STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

(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
F0000	INITIAL COMMENTS Survey Date: 8/24/25 to 8/29/25 Census: 52 Sample: 14 + 2 closed records A Recertification/LSC survey was conducted at Hamilton Place at the Pines at Whiting from 8/24/25 to 8/29/25, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		09/12/2025
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0609	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. The incident of an NJ Exec Order 26.4b1 , identified for Resident # 22, was reported after the survey to the New Jersey Department of Health and The New Jersey Long Term Care Ombudsman on 9/16/25. 2.How the facility will identify other residents having potential to be affected by the same deficient practices. Residents who may experience an injury of unknown origin have the potential to be impacted. The Administrator and Director of Nursing checked all incidents of injury with unknown origin within the last four months for compliance to the reporting regulations per CFR 483.12(c) and such compliance was met. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? All management and line staff will be re-educated about reporting requirements for incidents of unknown injury in accordance with CFR 483.12(c) and the Community's	09/30/2025

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F0609 SS = E	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review it was determined that the facility failed to report an NJ Exec Order 26.4b1 to the New Jersey Department of Health (NJDOH) for 1 of 3 residents reviewed for NJ Exec Order 2 and incidents (Resident #22). This deficient practice was evidenced by the following: Refer to F610 On 8/25/25 at 9:30 AM, the surveyor observed Resident #22 in bed. When the surveyor inquired regarding their care, Resident #22 informed the surveyor that they had an NJ Exec Order 26.4b1 and their Representative would be able to elaborate on the incident later. On 8/26/25 at 10:30 AM, the surveyor observed a visitor at Resident #22's bedside, the visitor informed the surveyor that NJ Exec Order 26.4b1, the resident had reported to them NJ Exec to the NJ Exec Order 26.4b1 after an incident that occurred during NJ Exec Order with the NJ Exec Order 26.4b1 in the NJ Exec Order 26.4 The visitor further stated that they had reported the incident to the US FOIA (b)(6). The surveyor reviewed the medical record for Resident #22. The admission Face sheet reflected that Resident #22 had diagnoses which included but were not limited to NJ Exec Order 26.4b1 . A review of the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ/15 indicative of NJ Exec Order 26.4b1 . Resident #22 also required NJ Exec Order 26.4b1 from staff for care. A review of Section NJ Exec of the MDS which addressed NJ Exec Order 26.4b1, reflected that Resident #22 was NJ Exec Order 26.4b1 on staff for NJ Exec Order 26 and required NJ Exec Order 26.4b1 to NJ Exec Order from the bed to a wheelchair. A review of the Comprehensive Care Plan initiated NJ Exec Order, revealed that Resident #22 had a Focus for NJ Exec Order initiated NJ Exec Order 2. The goal reflected that Resident #22 would need assistance to NJ Exec Order 2 Interventions/Tasks included, " I will need a NJ Exec Or ". Initiated NJ Exec Order 26.4	F0609	Continued from page 1 policy and procedure, “Abuse Investigations”. The community's workflow for tracking and addressing incidents of unknown origin was re-organized to better facilitate full compliance with the requirements. The Administrator and Director of Nursing/Nurse Designee will complete a joint review of each incident of unknown origin based upon the reporting requirements to determine if the incident must be reported to the state and other authorities when applicable. All incidents along with the date and time, will continue to be concurrently logged by the Director of Nursing/Nurse Manager Designee on the Community's Incident Log. The Incident Log was revised to include, on the back page, the reporting requirements per CFR 483.12(c) which serves as a readily available reference for completing a timely and comprehensive incident review, reportable determination, and report to the state, if applicable. In addition, new tracking columns were added to the Incident Log to prompt for and ensure compliance with the reporting requirements. The Director of Nursing/Nurse Designee will complete the revised Incident Log accordingly to track that the reporting requirements were applied to each incident of unknown origin, a reportable determination was concluded, and that the state and other authorities were notified accordingly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Administrator will audit the Incident Log weekly and all coinciding incident investigations for four months to monitor compliance with timely completion and satisfaction of the reporting requirements. Audit findings will be reported to the Quality Assurance Performance Improvement (QAPI) Committee quarterly. When 100% compliance is achieved for four consecutive months, this audit will be discontinued. The QAPI Committee may subsequently make recommendations for periodic auditing.	

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F0609 SS = E	Continued from page 2 A review of the NJ Exec Order 26.4b1/Incident Report, completed by the Licensed Practical Nurse (LPN#1), dated NJ Exec Order 26.4b1 and timed 18:40 PM,(6:40 PM), indicated that Resident #22's resident representative (RR) had requested to speak with the nurse related to something that happened in the room. RR reported that during the NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 "[Resident #22's] NJ Exec Order 26.4b1" and would like LPN #1 to come to the room to see the resident. LPN #1 went to the room and Resident #22 reported that their NJ Exec Order 26.4b1" during the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1. The Certified Nursing Assistant (CNA#1) who cared for Resident #22 was questioned regarding the above concerns, and she confirmed that during the NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 the 'NJ Exec Order 26.4b1 ." The physician was notified and ordered an NJ Exec Order 26.4b1 to rule out NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 results dated NJ Exec Order 26.4b1 indicated the following: There is a NJ Exec Order 26.4b1 at the NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 ...Conclusion: There is a NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 which appears fairly recent. A review of the undated summary provided by the US FOIA (b)(6) did not include documentation that the New Jersey Department of Health (NJDOH) was notified of the NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 report dated NJ Exec Order 26.4b1 showed a NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1. A review of the Interdisciplinary notes written by the US FOIA (b)(6) concluded the following, "Based on the resident's history the Interdisciplinary Team (IDT) felt that the incident did not result in the NJ Exec Order 26.4b1 but NJ Exec Order 26.4b1 with the resident's NJ Exec Order 26.4b1." On 8/29/25 at 11:30 AM, the survey team asked if the incident had been reported to the New Jersey Department of Health (NJDOH). The US FOIA (b)(6)) stated that she did not report the incident. The information that was provided by the US FOIA (b)(6) did not indicate that the resident sustained an NJ Exec Order 26.4b1 the facility. The US FOIA (b)(6) informed the survey team that the incident was not reported as the facility concluded that the NJ Exec Order 26.4b1 did not happen during the NJ Exec Order 26.4b1 and provided no additional details. The surveyor reviewed the undated facility policy, Section "G" which addressed Injuries of Unknown Origin which indicated the following: An injury should be classified as an injury of unknown source when both of the following conditions are met:	F0609		

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F0609 SS = E	Continued from page 3 The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. The injury is suspicious because of the extent of the injury or the location of the injury. Injuries of unknown origin should be reported immediately as soon as possible, but ought not to exceed 24 hours after discovery of the incident. If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within five working days. INJAC 8:39-9.4(f)	F0609		
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to ensure a thorough and complete investigation was conducted, and documented for an NJ Exec Order 26.4b1 to ensure a) when a resident reported they were NJ Exec during a NJ Exec Order 26.4b1	F0610	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. On 8/14/25 all Certified Nursing Assistants (CNAs) were re-educated on the current plan of care for Resident # 22 and that, in advance of providing care on each shift, the NJ Exec Order of care plan tasks must be checked for any updates/changes. The US FOIA (b)(6) completed education regarding addressing investigations of NJ Exec Order 26.4b1 based upon CFR 483.12(c)(2)-(4) and the Community's policy and procedures, "Abuse Investigations" and "Incident and Accident Investigations". The Director of Nursing completed an investigation of the incident reported by Resident #22, dated NJ Exec Order in accordance with CFR 483.12(c)(2)-(4) and the above policies and procedures. The plan of care for Resident#22 was also immediately re-evaluated by the interdisciplinary team and measures are in place to help prevent recurrence of the incident. The responsible US FOIA (b)(6) were educated on 8/27/25 about the community's policy and procedure, "Facilitation of Safe Resident Transfers/Mobility and "use of Mechanical Lifts". 2. How the facility will identify other residents having potential to be affected by the same deficient practices. Residents who may have experienced an injury of unknown origin have the potential to be affected. The Administrator and Director of Nursing checked all	09/30/2025

