] was NJ Ex Order 26.4(b)(1) [redacted]. The resident NJ Exec Order 26.4b1 and stated they were having a good day. The surveyor observed the NJ Ex Order 26.4(b)(1) had a piece of tape on it with illegible writing and the NJ Ex Order 26.4(b)(1) was not labeled or dated. On 1/30/25 at 11:38 AM, the surveyor was accompanied by LPN #1 to Resident #85's room to observe the NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1)	F 695		

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 02/03/2025

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 695	Continued From page 35	F 695		

bottle. LPN #1 confirmed that there was no labeling on the NJ Ex Order 26.4(b)(1) and the date on the NJ Ex Order 26.4(b)(1) was illegible. LPN #1 stated that the NJ Ex Order 26 should be changed weekly and that the 11:00 PM-7:00 AM (11-7) nurse was responsible to date the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) but must have forgotten.

On 1/30/25 at 11:42 AM, the surveyor interviewed UM/LPN #1, who stated that the 11-7 nurse had just changed all the NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26 unit on Tuesday NJ Ex Order 26.4(b)). UM/LPN #1 stated that she was not sure if the NJ Ex Order 26.4(b)(1) should be labeled with a date or initialed, but the date written on the NJ Ex Order 26.4(b)(1) must have smeared.

The surveyor reviewed the Treatment Administration record (TAR) that included a PO dated NJ Ex Order 26.4(, for NJ Ex Order 26.4(b)(1) to be changed and to date the NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) weekly every night shift on Tuesday. The TAR indicated that the NJ Ex Order 26 was changed NJ Ex Order 26.4(, but the date on the NJ Ex Order 26 was illegible. There was no physician's order to change or date the NJ Ex Order 26.4(b)(1).

On 2/3/25 at 10:14 AM, the surveyor interviewed the U.S. FOIA (b) who stated that the NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) should be dated and initialed and confirmed that a ICCP was not developed for Resident #85 when the physician ordered Resident #85 to be NJ Ex Order 26.4(b)(1)

A review of the facility's "Oxygen Administration" policy dated revised 7/1/24, included oxygen tubing would be dated and initialed when started each week...humidification bottle needed to be changed weekly or when empty if it was a week

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 02/03/2025

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 695	Continued From page 36 before it was completed...The policy did not include labeling or dating the humidification bottle of the storage of oxygen tubing when not in use. A review of the facility's "Care Plan Process" policy dated revised September 2024, included...that the resident's CP (care plan) will be developed was appropriate for each resident's needs and/or wishes based on the assessment and reassessment process with the required timeframes...the plans of care have key areas, may include but were not limited to health maintenance and daily care needs...CP would include problem statements to include medical problems for which the resident was on significant medications (i.e., hypertension, diabetes etc.)...a CP would include identified problem, onset date, related risk factors, build on the resident's strengths, reflect treatment goals and objectives, and interventions and approaches...	F 695		
F 697 SS=E	NJAC 8:39-27.1 (a) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure appropriate monitoring of [redacted] with adequate assessment prior to administration for a	F 697	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice.	2/28/25

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 02/03/2025

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 697	Continued From page 37 resident who was prescribed [NJ Ex Ord] medication. This deficient practice was identified for 84 of 131 doses administered for [NJ Ex Ord] management to Resident #42, and was evidenced by the following: On 1/28/25 at 11:25 AM, during initial tour of the facility, the surveyor observed Resident #42 resting in bed wearing NJ Ex Order 26.4(b)(1) and watching television. The resident told the surveyor that they were dealing with [NJ Ex Order 26.4(b)(1)]. On 1/29/25 at 12:27 PM, the surveyor observed the resident as they had completed their lunch in the main dining room and were walking out of the dining room, wearing NJ Ex Order 26.4(b)(1) and using a cane. The resident stated they were being managed for [U.S. FOIA (b)]. On 1/29/25 at 1:10 PM, the surveyor reviewed Resident #42's medical record. A review of the Admission Record face sheet (an admission summary) indicated that the resident was admitted to the facility with diagnosis which included but was not limited to; NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)(1)]. A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26.4(b)(1)], indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Ex] out of 15, indicating an NJ Ex Order 26.4(b)(1). The MDS further indicated that the resident received regularly scheduled [NJ Ex Ord] medication.	F 697	Resident #42 is NJ Ex Order 26.4(b)(1) in the facility. Involved nurses were provided with re-Inservice regarding appropriate monitoring of pain assessment prior to administration of resident with a prescribed PRN pain medication, and how to properly input physician order for a PRN pain medication in PCC with emphasis in inputting supplementary pain assessment scale and to use facility batch order set for PRN pain medication. This was completed on 2/5/2025. Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with prescribed PRN pain medication have the potential to be affected for cited practice. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. License nurses were provided with re-education regarding appropriate monitoring of pain assessment prior to administration of resident with a prescribed PRN pain medication, and how to properly input physician order for a PRN pain medication in PCC with emphasis in inputting supplementary pain assessment scale and to use facility batch order set for PRN pain medication by the facility educator. This was initiated on 2/5/2025 and ongoing. Inservice will be given during orientation for a newly hired license nurse, annually and as deemed necessary.	

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 02/03/2025

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 697	Continued From page 38 A review of the resident's Individualized Comprehensive Care Plan (ICCP) included a care focus with initiated [redacted], for [redacted] Interventions included but not limited to: administer pain medications as ordered. A review of the resident's physician's orders (PO) included an order with a start date of [redacted], and end date of [redacted], for NJ Ex Order 26.4(b)(1) [redacted] to be given as needed every six hours for [redacted] to [redacted] ranging from [redacted] on a scale of [redacted]. A second PO dated [redacted], for NJ Ex Order 26.4(b)(1) [redacted] to be given as needed every six hours for [redacted] ranging from [redacted] A review of the [redacted], [redacted], and [redacted] Medication Administration Record (MAR) indicated [redacted] was administered as ordered with no documented [redacted] assessment conducted prior to administering the following doses: [redacted]. There were a total of [redacted] administered with no [redacted] assessments. [redacted]	F 697	DON or nurse designee will generate a weekly report for residents with new PRN pain medication orders and will be utilized to check the order to ensure that the pain scale assessment monitoring is in-placed prior to administration of PRN pain medication. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. DON and or nurse designee will perform a weekly audit for 15 residents with prescribed PRN pain medication order x 4 and then monthly x 4 to assure that pain scale assessment monitoring is completed prior to administration of PRN pain medication. Negative findings will be addressed through one on one re-education of a license nurse involved and or progressive disciplinary measures as appropriate. The results of the audits will be submitted to the QAA committee, who meets quarterly for review and will determine necessity of further audits and recommendations.	

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 02/03/2025

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 697	Continued From page 39	F 697		

NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). There were a total of NJ Ex Order 26.4(b)(1) administered with no NJ Ex Order 26.4(b)(1) assessments.

NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1). There were a total of NJ Ex Order 26.4(b)(1) administered with no NJ Ex Ord assessment.

On 1/30/25 at 1:56 PM, the surveyor interviewed the U.S. FOIA (b) (6), who reviewed the MAR for the resident's NJ Ex Ord medication and confirmed that a NJ Ex Order 26.4(b)(1) assessment was not documented for each pain medication administered. The U.S. FOIA (b further stated there was a separate order for a NJ Ex Order 26.4(b)(1) assessment every shift, but acknowledged that the NJ Ex Order 26.4(b)(1) at the time of the assessment may not have been the same NJ Ex Order 26.4(b)(1) at the time the NJ Ex Ord medication was administered. The U.S. FOIA (b acknowledged that a NJ Ex Order 26.4(b)(1) assessment should have been documented at the time the pain medication was administered.

On 1/31/25 at 11:21 AM, the surveyor interviewed the U.S. FOIA (b) (6), who stated that when administering NJ Ex Ord medication, nurses were expected to assess the resident's level of NJ Ex Ord on a scale from NJ Ex Order 2 and document that level on the MAR at the time the medication was administered. The U.S. FOIA reviewed Resident #42's MAR with the surveyor, and confirmed that the portion requiring a NJ Ex Ord level assessment for each administered dose of NJ Ex Ord medication was marked with an "X", which indicated there was no

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 02/03/2025

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 697	Continued From page 40 [redacted] assessments documented for those doses. On 1/31/25 at 11:31 AM, the surveyor interviewed the [redacted], who reviewed the MAR with the surveyor for Resident #42 and stated based on the documentation provided, there were no [redacted] assessments done for the doses administered that had an "X" indicated for the [redacted]. On 2/3/25 at 10:13 AM, in the presence of the survey team, the [redacted] acknowledged that Resident #42 received [redacted] medication without properly documented [redacted] assessments. A review of the facility's "Pain Management" policy with a most recent created date of 11/2024, included...the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences...pain management...recognition, assessment, treatment and monitoring of pain...	F 697		
F 755 SS=D	NJAC: 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		2/28/25

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 02/03/2025

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 755	Continued From page 41 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 that the facility failed to: a) provide pharmaceutical services in accordance with professional standards of practice and b) accurately document the administration of NJ Ex Order 26.4(b)(1). This deficient practice was identified on 2 of 3 medication carts reviewed for medication storage. This was evidenced by the following: On 1/30/25 at 1:03 PM, the surveyor in the presence of the Licensed Practical Nurse/Unit	F 755	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. The DON immediately interviewed the nurses involved and counted the NJ Ex Order 26.4(b) medications against the NJ Ex Order 26.4(b)(1) declining inventory sheets. ALL NJ Ex Order 26.4(b)(1) [redacted] were accounted. Nurses that were involved of the cited practices were provided with one-on-one re-education regarding administration of NJ Ex Order 26.4(b)(1) [redacted] and accurate documentation	

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 02/03/2025

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 755	Continued From page 42 Manager (LPN/UM #1), reviewed the "Middle Cart North" medication cart. A review of the cart revealed the "Individual Patient NJ Ex Order 26.4(b)(1) Administration Record" sheet (declining inventory) for Resident #21's NJ Ex Order 26.4(b)(1) [redacted] tablets was not signed by the nurse who administered the medication on NJ Ex Order 26.4([redacted]. The declining inventory sheet revealed there should be a tablet count of 10 and the medication card revealed 9 tablets. A review of the cart revealed the declining inventory sheet for unsampled Resident #47's NJ Ex Order 26.4(b)(1) tablet was not signed by the nurse who administered the medication on NJ Ex Order 26.4([redacted]. The declining inventory sheet revealed there should be a tablet count of 30 and the medication card revealed 29 tablets. At the time of observation, the surveyor interviewed LPN/UM #1, who stated, there should be no missing signatures and acknowledged that there were missing signatures on the NJ Ex Order 26.4(b [redacted] declining inventory sheet. LPN/UM #1 acknowledged the NJ Ex Order 26.4(b [redacted] tablet count was incorrect. On 1/30/25 at 11:45 AM, the surveyor in the presence of LPN/UM #2, reviewed the "NJ Ex Order 26 [redacted]" medication cart. A review of the cart revealed the declining inventory sheet for unsampled Resident #71's NJ Ex Order 26.4(b)(1) [redacted] tablet was not signed by the nurse who administered the medication on NJ Ex Order 26.4(b)([redacted] The declining inventory sheet revealed there should be a tablet	F 755	on the NJ Ex Order 26.4(b) [redacted] Declining Inventory sheets by the nurse educator on 2/6/25 and 2/7/25 and on-going. Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with prescribed physician order for controlled medication have the potential to be affected by the cited practices Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Education for Licensed nurses was initiated on 2/7/25 and ongoing by the nurse educator regarding Medication of Controlled Medication and accurate documentation in the Narcotic Declining Inventory sheets. This Inservice will be given during the orientation of a newly hired license nurse, annually and as deemed necessary. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The nurse designee will perform with 10 residents with orders for Narcotic medications covering all med carts to assure that the proper procedures for Medication administration of Narcotic medication and documentations is followed through. Negative findings will be addressed through one-on-one education of involved nurses and progressive disciplinary measures as appropriate,	

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 02/03/2025

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 755	Continued From page 43 count of 30 and the medication card revealed 29 tablets. At the time of observation, the surveyor interviewed LPN/UM #2, who stated, there should be no missing signatures and acknowledged that there were missing signatures on the [NJ Ex Order 26.4(b)] declining inventory sheets. LPN/UM #2 acknowledged the [NJ Ex Order 26.4(b)] tablet count was incorrect. On 2/3/25/25 at 9:48 AM, the surveyor interviewed the [U.S. FOIA (b) (6)]), who acknowledged that the individual declining inventory sheets should be completed and filled out for each [NJ Ex Order 26.4(b)] dose dispensed immediately at the time the medication was removed from inventory. A review of the facility's "Medication Administration" policy dated revised 1/2025, included...Medications are administered by licensed nurses...in accordance with professional standards of practice...if medication is a controlled substance, sign narcotic book...	F 755		
F 757 SS=E	NJAC 8:39-29.7(c) Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		2/28/25

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 02/03/2025

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 757	Continued From page 44 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical records and other facility documentation, it was determined that the facility failed to provide adequate monitoring for the use of NJ Ex Order 26.4(b)(1) medication. This deficient practice was identified for 1 of 5 residents reviewed for NJ Ex Order 26.4(b)(1) medication used (Resident #85), and was evidenced by the following: On 1/30/25 at 12:07 PM, the surveyor observed Resident #85 sitting up in the wheelchair reading a book. The resident was NJ Ex Order 26.4(b)(1) and stated they were NJ Ex Order 26.4(b)(1) and had no complaints. The surveyor reviewed the medical records for Resident #85. A review of the Admission Record face sheet (an admission summary) reflected that Resident #85 was admitted to the facility with the diagnoses which included but not limited to; NJ Ex Order 26.4([redacted] and NJ Ex Order 26.4(b)(1)).	F 757	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. The license nurses that were involved in the cited practice were re-educated on facility's policy on behavior monitoring and documentation for residents receiving NJ Ex Order 26.4(b)(1) medications. This Inservice was provided and completed by the nurse educator on 1/30/2025. Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with prescribed psychotropic medication orders have the potential to be affected by the cited practice. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. License nurses were provided with	