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F0610 SS = E	Continued from page 4 NJ Exec Order while in the NJ Exec Order 26.4b experienced NJ Exec and b) was diagnosed with a NJ Exec Order 26.4b1, to determine the root cause and implement interventions to prevent recurrence. This deficient practice occurred for 1 of 3 residents reviewed for NJ Exec Order 26.4 and incidents (Resident #22) and was evidenced by the following: On 8/25/25 at 9:30 AM, the surveyor observed Resident #22 in bed. When surveyor inquired regarding the resident's care, Resident # 22 informed the surveyor that they had an NJ Exec Order 26.4b1 and their Representative (RR) would be able to elaborate on the incident later. On 8/26/25 at 10:30 AM, the surveyor observed the RR at the bedside, who then informed the surveyor that NJ Exec , Resident # 22 reported NJ Exec to their NJ Ex and informed them of an incident that had occurred during the NJ Exec Order with the NJ Exec Order 26.4b1) while in the NJ Exec Order 26.4b RR further stated that they then reported the incident that Resident #22 reported to the US FOIA (b) (6) (Licensed Practical Nurse- LPN #1). The surveyor reviewed the medical record for Resident #22. The admission Face sheet reflected that Resident #22 had diagnoses which included, but were not limited to; NJ Exec Order 26.4b1 . A review of the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ /15 indicative of NJ Exec Order 26.4b1 . Resident #22 also required NJ Exec Order 26.4b1 from staff for care. A review of Section NJ Exec of the MDS which addressed NJ Exec Order 26.4b1 reflected that Resident #22 was NJ Exec Order 26.4b1 , and required NJ Exec Order 26.4b1 to NJ Exec Order from the NJ Exec to NJ Exec Order 26.4b1 A review of the Comprehensive Care Plan initiated NJ Exec Order 2 revealed that Resident #22 had a Focus for NJ Exec Order initiated NJ Exec Order 2. The goal reflected that Resident #22 will need assistance to NJ Exec Order 2 Interventions/Tasks included, "I will need a NJ Exec Order 26) NJ Exec Order 26.4b1)". Initiated NJ Exec Order 26.4 A review of the Facility's Accident/Incident Report, completed by LPN #1, dated NJ Exec Order 2 and timed 18:40 PM	F0610	Continued from page 4 incidents of injury with unknown origin within the last four months for compliance to the reporting regulations per CFR 483.12(c)(2)-(4) and such compliance was met. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? On 9/12/25 the US FOIA (b)(6) completed education regarding policies and procedures, “Abuse Investigations” and “name” and the related protocol for conducting a comprehensive investigation that complies with CFR 483.12(c)(2)(4). An Incident Investigation Checklist was developed to prompt for and facilitate adherence to the investigation protocol for injuries of unknown origin. The Director of Nursing/Nurse Designee will initiate check list upon occurrence of an alleged incident of unknown and complete all components as specified, and document accordingly on the checklist. If the reporting requirements are met, then the incident will be reported to the state and other authorities when applicable. Refer to the measures in POC F0609. All CNAs were re-educated about the location of the Kardex in electronic medical record and to check for updates/changes in advance of providing care at the beginning of each shift. The Nursing Assignment Sheet will also be revised to include the transfer status of each resident that is documented in the resident care plan. The Nurse Manager/Nurse Designee will update the Nursing Assignment Sheet with any changes at time they are made. The Director of Nursing/Nurse Designee will educate all Nursing staff about the revised Nursing Assignment Sheet and required responsibilities for implementation. Education will also be provided to all Nursing staff about the Community’s policy and procedure, “Facilitation of Safe Resident Transfers/Mobility and "use of Mechanical Lifts". Re-education will continue to be provided annually thereafter. An annual competency of lift transfers will be completed by each CNA in accordance with the policy. Completion of this education and competency will also be continued as part of the CNA orientation process. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing/Nurse Designee will audit the Nursing Assignment Sheets weekly for three months for timely completion and transfer status accuracy. The	

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F0610 SS = E	Continued from page 5 (6:40 PM), indicated under "Incident Description: that Resident #22's RR, requested to speak with the nurse related to something that happened in the room. RR reported that during the [redacted] in the [redacted] [R 22's] '[redacted] and would like the nurse to come to the room to see" the resident. The nurse went to the room and Resident #22, who was lying in bed with [redacted] "got [redacted] during the NJ Exec Order 26.4b1 in the [redacted] The Certified Nursing Assistant (CNA #1) who cared for Resident # 22 was questioned regarding the above concerns, and she confirmed that during the [redacted] in the [redacted] the NJ Exec Order 26.4b1 [redacted] " yhe document did not identify how the resident was then [redacted] to [redacted] or by whom. Resident Description: '[redacted]". Was the incident witnessed: "no". Immediate Action Taken: Description: Assessment of resident "who is in bed", [redacted], resident interview, staff interview, call to [redacted] medical doctor. Order for [redacted] obtained. Notification to maintenance for [redacted] [redacted] Type: '[redacted] observed at time of incident." There was no documented assessment completed by a US FOIA (b)(6) . Predisposing environmental factors: "Medical Equipment" was checked. The Agencies/People Notified: [redacted] ". An [redacted] of the [redacted] to rule out [redacted] The [redacted], comparison: [redacted] indicated the following: There is a [redacted] at the [redacted] of the [redacted] and [redacted] of the [redacted]) ... Conclusion: There is a [redacted] in the [redacted] which appears "fairly recent." The incident report provided by the US FOIA (b)(6)) did not include statements from all staff involved with the incident. The causal factor was not identified. On 8/28/25 at 8:00 AM, the US FOIA (b)(6)) provided a questionnaire filled by the Certified Nursing Assistant (CNA #1) who cared for the Resident on [redacted] during the 3:00 PM- 11:00 PM shift. There were no statements from the 7:00 AM-3:00 PM shift. CNA #1 used the [redacted] and [redacted] Resident #22 [redacted] from the [redacted] to the [redacted] The facility was not aware that the [redacted] was being used for [redacted] device. An interview with CNA #1 revealed that she was not asked to write a statement, she was provided with a questionnaire to complete. On 8/28/25 at 9:08 AM, the [redacted] provided a statement	F0610	Continued from page 5 Administrator will monitor the timely completion and accuracy of the Incident Investigation Checklist weekly for four months. The Director of Nursing/Nurse Designee will also randomly conduct two weekly observations of resident lift transfers on alternating day and evening shifts, to monitor compliance with the policy and procedure, "Facilitation of Safe Resident Transfers/Mobility and "use of Mechanical Lifts". All audit results will be reported to the QAPI Committee quarterly. When 100% compliance of each audit is achieved over the consecutive months of monitoring specified, it will be discontinued. The QAPI Committee may subsequently make recommendations for periodic monitoring to continue.	

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F0610 SS = E	Continued from page 6 from CNA #2. However, CNA #2 was not involved with the [redacted] On 08/29/25 at 9:25 AM, the surveyor, in the presence of the survey team, interviewed CNA #1 about the incident with Resident #22. CNA #1 stated the RR requested that the [redacted] and take the resident to the [redacted] CNA #1 stated she asked LPN #1, the [redacted] for the shift, for clarification since there was a NJ Exec Order 26.4b1 next to Resident #22's bed (a [redacted]) and LPN #1 then told her that per the Care Plan for Resident #22, CNA #1 had to use the [redacted] to take Resident #22 from the [redacted] to the [redacted] And according to CNA #1's assignment sheet for Resident #22 they were identified as requiring a [redacted] with NJ Exec Order 26.4b1. CNA #1 stated it was not the first time she used the [redacted] by herself. When asked if she had been trained to use the [redacted] she stated, "no." CNA #1 stated, she always thought it was one person for a [redacted] and two people were required for [redacted] CNA #1 stated she had access to the Care Plan, but the assignment had the [redacted] status and CNA #1 went with that, and what LPN #1 instructed her to do. CNA #1 stated, when she was [redacted] Resident #22 to the [redacted] and [redacted] them, "the NJ Exec Order 26.4b1, and when it [redacted], and [Resident #22] [redacted] Then, "the [redacted] part that was around [redacted] up to [redacted] and [redacted], and Resident #22 [redacted] in the [redacted] and is a NJ Exec Order 26.4b1], and I've been saying they should be [redacted]." CNA #1 stated that CNA #3 came when I called for help and stated that Resident #22 "[redacted]." When asked who assessed Resident #22? CNA #1 could not recall, and stated she reported what happened to the nurse immediately and LPN #1 gave both her and CNA #3 a questionnaire to fill out, and CNA #3 no longer worked at the facility. CNA #1 stated she was not asked specifically what happened or to document it. When asked if she was educated, to provide a return demonstration with the [redacted] she stated, "no". On 08/29/25 at 11:10 AM, a follow-up interview with CNA #1 was conducted and the survey team asked if a nurse was present and assessed the resident. CNA #1 stated, the Registered Nurse (RN #1) did not assess Resident #22 after the [redacted] and she did not come into the [redacted] to assess the resident. On 8/29/25 at 11:30 AM, the [redacted] confirmed that the investigation was not complete. When inquired regarding a statement from CNA #3, the [redacted] stated that she attempted on [redacted] (14 days later) to reach CNA#3 but he would not answer the call.	F0610		