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 02/03/2025

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 757	Continued From page 45 A review of the comprehensive Minimum Data Set (MDS), an assessment tool, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ] out of 15, which indicated NJ Ex Order 26.4(b)(1). The MDS further reflected the resident was [NJ Ex Order 26.4(b)(1)] on staff for activities of daily living (ADLs) and received [NJ Ex Order 26.4(b)(1)] medications. A review of the Medication Administration Record (MAR) revealed that the resident was on the following [NJ Ex Order 26.4(b)(1)] medications: A physician's order (PO) dated [NJ Ex Order 26.4(b)(1)] for NJ Ex Order 26.4(b)(1); give [NJ Ex Order 26.4(b)(1)] by mouth at bedtime for NJ Ex Order 26.4(b)(1). A PO dated [NJ Ex Order 26.4(b)(1)], for NJ Ex Order 26.4(b)(1); give 1 tablet by mouth two times a day for [NJ Ex Order 26.4(b)(1)] A PO dated [NJ Ex Order 26.4(b)(1)], for NJ Ex Order 26.4(b)(1); give 1 tablet by mouth two times a day for [NJ Ex Order 26.4(b)(1)] A PO dated [NJ Ex Order 26.4(b)(1)], NJ Ex Order 26.4(b)(1), give [NJ Ex Order 26.4(b)(1)] by mouth every 12 hours for [NJ Ex Order 26.4(b)(1)]. A review of the individual comprehensive Care Plan (ICCP) which included the following focus areas: A focus area dated initiated [NJ Ex Order 26.4(b)(1)], that Resident #85 had the potential to express [NJ Ex Order 26.4(b)(1)] related to recent admission to the facility and history of [NJ Ex Order 26.4(b)(1)] Interventions included:	F 757	re-education regarding facility policy on behavior monitoring and documentation for residents receiving psychotropic medications by the facility nurse educator on 2/19/2025 and ongoing. Same in-service education will be given during orientation for a newly hired license nurse, annually and as deemed necessary. CNAs were re-educated on the importance of reporting behavior observed to the nurses during their shift, by the nurse educator. This re-education was initiated on 2/19/2025 and ongoing. Same in-service education will be given during orientation of newly hired CNAs, annually and as deemed necessary. The DON reviewed and revised the facility policy on “Behavior Management, Interventions and Monitoring” on 2/24/25, a Behavior Flow sheets will be utilized for behavior monitoring and documentation and will be used starting 2/27/25. Inservice of the license nurses regarding the new Behavior Flow Sheets was initiated on 2/24/25 An audit form has been developed that will be utilized in auditing behavior monitoring and documentation for residents receiving psychotropic medication. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The nurse unit manager and or nurse designee will perform a weekly audit for 10 residents x 4 and monthly x 4 who receives psychotropic medications to assure that behavior is monitored and documented in the resident medical	

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 02/03/2025

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 757	Continued From page 46 monitor, record, report to the U.S. FOIA (b) (6)) as needed (prn) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) or NJ Ex Orde NJ Ex Order 26.4(b)(1) , change in NJ Ex Order 2 , NJ Ex Order 26.4(b)(1) ; change in NJ Ex Order 26.4(b)(1); and monitor, record, report to MD prn NJ Ex Order 2 patterns signs and symptoms of NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) as per facility NJ Ex Order 26.4(b)(1) protocols. A focus area dated initiated NJ Ex Order 26.4(b)(1 that the resident had the potential to be NJ Ex Order 26.4(b)(1)) related to (r/t) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1). Resident #85 was noted to be NJ Ex Order 26.4(b)(1) and refused frequently to allow NJ Ex Order 26.4(b)(1) care, refused frequently to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) , refused labs, refused to NJ Ex Order 26.4(b)(1) despite verbalization of NJ Ex Order 26.4(b)(1) with continuous education. Interventions included to: monitor NJ Ex Order 26.4(b)(1) every shift; document and observed NJ Ex Order 26.4(b)(and attempted interventions. A focus area dated initiated NJ Ex Order 26.4(b) , Resident #85 used NJ Ex Order 26.4(b)(1) medication NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) with staff. Interventions included to: administer NJ Ex Order 26.4(b)(1) medications as ordered by physician, monitor and document side effects and effectiveness; monitor, document, report prn adverse reactions to NJ Ex Order 26.4(b)(1): change in NJ Ex Order 26.4(b)(1) NJ Ex Order 26 or NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) ; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) decline in NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) no NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1 NJ Ex Or	F 757	record.	

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 02/03/2025

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 757	Continued From page 47 NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1). A Review of Resident #85's MAR and the Treatment Administration Record (TAR) did not include documentation that the facility was monitoring the resident's NJ Ex Order 26.4(b)(for the use of NJ Ex Order 26.4(b)(1) medications. On 1/31/25 at 9:50 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that Resident #85 required NJ Ex Order 26.4(b)(1) with ADLS. The U.S. FOIA (stated that the resident was NJ Ex Order 26.4(b)(1) and wore NJ Ex Order 26.4(b)(1). The U.S. FOIA (stated that the resident was able to NJ Ex Order 26.4(b)(1) and became NJ Ex Order 26.4(b at times. The U.S. FOIA (stated that the resident became NJ Ex Order 26.4(b)(1) and thought they were NJ Ex Order 26.4(b)(1). The U.S. FOIA (stated that the resident did not become NJ Ex Order 26.4(b or NJ Ex Order 26.4(b)(1) when she provided them care. On 1/31/25 at 9:55 AM, the surveyor interviewed Resident #85's U.S. FOIA (b) (6)), who stated the resident required NJ Ex Order 26.4(b)(1) with activities of ADLs. The U.S. FOIA explained that Resident #85 could be NJ Ex Order 26.4(b)(1) and then could be NJ Ex Order 26.4(b)(1) at the staff the NJ Ex Order 26.4(b)(1). The US FOIA (b explained that the resident usually exhibited NJ Ex Order 26.4(b)(1) during the NJ Ex Order 26.4(b shift and during NJ Ex Order 26.4(b)(1). She stated that the resident usually NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . The U.S. FOIA stated that if the resident had behaviors, the behaviors were documented in the Progress Notes. The U.S. FOIA reviewed Resident #85's medical	F 757		

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 02/03/2025

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 757	Continued From page 48	F 757		

record, and confirmed that the resident did not have physician's orders for NJ Ex Order 26.4(b)(1) or monitoring for side effect from NJ Ex Order 26.4(b)(1) medication use. The U.S. FOIA stated that she had seen other residents that had orders for that, and she was not sure why some residents on NJ Ex Order 26.4(b)(1) medications had orders for side effects and NJ Ex Order 26.4(b)(monitoring and some did not.

On 1/31/25 at 10:14 AM, the surveyor interviewed the U.S. FOIA (b) (6) who explained that when residents started a new NJ Ex Order 26.4(b)(1) medication or any changes in medications, the resident was monitored for 14 days. The U.S. FOIA (b) (6) stated that medication monitoring was documented in the Progress Notes. The U.S. FOIA (b) (6) stated that behavior monitoring and side effect monitoring for the use of NJ Ex Order 26.4(b)(1) NJ Exec Orde was done on a case-by-case bases. The surveyor and the U.S. FOIA (b) (6) reviewed the resident's ICCP which specified that the resident's NJ Ex Order 26.4(b)(was to be monitored every shift for the use of NJ Ex Order 26.4(b)(1) medications, and the U.S. FOIA (b) (6) stated that she did not know the facility's NJ Ex Order 26.4(b)(monitoring protocol.

On 1/31/25 at 10:37 AM, the surveyor attempted to call the US FOIA (b)(6) but the phone number documented in the medical record was the wrong number.

A review of the facility's policy "Behavior Management, Intervention and Monitoring" policy dated 7/1/24, indicated that the facility was to monitor specific behavior for resident's receiving psychotropic medications and that a licensed nurse would monitor and document drug side

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 02/03/2025

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 757	Continued From page 49 effects of all psychotropic use daily and will note in the resident medical record for behavior and side effects observed. On 2/3/25 at 10:14 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that NJ Ex Order 26.4(b)(1) were documented by exception, meaning only when the resident exhibited NJ Ex Order 26.4(b)(1) The U.S. FOIA (b stated that the facility only documented and monitored the resident when a resident was being NJ Exec Order 26.4b1 from a NJ Ex Order 26.4(b)(1) medication. The U.S. FOIA (b stated that monitoring was only done daily if the resident was started on a new NJ Ex Order 26.4(b)(1) medication or if there was a change in the NJ Ex Order 26.4(b)(1) medication. The U.S. FOIA (b could not speak to why the policy specified that a licensed nurse would monitor and document drug side effects and all NJ Ex Order 26.4(b)(1) medication used daily and would note in the medical records for NJ Ex Order 26.4(b)(and side effects.	F 757		
F 812 SS=F	NJAC 8:39-27.1(a) 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	F 812		2/28/25

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 02/03/2025

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 812	Continued From page 50 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 pertinent facility 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: On 1/28/25 at 10:00 AM, during initial tour of the kitchen, the surveyor, accompanied by the U.S. FOIA (b) and the U.S. FOIA (b) (6)) observed the following: Upon entering the kitchen, the U.S. FOIA washed her hands at the hand washing sink, and lathered with soap outside the flow of running water for 14 seconds. The U.S. FOIA (b) then washed his hands lathering with soap prior to rinsing for a total of 13 seconds. The surveyor used a digital stopwatch to record the time. The U.S. FOIA (b) had a long beard with a beard net that was worn under his chin and not covering his beard hair while he actively worked in the kitchen. At that time, the U.S. FOIA confirmed it should not have been worn that way. A plastic bin of powdered mashed potatoes and a bin of flour both had the scooper stored inside the bin hanging off the edge. The scoopers caused	F 812	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. The U.S. FOIA (b) / U.S. FOIA (b) and all dietary staff received in-service on handwashing Cook and all dietary staff received in-service on beard net policy All cooks and dietary staff received in-service on proper bulk food storage, eliminating storing scoops inside the containers. All cooks and dietary staff received in-service on proper labeling and dating. Ice-scoop was relocated. Pie was immediately discarded and all cooks and dietary staff received Inservice on labeling and dating. Storage of bowls was relocated. All bowls are stored inverted to ensure no contamination of eating services. All dietary staff received in-service on storage of food holding items. All cutting boards were discarded. New cutting boards were immediately put into rotation. All dietary staff Inservice on cutting board usage. Mashed potatoes were immediately discarded. New Mashed potatoes were made. DA was immediately removed	

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 02/03/2025

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 812	Continued From page 51 the lids to remain slightly open. At that time, the U.S. FOIA confirmed it should not have been stored that way and could allow rodents to get in. One 16-ounce (oz.) container of dried parsley flakes, one 16 oz container of bay leaves, and one 16 oz container of dried thyme which were opened and not dated with an opened date. The ice scooper bin was mounted on the wall above seven uncovered racks of clean coffee mugs and soup bowls. The mugs and bowls had water on them. The U.S. FOIA stated that the ice scooper bin had been there "forever" meaning above the spot where racks of clean supplies were stored. In the walk-in freezer was one pie, identified by the U.S. FOIA as an apple pie, covered with plastic wrap and not labeled or dated. Next to the walk-in refrigerator were two racks of clean dessert bowls that were uncovered with an exterior exhaust fan cage above it. The fan was covered with a thick layer of gray dust-like material. Next to the two racks of clean dessert bowls was the refrigerator's cooling system/motor which was also covered in a thick layer of gray dust. On the drying rack were two red and two white cutting boards which were pitted and had deep cut marks. On 1/30/25 at 11:15 AM, during a follow-up tour of the kitchen, the surveyor observed the following: The U.S. FOIA (D went to the hand washing station, wet his hands, dispensed foam soap into his hands,	F 812	from cooking area and in-serviced on proper body posture and prepping away from direct heat source. All in-services were performed on 2/3/2025. Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents could have been affected by these alleged deficient practices. An immediate audit was conducted on all Food Procurement, Store/Prepare/Serve-Sanitary to eliminate the potential to be affected by alleged deficit practices. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. New signage was hung specifying 20 seconds of lathering posted 2/4/2025. All dietary staff re-educated on beard net usage. 2/20/2025 New labeling system implemented to clearly identify and date all food items, 2/28/2025. Ice-scoop will remain in permanent area clear of any kitchen item below. Cutting boards replaced. All dietary staff re-education on storage of kitchen items, 2/20/2025. All dietary staff re-education on body posture and prepping techniques, 2/20/2025. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Nursing/ Designee will conduct	

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 02/03/2025

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 812	Continued From page 52 and immediately began to rinse his hands with no lather time. Following the [U.S. FOIA (b)] a Dietary Aid (DA #1) washed his hands lathering with soap for 16 seconds prior to rinsing The usrveyor used a digital stopwatch to record the time. DA #2 was observed at the steam table leaning over a large tray of mashed potatoes as he used a large whisk to mix the potatoes. The surveyor observed DA #2 with a large amount of sweat drops on his face and running down his nose, dripping into the tray of mashed potatoes as he mixed. At that time, the surveyor approached the U.S. FOIA (b) (6) and informed him of that observation. The [U.S. FOIA (b)] approached DA #2, observed the sweat on his face, and acknowledged the concern. On 1/31/25 at 11:46 AM, the surveyor interviewed the U.S. FOIA (b) (6)) in the presence of the [U.S. FOIA (b)] and the U.S. FOIA (b) (6)). The [U.S.] stated that she provided infection control education including hand hygiene to all facility staff including kitchen staff and administration. The [U.S.] stated that the required minimum time for lathering with soap when washing hands for infection control was 20 seconds. At that time, the [U.S. FOIA (b)] added that he was also educated on the proper amount of time to lather with soap when washing his hands and acknowledged the surveyor's observation of him not meeting the minimum 20 seconds. The [U.S.] further stated that anyone who entered the kitchen was required to wear proper hair and beard nets appropriately and that those items were readily available at the kitchen entrance. The [U.S.] stated that having beard hair and any other hair outside of the hair net	F 812	handwashing competencies with all dietary staff FSD/ designee will monitor all staff with beards on beard net usage, and these observations will be made into quality assurance and performance audits which will be completed once weekly for 4 weeks and then monthly for 2 months and will alternate between morning and evening shifts. Staff will be educated about the results of the audit for ongoing improvement. The results of the audits will be presented to the QAPI committee for review and recommendations quarterly. FSD/ designee will monitor bulk food storage/ label and dating/ and kitchen item storage, and these observations will be made into quality assurance and performance audits which will be completed once weekly for 4 weeks and then monthly for 2 months. Staff will be educated about the results of the audit for ongoing improvement. The results of the audits will be presented to the QAPI committee for review and recommendations quarterly. FSD/ designee will monitor cutting boards for pitting and deep cuts, and these observations will be made into quality assurance and performance audits which will be completed once weekly for 4 weeks and then monthly for 2 months. Staff will be educated about the results of the audit for ongoing improvement. The results of the audits will be presented to the QAPI committee for review and recommendations quarterly. FSD/ designee will audit body posture and	

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 02/03/2025

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 812	Continued From page 53 posed an infection control risk. On 2/3/25 at 10:13 AM, in the presence of the survey team, the [U.S. FOIA (b)] acknowledged that personal hygiene when preparing food, appropriate hand hygiene, and proper use of hair and beard nets should have been followed appropriately in the kitchen. The [U.S. FOIA (b)] also acknowledged that kitchen supplies and equipment should have been maintained in a sanitary manner, and that all items should have been labeled and dated appropriately. A review of the facility's "Hand Hygiene" policy with a most recent created date of 8/1/24, included all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, resident, and visitors. This applies to all staff working in all locations within the facility...hand hygiene technique when using soap and water: a. wet hands with water. avoid using hot water to prevent drying of skin. b. apply to hands the amount of soap recommended by the manufacturer. c. rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. rinse hands with water... A review of the facility's dietary "Dating" policy with a reviewed date of 8/2023, included all fresh and frozen foods must be dated with the date it was received into the kitchen, unless it has a purveyor shipping label on it. Make sure to not date over or cover up the manufacturer's expiration date on the product... A review of the facility's "Personal Hygiene" policy with a reviewed date of 8/2024, included cover hair and facial hair with restraint (hairnet, cap,	F 812	prepping areas to ensure prep is being conducted outside of a heat source, and these observations will be made into quality assurance and performance audits which will be completed weekly for 4 weeks and then monthly for 2 months. Staff will be educated about the results of the audit for ongoing improvement. The results of the audits will be presented to the QAPI committee for review and recommendations quarterly.	