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F0610 SS = E	Continued from page 7 On 08/29/2025 at 1:29 PM, the survey team met with US FOIA and the US FOIA (b)(6) and shared the above, and the facility stated the NJ Exec was for NJ Exec Order 2 "not transport", and confirmed they were not aware that CNA #1 used the NJ Exec for transport. There was no "Root Cause Analysis". There were no interviews available from CNA #3 and all of the staff who worked during the 3:00 PM-11:00 PM shift according to the documentation reviewed. The US FOIA was unable to provide interviews or documented statements from all staff that were present during the incident. The surveyor reviewed the facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property) under procedure the following were documented: The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. The investigation will include: Who was involved. Residents' statement. Resident's roommate statements. Involved staff and witness statements. A description of the resident's behavior and environment at the time of the incident. Injuries present including a resident assessment. Observation of resident and staff behaviors during the investigation. Environmental considerations. All staff must cooperate during the investigation to assure the resident is fully protected. NJAC 8:39-4.1(a)5	F0610		
F0686 SS = E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F0686	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. On 8/28/25 the Nurse assigned to Resident # 2 was	09/30/2025

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(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
F0686 SS = E	Continued from page 8 §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: Based on observation, interview, and record review, it was determined that the facility failed to: a.) ensure wound care was done in accordance with professional standards of practice, and b) staff were trained and followed infection control measures during NJ Exec Orde care to prevent potential NJ Exec Order 26 This deficient practice was identified for 1 of 2 residents reviewed with NJ Exec Order 26.4b1 (Resident # 2) and was evidenced by the following: On 8/25/25 at 7:58 AM, the surveyor inquired about Resident#2's NJ Exec Orde and the nurse confirmed that Resident #2 was admitted with a NJ Exec Order 26.4b1 surveyor informed the US FOIA that she would observe the NJ Exec Orde care on the next day. On 8/26/25 at 11:15 AM, the surveyor observed the following NJ Exec Orde care provided by the US FOIA (b)(6) -The US FOIA entered the room to provide NJ Exec Orde care to Resident #2 NJ Exec Order 26.4b1 . The US FOIA performed hand hygiene (HH) with soap and water, then returned to the treatment cart to collect the items needed for the NJ Exec Orde care. -At 11:30 AM, the surveyor observed the US FOIA placed all the items needed on the resident's bedside table. The US FOIA NJ Exec Order 26.4b the resident to the NJ Exec Order 26.4b1 the NJ Exec Or to be treated. The US FOIA removed and disposed of the NJ Exec Order 26.4b1 in the plastic bag. The US FOIA did not remove her gloves, or perform HH. -The surveyor hen observed the US FOIA NJ Exec Order 2 the resident's NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1 , patted the NJ Exec Order 26.4b1 and then without first performing HH,	F0686	Continued from page 8 re-educated regarding professional standards of NJ Exec Orde care and required NJ Exec Order 26.4b1 and control practices in accordance with CFR 483.25(b)(1)(i)(ii) and the Community's NJ Exec Orde care policy and procedure Wound Care Treatment Management" and the "Clean Dressing Change Procedure Guide". 2.How the facility will identify other residents having potential to be affected by the same deficient practices. All residents with wounds have the potential to be affected. 3.What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? The Infection Preventionist in-serviced all Nurses regarding the Community's wound care policy and procedure Wound Care Treatment Management" and the "Clean Dressing Change Procedure Guide on 8/28/25. The Infection Preventionist will ensure that each Nurse completes a wound care competency through return demonstration to evaluate compliance with the wound care policy and procedure and CFR 483.25(b)(1)(i)(ii). The same re-education will be continued annually and will include the completion of the wound care competency by each Nurse. Further, this education is included in the orientation of newly hired Nurses, and successful completion of the wound care competency will be added as a requirement. The Infection Preventionist/Designee will provide re-education and arrange a repeat wound care competency if initial completion is unsuccessful. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The Infection Preventionist will conduct wound care competency audits twice weekly for three months through the observation of different, individual Nurses including those on the off-shifts. The Infection Preventionist will report the audit results to the Director of Nursing weekly, and to the Infection Prevention and Control (IPC)/QAPI Committee quarterly. This audit will be discontinued when 100% compliance is	

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F0686 SS = E	Continued from page 9 used the same gloves to [NJ Exec] the [NJ Exec Order]. The [US FOIA] then covered the [NJ Exec Ord] with the NJ Exec Order 26.4b1 and ordered and [NJ Exec Order 26.4b1] the resident to the [NJ Exec Ord] area. The [US FOIA] then, without first performing HH, used the same gloves hand to apply NJ Exec Order 26.4b1 to the resident's [NJ Exec]. The [US FOIA] then removed her gloves, washed her hands, and put on another pair of gloves and informed the surveyor that she had to [NJ Exec Order] Resident #2's [NJ Exec Order 26.4b1]. The surveyor reviewed Resident #2's electronic medical record. The admission Face Sheet reflected that Resident # 2 had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Ord] reflected that the resident was at [NJ Exec Order 2] for NJ Exec Order 26.4b1 [redacted]. The Comprehensive Care Plan initiated [NJ Exec Order] had a focus for [NJ Exec Order 26.4b1] on the [NJ Exec Order 26.4b1] [redacted]. The interventions included to assess and document status of [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1] and [NJ Exec Order] progress. Administer treatments as ordered and monitor effectiveness. Report improvements and declines to the physician. A review of the Physician's Orders sheet (POS) for [NJ Exec Order 26.4b1], reflected an order dated [NJ Exec Order] for the [NJ Exec Order 26.4b1] to be [NJ Exec Order 26] with NJ Exec Order 26.4b1. Apply NJ Exec Order 26.4b1 and [NJ Exec O] with NJ Exec Order 26.4b1 during the day shift for [NJ Exec O]. On 8/26/25 at 12:30 PM, the surveyor requested the facility [NJ Exec Ord] care policy for review. On 8/26/25 at 1:48 PM, the US FOIA (b)(6) provided the [NJ Exec Order 26.4b1] change procedure guide dated [NJ Exec Order 2]. The following were noted: Policy: It is the policy of this facility to provide wound care in a manner to decrease the potential for infection and/ or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. Policy Explanation and Compliance Guidelines:	F0686	Continued from page 9 achieved for three consecutive months. The QAPI Committee may subsequently make recommendations for periodic monitoring to continue.	

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F0686 SS = E	Continued from page 10 4. Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application. Place only supplies to be used per wound on the clean field at one time. Wash hands and put on gloves. Place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites Loose the tape and remove the existing dressing. Remove gloves, Discard into appropriate receptacle. Wash hands and put on clean gloves. Cleanse the wound as ordered. Wash hands an put on clean gloves. Apply topical ointment and dressed the wound as ordered. On 8/26/25 at 2:15 PM, the surveyor reviewed the [NJ Exec Or] [redacted] procedure guide with the [US FOIA] in the presence of the survey team. The [US FOIA] confirmed that she did not change her gloves as indicated in the policy. The [US FOIA] stated also that she was not aware of the facility procedure guide for clean [NJ Exec Order 26.4b1]. NJAC 8:39-27.1 (e)	F0686		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F0690	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Resident # 20 immediately received a new privacy cover and [NJ Exec Order 26.4b1] [redacted] which was hooked to the bed to prevent [NJ Exec Order 26.4b1] The responsible [US FOIA] was educated about the Community's policy and procedure, "Catheter Care, Urinary Catheter Leg Drainage Bags" to comply with CFR 483.25(e)(1)-(2). 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents with indwelling urinary catheters have the potential of being affected. All residents with indwelling urinary catheters were checked for proper	09/30/2025

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F0690 SS = D	Continued from page 11 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and review of facility documents, the facility failed to provide appropriate [redacted] care for 1 of 2 residents reviewed for [redacted] (Resident #20). This deficient practice was evidenced as follows: On 8/24/25 at 8:30 PM, the surveyor observed Resident #20 in bed. The residents [redacted] was noted to be on the left side of the bed, [redacted] on the floor. The [redacted] was not in a [redacted]. On 8/24/25 at 9:45 PM, the surveyor observed that the resident's [redacted] was in the same position, directly touching the floor and was not in a [redacted]. Same observation verified with another surveyor. A review of Resident #20's Admission Record reflected that the resident was admitted with diagnoses which included but were not limited to: [redacted] A review of Resident #20's Admission Minimum Data Set (MDS), a tool to facilitate the management of care, dated revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which reflected that he/she was [redacted]. Normal Score [redacted] The MDS also reflected that the resident required [redacted] of 1 [redacted]	F0690	Continued from page 11 catheter bag positioning/placement, storage and coverage. No other residents were affected by the deficient practice. Infection Preventionist will also in-service all Nurses and CNAs about the Community's policy and procedure, "Catheter Care, Urinary Catheter Leg Drainage Bags on 8/25/25. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? A new model of indwelling catheter bags was purchased that provides more secure fastening to the bed and chair to prevent floor contact and includes consistent, privacy coverage. On 9/3/25 the new indwelling catheter bags were applied to replace all existing ones. On 9/2/25 the Infection Preventionist will also in-service all Nurses and CNAs about the Community's policy and procedure, "Catheter Care, Urinary Catheter Leg Drainage Bags" to facilitate compliance with CFR 483.25(e)(1)-(2). 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Infection Preventionist/Designee will conduct two weekly, random audits, rotating the shifts, to monitor compliance with positioning of the catheter draining bag off the floor, maintaining privacy coverage protection, and proper storage of urinary drainage bag when temporarily replaced. The Infection Preventionist/Designee will complete a weekly observation audit, rotating day and evening shifts, to monitor CNA compliance with the proper emptying and cleaning of a catheter draining bag/port. The Infection preventionist/Designee will complete these audits for three months and present the results to the Director of Nursing weekly and to QAPI Committee quarterly. When 100% compliance achieved for three consecutive months, the audits will be discontinued. The QAPI Committee may subsequently make recommendations for periodic monitoring to continue.	