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 02/03/2025

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 812	Continued From page 54 beard net or hat). Mustaches and beards must be well trimmed... A review of the facility's "Kitchen Supplies: Storage" policy with a most recent created date of 6/2024, included all food service equipment should be cleaned, sanitized, air-dried, and reassembled after each use. Plastic-ware or dishware that has lost its glaze or is chipped or cracked must be disposed of... A review of the facility's "Food Prep Hygiene" policy with a last revised date of 6/2024, included during food preparation, maintain appropriate distance and body posture from food prep area to avoid possible contamination... NJAC 8:39-17.2(g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to properly dispose and maintain waste in garbage dumpster areas. This deficient practice was identified in 1 of 1 kitchen garbage dumpster areas, and was evidenced by the following: On 1/28/25 at 10:38 AM, during initial tour of the kitchen, the surveyor, in the presence of the [redacted] and the U.S. FOIA (b) (6) [redacted]) observed the kitchen's garbage dumpster area. The surveyor	F 814	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Inservice was conducted with all dietary staff, 2/3/2023. All debris, bread, and gloves were picked up and disposed of properly and dumpster is to be remained closed. Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	2/28/25

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 02/03/2025

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 814	Continued From page 55 observed food debris including: bread slices and other unidentifiable disposed food and disposable gloves scattered on the ground. The surveyor also observed a half full garbage compactor which had the door wide open and was not actively being used by staff. At that time, the [U.S. FOIA (b)] stated that the dumpster area should have been maintained and cleaned; that leaving the garbage compactor open and having food debris on the ground was "disgusting" and could promote rodents. On 2/3/25 at 10:13 AM, in the presence of the survey team, the [U.S. FOIA (b)] acknowledged that the dumpster area should have remained clean, and the garbage containers should have remained closed when not in use. A review of the facility's "Dumpster Area" policy with a revised date of 11/2024, included...the trash area should be clean, odor-free, and free from pest infestation. Trash containers should be sealed, leak proof, and covered at all times to prevent exposure to waste...all trash shall be placed inside the dumpster... NJAC 8:39-19.3(c)	F 814	This identified practice has the potential to affect all residents. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All dietary staff were re-educated to ensure the dumpster area remained clean and garbage containers remained closed when not in use. Checking the dumpster will be added to the cook's routine upon end of their shift. Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. FSD/designee will monitor dumpster area to be free of debris and closure of dumpster, and these observations will be made into quality assurance and performance audits which will be completed weekly for 4 weeks and then monthly for 2 months. Staff will be educated about the results of the audit for ongoing improvement. The results of the audits will be presented to the QAPI committee for review and recommendations quarterly.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		2/28/25

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 02/03/2025

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 880	Continued From page 56 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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 02/03/2025

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 880	Continued From page 57 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Complaint # NJ 182108 Based on observation, interview, and review of other pertinent facility documentation it was determined that the facility failed to: a) ensure that soiled linen and NJ Ex Order 26.4(b)(1) were properly stored in a sanitary manner and b) ensure soiled medical equipment was sanitized prior to storage to prevent cross contamination and the spread of infection. This deficient was identified on 1 of 2 nursing units observed ([redacted] Unit) and 1 of 2 medication storage rooms observed ([redacted] Unit), and it was evidenced by the following: 1. On 1/28/25 at 12:00 PM, the surveyor was conducting a dining observation on the [redacted] Unit. The surveyor entered Resident Room [redacted] and observed one bag of dirty linen and one bag	F 880	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. 1. The Certified Nursing Assistant #1 who was involved in the cited deficient practice was re-educated on the importance of proper handling and transporting of soiled linen and soiled briefs and that it is not acceptable to place on the floor. This in-service was provided and completed by the nurse educator on 1/28/2025 2. All staff who have access to the Medication Room were re-educated on the importance of keeping the medication room clean with no soiled equipment to be stored in the Medication Room. This in-service was provided by the nurse educator from 2/5/2025 2/10/2025.	

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 02/03/2025

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 880	Continued From page 58 of trash which contained NJ Ex Order 26.4(b)(1), on the floor in the room. On 1/28/25 at 12:30 PM, the surveyor returned to Resident Room #[NJ Ex O] on the [NJ Ex Order 2] Unit and observed a Certified Nursing Assistant (CNA #1) feeding the resident in bed B (near window). There were two bags of dirty linen and trash now moved in the front of the resident's bed while the CNA #1 continued to feed the resident. The surveyor interviewed CNA #1 at that time, and asked the CNA what the two bags were, and the CNA stated that the one bag contained resident NJ Ex Order 26.4(b)(1), and the other bag contained dirty linen. CNA #1 then revealed that she utilized the same bags of dirty linen and [NJ Ex Order 2] going from resident room to resident room because she did not want to waste bags so used the same bag for all residents she cared for. On 1/28/25 at 12:35 PM, the surveyor interviewed the License Practical Nurse (LPN #1) for the [NJ Exec Order 26.4b1], who stated that CNA #1 should not be taking bags of dirty linen and [NJ Ex Order 2] room to room after she performed resident care. LPN #1 stated that after resident care, CNA #1 should be utilizing individual bags for each resident for dirty [NJ Ex Order 2] and dirty linen. LPN #1 stated that after caring for the resident, the linen and trash should immediately be removed from the resident's room and placed in the soiled utility room. LPN #1 accompanied the surveyor to Resident Room #[NJ Exec] and observed the dirty linen in front of the residents' bed while CNA #1 was feeding the resident. LPN #1 stated that this should not have occurred and that if was an infection control issue. LPN #1 stated that going room to room with [NJ Ex Order 26.4(b)(1)] and linen could cause cross contamination.	F 880	Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 1. All residents have the potential to be affected by the cited practice. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 1. Nursing staff were provided with re-education by the facility educator regarding facility policy on the importance of proper handling and transporting of soiled linen and soiled briefs and that it is not acceptable to place on the floor. This in-service education was initiated on 2/5/2025 – 2/10/2025 and its ongoing and will be given during orientation for all newly hired nursing staff, annually and as deemed necessary. 2. An audit form has been developed that will be utilized in auditing linen handling and transportation. 3. Staff who have access to the Medication Room were re-educated on the importance of keeping the medication room clean with no soiled equipment to be stored in the Medication Room. This in-service education was initiated on 2/5/2024 and ongoing. Same in-service will be given during orientation of newly hired staff who have access to the Medication Room, annually and as deemed necessary. An audit form has been developed that will be utilized in auditing the medication room for any soiled equipment.	