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F0690 SS = D	Continued from page 12 NJ Exec Order 26.4b1. In addition, the MDS reflected that the resident had a NJ Exec Order 26.4b1 A review of Resident #20's Order Summary Report for NJ Exec Order 26.4b1 reflected a physician's order for NJ Exec Order one time a day starting on the NJ Exec and ending on the NJ Exec every month for NJ Exec care NJ Exec Order 26.4b1. A review of Resident #20's Care Plan initiated NJ Exec Order 26.4b, reflected an order for NJ Exec Order 26.4b1. The goal was for Resident #20 will show no signs and symptoms of NJ Exec Order through review date. The interventions included: Change NJ Exec Order 26.4b1 as per Physician order. NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the level of the NJ Exec Order and away from entrance room door. Maintain NJ Exec Order 26.4b1 as ordered. Resident #83 not to have NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1. The interventions included to maintain the NJ Exec Order 26.4b1 below NJ Exec Order 26.4b1, secure the NJ Exec Order with a NJ Exec Order 26.4b1, and report signs of a NJ Exec to the physician. On 8/25/25 at 9:15 AM, the surveyor observed the resident seated in a recliner chair at the bedside. A US FOIA (b)(6)) was at the bedside assisted the resident with the breakfast meal. Upon inquiry, the US FOIA informed the surveyor that Resident #20 NJ Exec Order 26.4b1 during the day for ease of NJ Exec Order The surveyor went to the resident's NJ Exec Order 26.4 and observed the NJ Exec Order 26.4b1 stored in a plastic bag hung on the rail in the bathroom. The NJ Exec Order 26.4b1 was not NJ Exec Order and NJ Exec Order 26.4b1 residual was noted in the NJ Exec On 8/25/25 at 9:30 AM the surveyor interviewed the US FOIA regarding the storage of the NJ Exec Order 26.4b1 The US FOIA stated in the morning she would empty the NJ Exec Order 26.4b1, measured the NJ Exec O rinsed the NJ Exec with water and stored the NJ Exec in the NJ Exec Order 26.4b The surveyor then inquired regarding the NJ Exec Order 26.4 of the NJ Exec Order 26.4b1. The US FOIA stated, 'NJ Exec O ars ago it was the norm to NJ Exec Order 26.4b1, but not anymore". The US FOIA added upon orientation I was not informed to NJ Exec Order 26.4b1. On 8/25/25 at 10:15 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the protocol for	F0690		

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F0690 SS = D	Continued from page 13 the storage of the NJ Exec Order 26.4b1 . The US F stated she preferred a closed system to NJ Exec Order However the facility reused the NJ Exec Order 26.4b1 and used a NJ Exec Order during the day. The US F stated that the CNAs were to NJ Exec Order 26.4b1 before switching the NJ Exec O rinse the NJ Exec NJ Exec and store in a plastic NJ Exec in the NJ Exec Order 26.4b The surveyor accompanied the US F in the NJ Exec Order 26.4 and observed the NJ Exec Order 26.4b1 stored in the NJ Exec Order 26.4 with NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 was not NJ Exec Order 2 During a second interview with the US FOIA in the presence of the US F the US FOIA stated clearly, "I did not know that I have to disinfect the NJ Exec O I learned something today>" On 8/28/25 at 2:15 PM, the surveyor interviewed the US FOIA (b)(6) assigned to Resident #20 regarding the storage of the NJ Exec Order 26.4b1 The US FOIA stated ,that the NJ Exec Order 26.4b1 be in a NJ Exec Order 26.4b1 for NJ Exec Order and should not be stored with NJ Exec Order 26.4b1. On 8/28/25 at 2:30 PM, the surveyor interviewed CNA #2. She stated that if a resident had a NJ Exec Order 26.4b1 it should have been in a NJ Exec Order 26.4b1 and, it should not touch the floor to avoid contamination. A review of the facility policy "Catheter Care, Urinary Catheter Leg Drainage Bags" with a revised date of 6/17/25, indicated the following: "It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheter are in use. When assisting resident back to bed, Wash hands or use alcohol-based hand rub. Apply clean gloves. Disconnect the leg bag from catheter tubing reconnect to Foley drainage bag. Rinse, replace cap on leg bag connector, and store leg bag in plastic bag in the resident's bedside stand or designated spot in resident's bathroom. " Under Infection Control it is stated: "Use standard precautions when handling or manipulating the drainage system." "Be sure the catheter tubing and drainage bag are kept off the floor." The policy was not being followed." NJAC 8:39-19.4 (a)5	F0690		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F0812	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies.	09/30/2025

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F0812 SS = F	Continued from page 14 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that the facility failed to ensure the kitchen and remote food service pantry were maintained in a clean and sanitary manner to prevent the spread of potential infection and food borne illness. The deficient practice was evidenced by the following: On 08/25/2025 at 8:59 AM, the surveyor toured the food service pantry with a US FOIA (b)(6)) who stated the meals were brought up to the pantry from the main kitchen, and served via the pantry. The US FOIA confirmed the dish machine located in the pantry was also utilized to wash the lunch and dinner dishes. The surveyor observed the following:The walls and ceilings were soiled with various colored debris and stained throughout.The cutting board, attached to the steam table was visibly stained and grooved. The US FOIA moved the steam table away from the wall and the area behind the steam table was soiled with various crumb type debris.The plastic wrap container was soiled with grease type marks.The metal shelves underneath the counter contained three containers that held lids and containers. The shelves had visible debris on them, and the containers were visibly soiled with various debris on the outside. The dish machine drain area had debris in the drain and small flies were flying around with debris including paper and a pink wipe were crumbled up	F0812	Continued from page 14 a. In the Pantry: The soil, debris and stains were cleaned from walls, floors and ceiling, the cutting board was immediately discarded, and a new cutting replacement board was ordered, and the area behind steam table was cleaned. The soiled plastic wrap containers and shelves identified were cleaned. The dish machine drain was cleared of crumbs and debris and cleaned, and the dish machine vent hood was cleaned. Further, the reach in the refrigerator gasket was cleaned. Steak knives with worn handles were replaced with new steak knives. The containers on the metal shelves were replaced with covered containers to store the lids. The soiled garbage can was cleaned and white wall vent cleaned behind the plate warmer. All items listed were completed on 8/25/2025. b. In the Main Kitchen: The walk-in refrigerator was cleaned of dust like debris in the fan vents and the corner wall noted was cleaned. All sprinkler heads noted, and the ceiling vents were cleaned. The ice scoop was cleaned and a new holder with cover was installed. Dust and debris were cleaned from walls, floor to ceiling. The stainless steel, hood filters above the stove area were cleaned. The fryer oil was replaced and surrounding area including the floor was cleaned. The knife rack and surrounding food preparation area including metal shelf were cleaned. The vent area noted, and utensils underneath were cleaned, and the cobwebs noted were removed and the area was clean/dusted. The can opener insert was replaced. The dry storage room metal racks were cleaned and free of dust and debris. New metal racks were ordered and installed to replace the racks. All items listed were completed on 8/25/2025. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents and staff have the potential of being affected by failing to ensure the kitchen and remote food service pantry were maintained in a clean manner to prevent the spread of potential infection and food borne illness.NJ Exec Order 26.4b1 have completed a thorough inspection and review of the kitchen area to ensure no other deficient items are present or issues exist. 3. What measures will be put into place or systemic	

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F0812 SS = F	Continued from page 15 on the floor. The vent hood over the dish machine was visibly soiled with dust like debris surrounding the opening of the vent as well as inside the vent. A pink cleaning wipe was rolled up on the floor.The reach in refrigerator had blackened debris inside the gasket.Steak type knives with wood handles were in the knife rack and the handles were visibly worn.A garbage can was visibly soiled on the exterior of the canThe white wall vent behind the plate warmer was visibly soiled with blackened debrisThe surveyor then entered the main kitchen at 9:24 AM and observed the following in the presence of the US FOIA (b)(6) The large walk in refrigerator had dust like debris above both fans and blackened areas with debris in both of the vents of the fans, and debris in the corner of the wall where the wall meets the ceiling.The sprinkler head on the walk in refrigerator ceiling had blackened debris. The US FO confirmed the observations and the US FOIA stated the vents were cleaned quarterly. The ice scoop was uncovered and on a wall next to the ice machine.The ceiling vents throughout the main kitchen had visible dust like debris and darkened areas inside the vents. The US FO stated, the kitchen staff were responsible to clean up until 6 feet high on the wall and not the ceiling vents. Dust like debris was observed on the wall throughout various areas on the kitchen ceiling tiles.Two stainless steel hood filters above the stove had blackened areas of debris and a nozzle over the area that dispensed a fire protection agent appeared embedded with a grease like substance. The dry storage room contained metal racks with embedded dust like debris and dust like debris was under the food storage racks. The observations were confirmed by the US FO .The fryer oil was black and dark and the US FO stated, "it needed to be changed." Visible debris was on the floor under the fryer.The knife rack by the food preparation area was soiled with debris and the metal shelf in the same area had visible crumb like debris.The vent area was visibly soiled with debris. Under the vent area where uncovered utensils that were hanging, in that area a cob web was observed and was pulled down by the DM.The can opener insert had blackened debris on it.NJAC 8:39-17.2(g)	F0812	Continued from page 15 changes made to ensure that the deficient practice would not recur? NJ Exec Order 2 Food Service company will complete a thorough Daily/Weekly and monthly inspection and review of all kitchen areas to ensure no issues exist. Kitchen inspection checks listed, and daily task list were developed to include all areas found deficient noted from survey. NJ Exec Order 2 Food Services Director and NJ Exec Order 2 Food Services Registered Dietitian will conduct 5 audits of pantry and 5 audits of main kitchen each week and will review the completed daily check list weekly for thorough completion of daily cleaning tasks for 6 months. The NJ Exec Order 2 Food Service Director will report to Administrator all findings. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. NJ Exec Order 2 Food Service company, and NJ Exec Order 26.4b1 will complete quarterly inspections and reviews of the main kitchen area and pantry to ensure no issues exist and the continued effectiveness of the systemic changes. The Culinary Services Director will report all findings of audits to the Administrator weekly for 6 months and to QAPI Committee quarterly. All findings will be reported to the QAPI committee quarterly for 6 months and if 100% compliance is reached the committee will determine the time frame of continued monitoring as necessary or discontinuation.	
F0880 SS = E	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	F0880	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. The US FOIA (b)(6) completed education on 9/2/25 about strict and timely adherence to and oversight of the Community's infection	09/30/2025

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HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

(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
F0880 SS = E	Continued from page 16 prevent the development and transmission of communicable diseases and infections. §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 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.	F0880	Continued from page 16 prevention and control policies in response to a positive COVID-19 case. Education addressed that all measures of the Community's "Outbreak Response Plan", policy and procedure, "Standard Precautions Infection Control" and the current "NJDOH Respiratory Outbreak Checklist" must be implemented timely to ensure compliance with CFR 483.80, and CDC and state guidelines for respiratory viruses. On 9/3/25, the Infection Preventionist educated all Nurses, CNAs and Dining Room servers who were working about the requirement to perform proper hand hygiene, in accordance with CFR 483.80 and the Community's policy and procedures, "Hand Hygiene and Standard Precautions Infection Control" including when assisting with meals and using the phone. Signage in the Dining Room was immediately placed for the cueing of proper hand hygiene. On 8/27/25 and 9/3/25, all Nurses and Certified Nursing Assistants who were working also received an in-service about protocol for offering hand sanitizer to all residents prior to dining and assisting them with hand hygiene as necessary. In addition, working Life Enrichment staff were educated on 9/4/25 about offering hand sanitizer to residents prior to dining. The above education was continued and completed on 9/9/25 for all remaining Nursing, Dining and Life Enrichment staff. 2.How the facility will identify other residents having potential to be affected by the same deficient practices. All residents, visitors, and staff have the potential to be affected. 3.What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? On 9/3/25 The Infection Preventionist re-educated all Nursing staff about the performance of proper hand hygiene in accordance with policies and procedures, "Hand Hygiene and Standard Precautions". The Infection Preventionist/Designee will complete a hand hygiene competency for each Nursing staff member that is based upon successful return demonstration. The protocol for completion of hand hygiene competencies was updated to include a semi-annual competency for Nursing staff. Re-education about the hand hygiene policy and competency completion will be repeated to address any unsuccessful return demonstration of hand hygiene. On an ongoing basis, the Infection	

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F0880 SS = E	Continued from page 17 §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: Based on observation, interview and document review, it was determined that the facility failed to ensure infection surveillance was implemented during a NJ Exec Order 26.4b1 and prevent the spread of potential infections ensuring that a.) staff performed hand hygiene prior to serving meals and b.) residents were provided with opportunities to wash their hands prior to dining. This deficient practice was evidenced by the following: During the initial tour of the facility on 8/24/25 at 8:00 PM, the surveyor observed signage posted at the entrance door for all to wear a mask prior to entering the facility. The US FOIA (b) (6) informed the team that the facility was in an NJ Exec Order 26.4b1 . On 8/25/25 at 11:21 AM, the surveyor met with the US FOIA (b)(6) who confirmed the facility was in a NJ Exec Order 26.4b1 which started on NJ Exec Order 26 The US confirmed that the NJ Exec Order 26 included NJ E residents and NJ staff members who tested NJ Exec Order 2 for NJ Exec Order 26.4b . The US stated that the NJ Exec Order 26 will be completed on NJ Exec Order if no other cases were identified. The surveyor requested the facility's line listing for review which revealed NJ E residents and N staff members had been identified. According to the document provided, the NJ Exec Order 26.4b1 with one staff member. The staff was NJ Exec Order 26.4b1 at work and presented with the following NJ Exec Order 26.4b1 The staff member tested at the facility and was NJ Exec Order 26.4b1 .	F0880	Continued from page 17 Preventionist/Designee will also conduct at least three weekly, random observations of Nursing staff, hand hygiene compliance, across all shifts and including during Dining. During outbreaks, the observations will be done at least five times weekly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Infection Preventionist/Designee will conduct ten random observations of staff hand hygiene on a weekly basis, alternating the shifts. This audit will be completed for four months, and the results will be reported to the IPC/QAPI Committee quarterly. The audit will be discontinued when 100% compliance is achieved for four consecutive months. Additionally, the Infection Preventionist/Designee will randomly complete five weekly audits of staff adherence to protocol for offering and facilitating resident, hand hygiene prior to Dining, alternating the observations between the Dining Room and resident suites. This audit will be discontinued when 100% compliance is achieved for four consecutive months. Thereafter, the Infection Preventionist/Designee will report the results of the ongoing audits, i.e., listed under # 3, to the IPC/QAPI Committee on a quarterly basis. When 100% compliance achieved for three consecutive months, the audits will be discontinued. The QAPI committee may subsequently make recommendations for periodic monitoring to continue.	