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 02/03/2025

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 880	Continued From page 59 On 1/28/25 at 12:37 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM #1), who went to Resident Room #[NJ Ex Ord] and immediately removed the bag of linen and [NJ Ex Order 26] LPN/UM #1 stated that this was "gross" and a dignity issue. LPN/UM #1 stated, "If I was a resident I would not want to NJ Ex Order 26.4(b)(1)." LPN/UM #1 then stated that this was an infection control issue and dirty bags of linen and [NJ Ex Order 2] should not be going from resident room to resident room. On 1/30/25 at 08:27 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that during meal service, dirty linen and [NJ Ex Order 2] should be bagged and taken to the soiled utility room. The [U.S.] stated that the staff should never be taking dirty trash or linens from room to room; that it could pose an infection control issue related to cross contamination. The [U.S.] stated that the staff should never be feeding residents with dirty linen and [NJ Ex Order 26.4(b)(1)] in bags in the resident's rooms. On 2/3/2025 at 9:30 AM, the U.S. FOIA (b) (6) stated that the facility took this matter seriously and education was provided to the staff regarding proper handling and disposal of soiled linens, particularly during resident care activities. A review of the facility's "Linen Handling" policy dated 6/2024, included it was the policy of the facility to handle, store, process and transport clean linen and sanitary method to prevent contamination of the linen which could lead to infection ...contaminated linen was linen that was soiled with blood or other potentially infectious materials ...clean linen should be stored separately from soiled and that linen could become contaminated with pathogens from	F 880	Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 1. The infection preventionist or designee, or nurse designee will perform a weekly audit on ten nursing staff covering all shifts who are handling soiled linen and soiled briefs x four weeks and then monthly x four to ensure that the soiled linen has been properly handled and transported and not put on the floor. 2. The infection preventionist or nurse designee will perform a weekly audit on each unit medication rooms x four and monthly x four to ensure that there is no soiled equipment that was stored in the medication rooms.	

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 02/03/2025

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 880	Continued From page 60 contact with intact skin or body substance, or from environmental contaminants or contaminated hands ... 2. On 1/30/25 at 8:49 AM, the surveyor, in the presence of LPN/UM #1, toured the "North Medication Storage Room". The surveyor observed; one soiled oxygen (O2) concentrator with a humidification bottle that was half-way filled with a liquid substance that was still attached and three soiled tube feeding pumps stored in the medication room. At that time LPN/UM #1 stated, the soiled equipment should have been placed in the soiled utility room so housekeeping could process the equipment. LPN/UM #1 acknowledged that the soiled equipment should not be in the medication room; it could cause cross contamination to the sterile supplies and medication preparation area. On 1/30/25 at 9:31 AM, the surveyor interviewed the [redacted] who stated that soiled equipment should "never" be placed in the medication room; there was a soiled utility room that used equipment should be placed in. The [redacted] stated it ensured housekeeping cleaned it, and when equipment was cleaned, a clear bag was placed on the equipment so that staff were aware, and it could go back into circulation. On 1/31/25 at 12:35 PM, the surveyor interviewed the [redacted] who stated that the facility's process for soiled equipment was to remove the equipment from the resident's room when it was no longer needed and placed it in the dirty utility room. The [redacted] stated housekeeping cleaned the item and covered it with a clear plastic bag signifying it had been cleaned.	F 880		

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 02/03/2025

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 880	Continued From page 61 A review of the facility's "Cleaning and Disinfection of Nursing Equipment" policy with a revised date of 3/2024, included...Policy; Equipment are to be free of soil and contamination with infectious organisms and product ... clean and disinfect all highly technical/sensitive equipment (pumps, etc..) per manufacturer's recommendations... NJAC 8:39-19.4	F 880		

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	3/14/2025 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 F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0644	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(e)(1)(2)	Completed
LSC	02/28/2025	LSC	02/28/2025	LSC	02/28/2025
ID Prefix F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0686	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	02/28/2025	LSC	02/28/2025	LSC	02/28/2025
ID Prefix F0695	Correction	ID Prefix F0697	Correction	ID Prefix F0755	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	02/28/2025	LSC	02/28/2025	LSC	02/28/2025
ID Prefix F0757	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.45(d)(1)-(6)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	02/28/2025	LSC	02/28/2025	LSC	02/28/2025
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/28/2025	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?
2/3/2025	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING **01** B. WING _____	**02/03/2025**

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
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		
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 01/28/2025 and 02/03/2025 and the facility 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Preferred Care of Hamilton was a one-story building with a partial basement that was built in the 1960's. It was composed of Type II construction. The facility was divided into 12-smoke zones. The external diesel generator powers approximately 100% of the building according to the Environmental Service Director. The facility had a wet sprinkler system. The fire alarm system had smoke detectors in corridors and common areas and 4 resident rooms. The resident rooms primarily have battery operated smoke alarms. There was a fire hydrant out front that the facility maintained.	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the	K 271		2/25/25

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

Electronically Signed | 02/25/2025

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
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 271	Continued From page 1 provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 01/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to maintain a stable, level walking surface at exit discharge for 2 of 9 exterior exits observed in accordance with NFPA 101:2012 Edition, Section 7.7, 7.1.6, 7.1.10.1 and 19.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:53 AM revealed that the corridor exterior exit number 6 (by room 232) exit discharge path to a public way posed a trip hazard in the path of egress for evacuation. There were 6 places in the sidewalk where the concrete was deteriorated, two of the deteriorated depressions went completely across the 5 foot wide sidewalk. An observation at 11:56 AM revealed the corridor exterior exit number 5 (by room 214) exit discharge path to a public way posed a trip hazard in the path of egress for evacuation. There was a 37-inch by 14-inch wide depression in the sidewalk where the concrete was deteriorated across the 48 inch wide path. In interviews at the times, the U.S. FOIA [redacted] confirmed the observations. The facilities U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit	K 271	The exit discharge path by exit door number 6, 6 places in the sidewalk were repaired, exit discharge path by exit door number 5, sidewalk was repaired. All other exit discharge paths were inspected to ensure they are maintained and free of obstructions. All maintenance staff were re-educated by the Administrator on the requirement to ensure that exit discharge paths are maintained and free of obstructions. Maintenance Director/Designee will audit 3 exit discharge paths weekly x 4 and monthly x3 to ensure that exit discharge paths are maintained and free of obstructions. All results will be submitted and reviewed at the quarterly QAPI meeting for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 271	Continued From page 2 conference on 02/03/2025 at 3:28 PM. NJAC 8:39-31.2(e)	K 271		
K 300 SS=F	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 observations, documentation review and interviews on 01/28/2025 in the presence of the U.S. FOIA (b) (6)), it was determined the facility failed to ensure penetrations through smoke and fire barriers were sealed with materials and methods to protect through penetrations and membrane penetrations in accordance with NFPA 101: 2012 Edition, Sections 8.4, 8.4.4, 8.3.4 and 8.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. An observation at 10:20 AM of the stairwell to the basement revealed a 3-inch by 8-inch hole in the solid ceiling with two 1-1/2 inch orange flex tubes penetrating through it. The hole and tubes were sealed with an orange foam material bulging from the hole. There were also 3 individual holes with conduit penetrating through the ceiling in the	K 300	In the stairwell to the basement ceiling the orange foam material was removed and replaced with approved fire rated material, the three individual holes with conduit were filled with approved fire rated material, kitchen pot storage area the orange foam material was removed and replaced with approved fire rated material, cable TV equipment box area the orange foam material was removed and replaced with approved fire rated material, hole in the janitors closet by room 232 was filled with approved fire rated material, basement boiler room hatch door was closed, hole open in the ceiling of the boiler room was filled with approved fire rated material. This deficient practice has the potential to affect all residents. All other areas of the	2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 300	Continued From page 3 same area that had no material applied. In an interview at the time, the [U.S. FOIA] confirmed the observation and stated he did not know the fire rating or the manufacturers installation requirements of the orange foam material. 2. An observation at 10:44 AM of the kitchen pot storage area revealed a 3-inch by 8-inch hole in the concrete ceiling containing two 1-1/2 inch electrical supply lines penetration through the space and the penetration was sealed with an orange foam material bulging from the hole. In an interview at the time, the [U.S. FOIA] confirmed the observation and stated he did not know the fire rating or the manufacturers installation requirements of the orange foam material. 3. An observation during the tour of the cable TV equipment box area, revealed the drop ceiling above the mounted cable unit and an electrical box next to it had orange foam material bulging from the holes through the drop ceiling where wires penetrated above both units. In an interview at the time, the [U.S. FOIA] confirmed the observation and stated he did not know the fire rating or the manufacturers installation requirements of the orange foam material. 4. An observation at 11:55 of the janitors closet by room 232 revealed 2 copper pipes penetrating the drywall ceiling with no fire stop around them. In an interview at the time, the [U.S. FOIA] confirmed the observation. 5. An observation at 9:40 AM of the basement	K 300	facility were inspected to ensure penetrations through smoke and fire barriers are sealed with materials and methods to protect through penetrations. All maintenance staff were re-educated by the Administrator on the requirement to ensure that penetrations through smoke and fire barriers are sealed with approved fire stop materials and methods to protect through penetrations. Maintenance Director/Designee will audit 5 areas weekly x 4 and monthly x3 to ensure that penetrations through smoke and fire barriers are sealed with approved fire stop materials and methods to protect through penetrations. All results will be submitted and reviewed at the quarterly QAPI meeting for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING **01** B. WING _____	**02/03/2025**