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F0880 SS = E	Continued from page 18 On 8/26/25 at 9:30 AM, the surveyor again requested from the [US F] to identify the measures that were put in place following the onset. The [US F] informed the surveyor that she had been on [NJ Exec Order 2] at the time and the US FOIA (b)(6)) would have the documents requested. On 8/28/25 at 10:30 AM, the surveyor met with the [US F] to request the NJ Exec Order 26.4b1 of symptoms for three residents (Resident #20, Resident #45 and Resident #49) who were identified as [NJ Exec Order] for [NJ Exec Order 26.4b]. The [US F] stated the [NJ Exec Order 26.4b] should include vital signs and other symptoms, such as [NJ Exec Order 26.4b1] . The [US F] was unable to provide any NJ Exec Order 26.4b1 documents as requested. The surveyor then reviewed the Progress Notes (PN) with the [US F] who confirmed there was no documentation in the PN that residents had been [NJ Exec Order 26.4] for symptoms during the NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. On 08/29/2025 9:23 AM 8:10 AM, the survey team interviewed the [US F] about the [NJ Exec Order 26] of [NJ Exec Order 26]. The surveyor asked what was your evidenced based guidance that the facility used for infection control/surveillance to prevent the spread of [NJ Exec Order 26.4], and the [US F] stated, "I don't understand", and would find out and provide. Asked what were her roles, and the [US F] stated that infection control and other jobs as needed, when asked how many hours for NJ Exec Order 26.4b1. The [US F] then stated the employee worked who [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4] worked and left on [NJ Exec O] and went home and tested the following day. The [US F] then stated, she wasn't working during the [NJ Exec Order 26.4] she was on [NJ Exec Order 2] unti [NJ Exec Order 2] and she was not involved in the [NJ Exec Order 26] management. On 8/29/25 at 8:20 AM, the surveyor interviewed the US FOIA (b)(6)) who stated she became aware of the first staff NJ Exec Order 26.4b1 but did not document it. The next morning [NJ Exec Order] was when she had implemented wearing and told staff to wash hands. When asked about potential exposure of the [NJ Exec Order 26] [NJ Exec Order] staff to residents, the [US FOIA] stated there had to be NJ Exec Order 26.4b1. When asked if that exposure was at one time or cumulative over multiple small amounts of time, the [US FOIA] stated "I don't know". When the surveyor questioned the [US FOIA] regarding the testing of potentially exposed residents to the [NJ Exec Order] staff member the [US FOIA] stated "only after one resident had symptoms and [NJ Exec Order 26.4b1] were residents [NJ Exec Orc] on NJ Exec Order 26.4b1. The [US FOIA] further stated "this was the first time I dealt with	F0880		

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F0880 SS = E	Continued from page 19 NJ Exec O in this building." On 8/29/25 at 10:30 AM, during an interview with the US FOIA (b) she stated there was a discrepancy on the line listing. The US FOIA stated that the initial staff who NJ Exec Order 26.4b1 had tested at home after their shift and not during work at the facility. However, a review of the staff member's timecard revealed the staff member had been working and then became NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 for NJ Exec Orde prior to exiting the facility. The US FOIA could not provide any documentation to confirm measures had been implemented from NJ Exec Order 2. On 8/27/2025 at 8:40 AM, the surveyor observed CNA #1 assisting Resident #20 with their breakfast meal. CNA #1 first donned gloves, adjusted the resident's bed and positioned the resident for the meal. Then using the same gloved hand opened the resident's tray, their drink, peeled their banana and set the other items on their meal tray. The resident was not provided the opportunity to wash their hands prior to eating breakfast. CNA #1 confirmed there was no hand sanitizing cloth on the resident's meal tray. CNA #1 then went to the bathroom and washed her hands under running water for five seconds. On 8/27/25 at 8:50 AM, during an interview with CNA #1, she confirmed that she washed her hands under running water. CNA #1 stated, "if you want you can take your hands out of the water you can". The surveyor then asked CNA #1 if she had received an in-service on hand hygiene, she stated sometime this year but could not remember the exact date. On 8/27/25 at 10:10 AM, the surveyor interviewed the US FOIA (b) in the presence of the US FOIA (b)(6) and inquired whether the facility had a US FOIA (b)(6), both stated they were all responsible for the staff education. 3. On 8/28/25 at 8:45 AM, the surveyor observed the meal tray delivery in the dining area. The surveyor observed CNA #2 assist residents to their tables, went to the food cart collected their trays, set up the trays, used the phone to request assistance in the dining room, returned to the food cart to retrieve more trays and failed to sanitize her hands at any time between the tasks. In addition the residents were not provided with opportunities to sanitize their hands prior to their breakfast meal. On 8/28/25 at 11:30 AM, during an interview with CNA #2, she stated residents washed their hands during morning care and confirmed hand sanitizing cloths were	F0880		

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F0880 SS = E	Continued from page 20 not provided on resident's meal trays to sanitize the resident's hands. A review of the facility provided education transcript revealed that CNA #1 and CNA #2 had completed on-line education which included but was not limited to infection control and prevention, as well as hand hygiene. When the surveyor inquired regarding the CNAs' ability to then demonstrate proper handwashing technique, the US FOIA stated that depended on the topic and would not elaborate further. On 8/29/25 at 12:30 PM, the surveyor in the presence of the survey team informed the US FOIA (b)(6) about the above concerns, the US FOIA indicated that they acknowledged the concerns and staff would be re-educated. A review of the facility's outbreak response plan last revised 2/20/24 revealed the following: The Infection Preventionist actively monitors and for new and past outbreaks among residents and team members and documents positive findings (those with suspected symptoms and positive tests) on the line list. Surveillance activity will be increased to at least daily until the outbreaks ends. Nursing team members will monitor residents every shift for early recognition of infectious disease symptoms. A review of the Infection Preventionist/ Unit Support Nurse Job Description revealed the following under Essential Function: Conducts ongoing surveillance of infection, analyses data, and identifies trends to implement targeted interventions. The facility's policy for hand hygiene last revised 5/2/25... indicated the following: All team members will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors... alcohol based hand rub... is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. Hand hygiene technique when using soap and water: wet hands with water. Avoid using hot water to prevent drying of skin. Apply to hands the amount of soap recommended by the manufacturer. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse hands with water. Dry thoroughly with a single-use towel. Use clean towel to turn off the faucet...Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand	F0880		

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F0880 SS = E	Continued from page 21 hygiene prior to donning gloves, immediately after removing gloves. NJAC 8:39-19.4(e)(m)(n).	F0880		

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HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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S0000	Initial Comments Survey Date: 8/24/25 to 8/29/25 Census: 52 Sample: 14 + 2 closed records The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S0000		09/12/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 2 of 14 day shifts reviewed. This deficient practice was evidenced by the following: a) Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21:	S0560	How will the corrective action be accomplished for those residents found to be affected by deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. There were no negative outcomes noted to residents on the day shifts identified as not meeting the NJ staffing requirements on the dates of 8/11/25 and 8/23/25. All residents were assisted with their activities of daily living, meals, and call bell requests, without deviation from the plan of care. In addition, the rehabilitation team rendered bedside ADL assistance to residents receiving therapies. A key root cause identified by our team is the increase in higher paying, non-healthcare related positions of which a number do not require off-shift/weekend/holiday hours and involve less physical work. There has also been a decrease in enrollment in CNA certification courses. In addition, despite staffing for the appropriate ratios, staff call outs, at times without proper notice, were also a contributing factor. How the facility will identify other residents having	09/30/2025

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

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S0560	Continued from page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 8/10/2025 to 8/23/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: 8/11/25 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs. 8/23/25 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. On 8/27/2025 at 12:31 PM the surveyor interviewed the Staffing Coordinator (SC). The SC stated that she was aware of the staffing requirements. She stated the requirements were eight CNAs day shift, 10 CNAs 3-11 shift and 14 CNAs night shift and they met the requirements. A review of the facility policy "Nursing Services and Sufficient Staff" dated as revised 7/01/2025 provided by the Licensed Nursing Home Administrator (LNHA) revealed, “it is the policy of this community to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident”…	S0560	Continued from page 1 the potential to be affected by the same deficient practices. All residents have the potential to be affected by not meeting the staffing requirements N.J.S.A.30:13-18 on day shift. No residents were identified as having been affected. What measures will be put in place or systematic changes made to ensure that the deficient practice is being corrected and will not recur. The Administrator re-educated the staffing coordinator, charge nurses, and supervisors regarding state staffing requirements (N.J.S.A.30:13-18) the protocol for completing the nursing schedule, Director of Nursing/Administrator notification of staffing concern managing staff callouts. - The Director of Nursing/Designee educated nursing staff regarding procedures and time frames for call outs. - The facility has posted job openings on job sites to promote CNA job openings. - The staffing coordinator is offering staff the option to transfer to day shift, pick up extra shifts for overtime, and incentive and referral bonuses are being offered. - The community has signed contracts with three additional staffing agencies and will use agency staff as needed to meet staffing needs/requirements. - The community continues to make every effort to recruit and retain staff in this very competitive and struggling market. - The Director of Nursing/Designee meets with the staffing coordinator daily to review facility census, call outs if any, and staffing needs to meet required ratios. - HR/Designee will oversee the implementation of the Fellowship Spirit program, a team member recognition and award system for those including CNAs who demonstrate care and, or hospitality excellence. Recognition and an award are provided and announced by Management monthly and annually to help support	

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S0560		S0560	Continued from page 2 retention. - The HR Director/Designee will identify any CNA schools in the area to set up possible recruitment events for new graduates. - The Administrator/Designee will petition the New Jersey Governor to advocate for the state's participation in the CMS Nursing Home Staffing Campaign. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Staffing Coordinator/Designee will meet with the Director of Nursing/Designee and Administrator/Designee to review/audit staffing schedules to ensure ratio requirements are being met daily. The HR director/designee will provide a report to the Administrator regarding staff retention, recruitment progress and recruitment/retention activities weekly. The results of the audits will be presented to the community's QAPI Committee for further review and recommendations as needed, until sustained compliance is achieved.	
S2315	Mandatory Physical Environment CFR(s): 8:39-31.6(i)(1-2) (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.	S2315	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. The emergency Preparedness Manual including evaluation Plan was emailed to the Ocean County Emergency Management Official on 9/18/25 for review with email confirmation received of cursory review. Upon receiving the documentation of the full review from the office of Emergency Management official; the review report will be added to our records. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents, staff, and visitors have the potential to be affected by not having the record of the	09/30/2025

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S2315	Continued from page 3 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 8/28/25 in the presence of the Vice President of Capital Projects (VPCP) and the Administrator, it was determined the facility disaster planner failed to meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if the county or municipal officials are unavailable, notify the State Office of Emergency Management. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the emergency preparedness manual which included the evacuation plan revealed the facility management had reviewed the plan on 7/9/25. There was no documentation that the county or municipal Office of Emergency Management (OEM) officials or state OEM reviewed or were asked to review the emergency preparedness plan. In an interview at the time, the Administrator, VPCP and Executive Director (ED) confirmed the record review. The facility's Administrator, VPCP, ED, Vice President of Clinical Operations and Director of Nursing were informed of the deficient practice at the Life Safety Code exit conference at 4:46 PM.	S2315	Continued from page 3 emergency preparedness manual and evacuation plan reviewed by officials in accordance with 8:39-31.6(i)(1-2). 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Director will add annual review to calendar and Use Emergency Preparedness check sheet for the annual review of the manual and evacuation plan to ensure annual review is scheduled and the documentation of the review is obtained for our records. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager will report any scheduled dates of Emergency preparedness review of emergency preparedness manual and evacuation plan to Administrator, safety committee, and to the Quality Assurance Performance Improvement Committee quarterly. The Quality Assurance Performance Committee will determine the time frame of monitoring and/or discontinuance.	
S2345	Mandatory Physical Environment CFR(s): 8:39-31.6(o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 8/28/25 in the presence of the Vice President of Capital Projects (VPCP) and the Administrator, it was determined the facility failed to perform an evacuation drill and to invite county, municipal and state Office of Emergency Management (OEM) officials to at least one evacuation drill in the last 12 months. This deficient practice had the potential to affect all residents and was evidenced by the following:	S2345	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Next required Drill to include an evacuation or simulated evacuation was scheduled on 10/23/25 and the Plant Operations Director updated the directory of officials. An invitation was sent on 9/11/25 to state, county, and municipal officials in accordance with 8:39-31.6 (o). 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents, staff, and visitors have the potential to be affected by not performing one disaster drill to include an evaluation as well as not inviting state, county, and municipal officials in accordance with	09/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 656000	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

(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
S2345	Continued from page 4 A record review of the emergency preparedness plan and associated drills revealed, the facility had a tabletop in-service on 7/22/25. There was no evacuation drill. There was no documentation that the county, municipal and state Office of Emergency Management (OEM) officials were invited, 10 working days in advance to attend an emergency preparedness drill or that they attended a drill. In an interview at the time, the Administrator, VPCP and Executive Director (ED) confirmed the record review. The facility's Administrator, VPCP, ED, Vice President of Clinical Operations and Director of Nursing were informed of the deficient practice at the Life Safety Code exit conference at 4:46 PM.	S2345	Continued from page 4 8:39-31.6 (o). 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Director was re-education on regulation 8:39-31.6 (o) and will keep a tracking log on drills with one Drill to include an evacuation. Plant Operations Director will reminder one month in advance on calendar prior to drill to allow enough time for the invitation to be sent with notice in accordance with 8:39-31.6 (o) to officials and to keep record of invitation in our records. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Director will notify Staff of Scheduled drills with evacuations quarterly to the administrator and will audit the invite time frame to ensure compliance with notification period as well as to ensure one drill includes an evacuation and/or simulated evacuation. Plant Operations Director will report findings to the safety committee and to the Quality Assurance Performance Improvement Committee (QAPI) for 6 Months. The QAPI committee will determine if further monitoring required or discontinuance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/21/2025 in relation to the 8/29/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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.

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 656000	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 , WHITING, New Jersey, 08759**

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/21/2025 in relation to the 8/29/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/27/25 and 8/28/25, Hamilton Place at the Pines at Whiting was found to be in non-compliance 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 Occupancies.	K0000		09/12/2025
K0293 SS = E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observations and interview on 8/27/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to ensure any door, passage or stairway that is not an exit and arranged that it is likely to be mistaken for an exit was identified by a sign in accordance with NFPA 101: 2012 Edition, Sections 7.10.8.3.1, 7.10.8.3.2 and 19.2.10.1. This deficient practice had the potential to affect 26 of 52 residents and was evidenced by the following: Observations at 11:03 AM of the middle hallway stairwell across from central supply, revealed the stairwell was not an exit, it was labeled as a stairwell and resembled a stairwell exit door. The door	K0293	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Immediately following the surveyor's findings, the Plant Operations Director placed a paper sign stating, "Not an Exit" and removed an illuminated "exit" sign located at the bottom of the stairwell. New signs were ordered and received on 9/17/25 and installed same day. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents, staff, and visitors have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Manager added "Not an Exit" sign to rounding check list. Plant Operations Manager/or designee will check during rounds of building to ensure approved egress out of the facility is clearly and appropriately marked. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager and/or designee will round the approved building egress and Plant Operations Manager will and rectify any deficient findings and report	10/26/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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K0293 SS = E	Continued from page 1 was not identified by a sign that read NO EXIT and in the proportions as described by the code. Further observations inside the stairwell revealed at the ground level of the stairwell, there was an exterior door to an enclosed court yard that had an illuminated EXIT sign above the door. There was no passage to a public way. In an interview at the time, the [redacted] confirmed the observation. The [redacted] stated they don't use it as an exit since renovations where they closed off the first floor from the stairwell. The facility's [redacted] informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e)	K0293	Continued from page 1 findings to the safety committee and to the Quality Assurance Performance Improvement Committee for 6 months.	
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K0324	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Semiannual suppression system inspection and cleaning was scheduled and completed on 8/26/25. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents, staff, and visitors have the potential to be affected by not having the suppression system inspected and cleaned semiannually. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Manager added this inspection and cleaning to the Maintenance log and calendar to ensure inspections and cleanings completed according with NFPA 17A:2009 Edition, Section 7.2, 11.4, 11.6.1 and will also spot check system during rounds of the building.	10/26/2025

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K0324 SS = F	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on observations, record review and interviews on 8/27/25 in the presence of the US FOIA (b)(6) [redacted]), and US FOIA (b)(6) it was determined the facility failed to ensure the kitchen wet chemical fire suppression system monthly owners inspection was performed and recorded and the system was in compliance with the semiannual suppression system inspection and cleaning in accordance with NFPA 17A: 2009 Edition, Section 7.2, 7.2.1 through 7.2.6 and NFPA 96: 2011 Edition, Sections 11.4, 11.6.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 8/27/25 at 11:50 AM of the kitchen, revealed the kitchen range hood was equipped with a wet chemical fire suppression system. A record review on 8/27/25 at 11:50 AM revealed the suppression system had its last semi-annual inspection during August of 2025. The inspection tags on the cylinder box and on the pull station had blank rows on the back of the tag in the monthly inspection recording locations and no further documentation was provided that a monthly inspection was performed. In an interview on 8/27/25 at 11:56 AM, the US FOIA (b)(6) [redacted] confirmed the record review and stated they did not do a monthly owners inspection. A record review on 8/28/25 of the 8/26/25 semi-annual range hood suppression system report revealed the report was marked as non-compliant for "grease build up in ducts" as stated in description of deficiencies. Further record review of the last 2 semi-annual kitchen hood cleaning reports dated 8/26/25 and 2/25/25 revealed the notes section stated the "Ducts Inaccessible" on both cleaning reports. In an interview on 8/28/25 at the time of the exit conference, the US FOIA (b)(6) [redacted] confirmed the record review and stated they were not aware. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on	K0324	Continued from page 2 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager will report findings of checks and maintenance log audit to resident safety committee for 6 months and to the Quality Assurance Performance Improvement Committee for 6 months.	

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K0324 SS = F	Continued from page 3 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 17A, 96	K0324		
K0341 SS = F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/27/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure the unsupervised Fire Alarm Control Unit (FACU) was smoke detector protected in accordance with NFPA 72: 2010 Edition, Section 10.15. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:07 PM of the main fire alarm panel serving all occupancies and located in the main entrance foyer of the Independent Living lobby, revealed the panel was in the foyer space enclosed by 2 sets of sliding glass doors and the space was not smoke detector protected or if determined the environment was not compatible with smoke detector function, heat detector protected. The doors were kept closed and the adjacent reception desk is staffed from 9:00 AM to 5:00 PM leaving the area unattended overnight. In an interview at the time, the US FOIA (b)(6) confirmed the observation.	K0341	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Residents were not adversely affected by this finding. Immediately following the surveyor's findings, the fire alarm vendor, NJ Exec Order 26.4b1 was notified and scheduled to evaluate what is needed for the installation of a heat detector in the INDEPENDENT LIVING foyer. The detector was installed on 9/12/25 by vendor. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. It is possible that residents, staff, and visitors have the potential to be affected by the deficient practice in accordance with NFPA 72: 2010 Edition, Section 10:15. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Vendor will install a heat detector for this location in INDEPENDENT LIVING. Heat detector will be monitored through the vendor testing of the fire alarm system. The heat detector was added to the annual inspections log. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager or designee will report any concerns with smoke detector for the unsupervised Fire Alarm Control Unit immediately to Administrator and will also report to safety committee for 6 months and to the Quality Assurance Performance Improvement Committee for 6 months.	10/26/2025

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K0341 SS = F	Continued from page 4 The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 72	K0341		
K0353 SS = F	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 STANDARD is NOT MET as evidenced by: Based on observation, record review and interview on 8/27/25 and 8/28/25 in the presence of the US FOIA [redacted], it was determined the facility failed to ensure fire sprinkler dry valves were full trip tested and air leak tested every 3 years in accordance with NFPA 101: 2012 Edition, Sections 9.7 and NFPA 25: 2011 Edition, Section 13.4.4.2.2.2, 13.4.4.2.9. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a facility tour on 8/27/25 revealed	K0353	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Residents were not adversely affected by this finding. The Plant Operations Director was able to verify through the vendor that the Dry Valve three year Full trip test and air leak test were scheduled and completed on 11/28 /23 and 11/29/23. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents, staff, and visitors may be affected by not having the Dry Valve three year Full trip test and air leak test completed according to NFPA 25 and REMARKS 9.7.5, 9.7.7, 9.7..8. 3.What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Manager or designee will ensure the three year Full trip test and air leak test will be completed by adding to the vendor inspection requirements log and will audit log quarterly to ensure inspections scheduled and completed. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager or designee will audit the vendor inspection report log quarterly and report audits and inspections to safety committee for 6 months and to Quality Assurance Improvement Committee for 6 months.	10/26/2025

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K0353 SS = F	Continued from page 5 there was a dry valve sprinkler system located in and serving the long-term care unit. A record review on 8/28/25 of the facilities sprinkler inspection reports revealed there was no report of the dry valve having the 3-year full trip test and the 3-year air leak test performed. In an interview at the time, the [US FOIA (b)] confirmed the observation and stated the 2 tests were being scheduled. The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 25	K0353		
K0355 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 STANDARD is NOT MET as evidenced by: Based on observations and interviews on 8/27/25 in the presence of the [US FOIA (b)(6)], it was determined the facility failed to ensure: 1. fire extinguishers not exceeding 40 pounds were installed so that the top of the fire extinguisher is not more than 5 feet above the floor and 2. an instructional placard be placed near the class K extinguisher, in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition, Sections 5.5.5.3, 6.1.3.8.1 and 6.1.3.8.2. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0355	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Residents were not adversely affected by this finding. Immediately following the surveyor's findings, the Class K Fire Extinguisher was reinstalled immediately not above 5 feet above the floor along with instructional placard placed near extinguisher. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. It is possible that all residents in the facility have the potential to be affected by the deficient practice. All residents, staff, and visitors may be affected by not having the Class K Fire extinguisher and placard placed in accordance to NFPA 101:2012 Edition, section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition, Sections 5.5.5.3, 6.1.3.8.1 and 6.1.3.8.2. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Manager or designee will ensure this	10/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

(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
K0355 SS = F	Continued from page 6 Observations of the facility kitchen between 10:23 AM and 10:53 AM revealed the following:The 23-pound K class fire extinguisher by the entrance door was mounted approximately 68-inches from the floor to the top of the extinguisher. The class K fire extinguisher on the line by the pot sink had no instructional placard stating to use the fire protection system before the portable fire extinguisher. In interviews at the times, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 10	K0355	Continued from page 6 Fire Extinguisher and placard are in proper placement in accordance to NFPA 101:2012 Edition, section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition, Sections 5.5.5.3, 6.1.3.8.1 and 6.1.3.8.2. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager or designee will check all extinguishers in the kitchen monthly for 3 months to ensure the K fire extinguisher and placard are in place and will report findings to safety committee for 3 months and to the Quality Assurance Improvement Committee for 3 months.	
K0531 SS = F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on observations, record review and interview on 8/27/25 and 8/28/25 in the presence of the US FOIA (b)(6)	K0531	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Residents were not adversely affected by this finding. Immediately following the surveyor's findings, the status of annual inspections of the elevator labeled 1 and 7 were requested by the Plant Operations Director from NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 will advise of the inspection date when the state inspector is available and the inspection will be completed. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. It is possible that all residents, staff, and visitors have the potential to be affected by not having the elevators inspected according to ASME/ANSI A17.3 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Manager or designee will ensure the vendor has added the elevator inspection to the vendor list in accordance with ASME/ANSI A17. Plant Operations Manager or designee will request inspections 6 months in advance of due date and will audit inspection log	10/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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K0531 SS = F	Continued from page 7 US FOIA (b)(6)), it was determined the facility failed to ensure elevators were inspected annually in accordance with NFPA 101: 2012 Edition, Sections 9.4. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 8/27/25 of the healthcare facility (2nd floor) revealed there were 2 elevators that served the Long-Term Care and subacute units. The elevators were labeled as Elevators 1 and 7. A record review on 8/28/25 of the elevator certificates of compliance that were issued from passing elevator inspections, revealed the last certificates of compliance for both elevators expired on 11/ 30/2024, 9 months prior to the current survey. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e)	K0531	Continued from page 7 monthly. 4. How will the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager will report audits of the vendor inspection report log quarterly and report inspections to Safety committee for 6 months and Quality Assurance Improvement Committee for 6 months.	
K0741 SS = F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.	K0741	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Residents were not adversely affected by this finding. Immediately following the surveyor's findings, the campus has implemented a nonsmoking and smoke free campus as of 09/22/2025. Plastic cigarette towers were immediately removed from the location and no smoking signage posted. All metal NFPA approved and onsite. 2. How the facility will identify other residents having potential to be affected by the same deficient practices All residents, staff, and visitors may be affected by having the plastic cigarette towers in accordance to	10/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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K0741 SS = F	Continued from page 8 (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/27/25 in the presence of the [redacted], it was determined the facility failed to ensure the required ashtrays and metal container with self closing cover were provided in areas where smoking was permitted in accordance with NFPA 101: 2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:16 PM of the smoking area revealed there were 2 plastic cigarette towers with melted spots on top. There were no ashtrays of non-combustible material and safe design provided for smokers and there was no metal container with a self-closing cover device into which ashtrays could be emptied. In an interview at the time, the [redacted] confirmed the observation. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e)	K0741	Continued from page 8 NFPA 101:2012 Edition, Section 19.7.4 at the designated smoking area. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Manager or designee will add signage and metal towers to maintenance logs and Plant Operations Manager or designee will weekly check areas for three months to ensure signage and metal towers are in place in accordance to NFPA 101:2012 Edition, Section 19.7.4. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Director will report audit findings to safety committee for 3 months and to the Quality Assurance Performance Improvemnt Committee for 3 months.	
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K0918	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies.	10/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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K0918 SS = F	Continued from page 9 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 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 STANDARD is NOT MET as evidenced by: Based on record review and interview on 8/27/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to ensure the diesel power generator had the required 3 year 4 continuous hour load bank test performed in the last 3 years in accordance with NFPA 110: 2010 Edition, Sections 8.4, 8.4.9, 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review between 12:58 PM and 2:03 PM of the generator Inspection Tests and Maintenance (ITM) documents, revealed the load (Kilowatts) percent of the nameplate rating the diesel generator was exercised under during the monthly full load tests was not recorded. The generator had annual 2-hour load bank tests conducted as required if generator does not run at 30% or greater of the nameplate rating during the	K0918	Continued from page 9 Residents were not adversely affected by this finding. Immediately following the surveyor's findings, the diesel power generator 3 year 4 continuous hour load bank test is scheduled for 09/22/2025. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents, staff, and visitors in the facility have the potential to be affected by the deficient practice. All residents, staff, and visitors may be affected by not having the diesel power generator 4 continuous hour load bank test completed according to NFPA 