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
K 300	Continued From page 4 boiler room ceiling revealed: a. a fire rated 2-foot by 2-foot hatch left in the open position creating a passage for smoke and fire. b. a 32-inch by 42-inch hole open in the ceiling creating a passage for smoke and fire. In an interview at the time, the [redacted] confirmed the observations and stated the hole was opened to do work and was not closed back up. The facilities U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 02/03/2025 at 3:28 PM.	K 300		
K 321 SS=F	NJAC 8:39-31.2(e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier 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	K 321		2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 321	Continued From page 5 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 observations and interviews on 01/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7 and 8.4. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. An observation at 10:10 AM of the basement mattress storage room revealed it was greater than 50 square feet and contained flammable and combustible storage. The door to the mattress room was not equipped with a self closing or automatic closing device. 2. An observation at 12:53 revealed the Medication storage room across from the Director Of Nursing's office was greater than 50 square feet and stored combustible items and boxes. The storage room door was not equipped with a self closing or automatic closing device. In interviews at the times, the U.S. FOIA [redacted] confirmed the observations.	K 321	1-The doors to the mattress room and the medication storage room were both equipped with a self-closing device. 2-This deficient practice had the potential to affect all residents. All other areas of the facility were inspected to ensure that hazardous area enclosures have doors that are equipped with a self-closing device. 3-All maintenance staff were re-educated by the Administrator on the requirement to ensure that hazardous area enclosures have doors that are equipped with a self-closing device. 4-Maintenance Director/Designee will audit 5 hazardous area enclosures to ensure that the doors are equipped with a self-closing device, weekly x 4 and monthly x3. All results will be submitted and reviewed at the quarterly QAPI meeting for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 321	Continued From page 6 The facilities U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 02/03/2025 at 3:28 PM.	K 321		
K 353 SS=F	NJAC 8:39-31.2(e) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 01/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined the facility failed to ensure the automatic sprinkler system was maintained in accordance with NFPA 25: 2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 353	K353 1-In the basement corridor ceiling, four sprinkler escutcheon plates were replaced, in the kitchen six escutcheons plates were replaced, sprinkler head escutcheon plate by the dish washer escutcheon was replaced, sprinkler heads	2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING **01** B. WING _____	**02/03/2025**

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
K 353	Continued From page 7 Observations during a facility tour from 9:39 AM to 1:01 PM revealed: 1. In the basement corridor ceiling, 4 of 4 sprinkler escutcheon plates were coming down 3/4-inch. 2. In the kitchen: a. Six of 11 sprinkler escutcheons were coming down 3/4-inch leaving spaces in concrete around sprinkler pipes. Five were in the kitchen and one was by the freezer. b. The sprinkler head by the dish washer was missing its escutcheon. c. The sprinkler heads in the walk-in refrigerator with a freezer in back were both missing their escutcheons. d. Three kitchen ceiling sprinkler heads had a build up of dust material. One was by the range, 1 was by the line and 1 was by the reach-in refrigerator. 3. The dining room ceiling by the entrance double doors had 1 of 12 sprinkler heads that was missing its escutcheon. 4. In the Atrium room ceiling, a 2-foot by 8-inch ceiling tile was missing next to a sprinkler head and smoke detector. 5. In room 212, one of the two sprinkler heads had its escutcheon plate coming down 1/2-inch. 6. In the unit managers office, there was a space	K 353	escutcheon plates in the walk-in refrigerator was replaced, dining room ceiling by the entrance double doors escutcheon plate was replaced, room 212 escutcheon plate was replaced, the tub room 7 sprinkler head escutcheon plates were replaced, ceiling by room 113 escutcheon was replaced. Three kitchen ceiling sprinkler heads was cleaned of dust, room 104 sprinkler head was cleaned of dust. Atrium room ceiling tile was replaced, unit managers office ceiling tile was replaced. 2-This deficient practice has the ability to affect all residents. The facility was inspected to ensure that all sprinkler head escutcheon plates are properly placed and not rusted. The facility was inspected to ensure that all sprinkler heads are clean of dust. The facility was inspected to ensure all ceiling tiles are properly placed. 3-All maintenance staff were re-educated by the Administrator to ensure that all sprinkler head escutcheon plates are properly placed and not rusted, that all sprinkler heads are clean of dust and all ceiling tiles are properly placed. 4-Maintenance Director/Designee will audit 5 sprinkler heads throughout the facility weekly x 4 and monthly x3 to ensure that sprinkler head escutcheon plates are properly placed and free of rust, and that sprinkler heads are clean of dust. Maintenance Director/Designee will audit 5 areas to ensure ceiling tiles are properly placed, weekly x 4 and monthly x3. All results will be submitted and reviewed at the quarterly QAPI meeting for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 353	Continued From page 8 in the ceiling tile on the side of 1 of the 2 sprinkler head escutcheon plates. 7. In the tub room, 7 of 7 sprinkler head escutcheon plates were rusted. 8. In the corridor ceiling by room 113, the sprinkler head was missing its escutcheon plate. 9. In room 104, the sprinkler head in the ceiling by the window had significant build up of dust material. In interviews at the times, the [redacted] confirmed the observations. The facilities [redacted] was informed of the deficient practice during the Life Safety Code exit conference on 02/03/2025 at 3:28 PM. NJAC 8:39-31.2(e) NFPA 25	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/28/2025 in the presence of the [redacted]), it was determined the facility failed to ensure that a Class K portable fire extinguisher located in the kitchen was provided	K 355	1-Instruction placard that stated the fire suppression system shall be actuated prior to using the portable fire extinguisher was fixed above the Class K fire extinguisher.	2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING	02/03/2025

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
K 355	Continued From page 9 with an instructional placard conspicuously placed near the extinguisher in accordance with NFPA 101: 2012 Edition, Sections 9.7.4, NFPA 10: 2010 Edition, Sections 5.5.5.3, A 5.5.5.3 and NFPA 96: 2011 Edition, Sections 10.2.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:44 AM revealed the Class K fire extinguisher in the kitchen was not provided with an instruction placard that stated the fire suppression system shall be actuated prior to using the portable fire extinguisher. In an interview at the time, the [U.S. FOIA (b) (6)] confirmed the observation. The facilities [U.S. FOIA (b) (6)] was informed of the deficient practice during the Life Safety Code exit conference on 02/03/2025 at 3:28 PM. NJAC 8:39-31.2(e) NFPA 10, 96	K 355	2-This deficient practice has the potential to affect all residents. There are no other areas outside of the kitchen that have a fire suppression system. 3-All maintenance staff and dietary staff were re-educated by the Administrator to ensure that the Class K portable fire extinguisher located in the kitchen needs to be provided with an instructional placard stating the fire suppression system shall be actuated prior to using the portable fire extinguisher. 4- The Maintenance Director/designee will complete audits to ensure that the Class K portable fire extinguisher located in the kitchen is provided with an instructional placard stating the fire suppression system shall be actuated prior to using the portable fire extinguisher. These audits will be conducted monthly X3 months. All results will be submitted and reviewed at the quarterly QAPI meeting for further recommendations.	
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 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	K 374		2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 374	Continued From page 10 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 observations and interviews on 01/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to ensure smoke barrier doors closed into their door frame when released from their hold open devices or closed leaving only the minimum clearance necessary for proper operation to resist the passage of smoke and fire for 2 of 10 smoke barrier doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.7 to 19.3.7.9, 8.3.3, 8.5.4, 8.5.4.1 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. An observation at 11:08 AM of the north wing smoke barrier double doors by room 211 revealed, one door leaf hit the other preventing the leaf from closing all the way into its frame when released from the fully open position. 2. An observation at 12:50 PM of the south wing smoke barrier double doors by room 102, revealed the door leaf on room 102 side bounced back and did not close all the way into its frame when released from the fully open position. The door leaf stayed 1-inch from the door frame. In interviews at the times, the U.S. FOIA [redacted] confirmed the observations. The facilities U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 02/03/2025 at 3:28 PM.	K 374	The north wing smoke barrier double doors by room 211 and smoke barrier double doors by room 102 were repaired to ensure smoke barrier doors closed into their door frame when released. This deficient practice had the potential to affect all residents. All other smoke barrier double doors were inspected to ensure smoke barrier doors closed into their door frame when released. All maintenance staff were re-educated by the Administrator on the requirement that smoke barrier doors must close into their door frame when released. Maintenance Director/Designee will audit 3 smoke barrier doors weekly x 4 and monthly x3 to ensure that the smoke barrier doors close into their door frame when released. All results will be submitted and reviewed at the quarterly QAPI meeting for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 374	Continued From page 11 NJAC 8:39-31.2(e) NFPA 80	K 374		
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined the facility failed to ensure electrical receptacles were maintained in residents rooms in accordance with NFPA 99: 2012 Edition and NFPA 70: 2011 Edition. The deficient practice had the potential to affect 4 residents and was evidenced by the following: 1. An observation at 11:10 AM of room 202 revealed a 4 way electrical receptacle cover plate had one side broken off exposing the metal of the right side receptacle. 2. An observation at 12:30 PM of room 121 revealed a duplex electrical outlet on the window wall by B bed was loose and protruding 1/2-inch out of the wall.	K 912	Room 202 receptacle cover plate and room 121 B bed receptacle cover plates were replaced. The deficient practice had the potential to affect 4 residents. All other resident rooms were inspected to ensure electrical receptacle covers were maintained correctly. All maintenance staff were re-educated by the Administrator on the requirement to ensure electrical receptacle covers are maintained correctly. Maintenance Director/Designee will audit 5 electrical receptacle covers weekly x 4 and monthly x3 to ensure the covers are maintained correctly. All results will be submitted and reviewed at the quarterly QAPI meeting for further recommendations.	2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING **01** B. WING _____	**02/03/2025**

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
K 912	Continued From page 12 In interviews at the times the [U.S. FOIA (b) (6)] confirmed the observations. The facilities [U.S. FOIA (b) (6)] was informed of the deficient practice during the Life Safety Code exit conference on 02/03/2025 at 3:28 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 912		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING 01 B. WING _____	02/03/2025

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
K 918	Continued From page 13 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interviews on 01/28/2025 and 02/03/2025 in the presence of the U.S. FOIA (b) (6)), it was determined the facility failed to: 1. ensure the diesel powered emergency power generator was exercised at equal to or greater than 30% of its name plate rating during the monthly full load tests or an annual 90 minute load bank test was conducted and 2. provide a remote emergency shut off station at a safe distance from the generator. In accordance with NFPA 110: 2010 Edition, Sections 8.4, 8.4.2, 8.4.2.3 and 5.6.5.6. The deficient practice had the potential to affect all residents and was evidenced by the following: 1. A documentation review on 02/03/2025 of the emergency power generator's inspection, testing and maintenance logs revealed the generator was exercised under full load each month for the last 12 months and no apparent percentage of the nameplate rating was recorded. In an interview at the time the U.S. FOIA stated the values given for Load: KW per Phase were percents of the nameplate rating for each of the 3 legs of the circuit.	K 918	Full load test was conducted on the generator and percentage of the nameplate rating was recorded. 90 minute load bank test was completed. The generator's emergency shut off button was relocated at a safe distance from the generator. This deficient practice had the potential to affect all residents. All maintenance staff were re-educated by the Administrator on the requirement to ensure the percentage of the nameplate rating is recorded when completing a full load each month. 90 minute load bank test conducted annually for where a diesel generator does not meet the 30% monthly load requirement. The generator's emergency shut off button is located at a safe distance from the generator. Maintenance Director/Designee will audit the generator log to ensure the percentage of the nameplate rating is recorded when completing a full load test. 90 minute load bank test conducted annually for where a diesel generator does not meet the 30% monthly load requirement. The generator's emergency shut off button is located at a safe	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING **01** B. WING _____	**02/03/2025**

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
K 918	Continued From page 14 The values were listed as: L1, L2, and L3 and were consistently less than 30% of the nameplate rating for each months test from January 2025 to January 2024 except June and July 2024 where leg 2 and leg 3 were above 30% and leg 1 was not, for those 2 months only. Further documentation review revealed there was no 90 minute load bank test conducted annually for where a diesel generator does not meet the 30% monthly load requirement. In an interview at the time, the [redacted] confirmed the documentation review. 2. An observation on 01/28/2025 at 10:28 AM revealed the generator's emergency shut off button was located on the exterior housing of the generator directly above the 720 gallon diesel fuel tank. In an interview at the time, the [redacted] confirmed the observation. The facilities U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 02/03/2025 at 3:28 PM. NJAC 8:39-31.2(e) NFPA 99, 110	K 918	distance from the generator, monthly x3. All results will be submitted and reviewed at the quarterly QAPI meeting for further recommendations.	

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 01 - MAIN BUILDING 01 B. Wing Y2	3/14/2025 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0271	02/25/2025	LSC K0300	02/27/2025	LSC K0321	02/27/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	02/27/2025	LSC K0355	02/27/2025	LSC K0374	02/27/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0912	02/27/2025	LSC K0918	02/27/2025	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	
2/3/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO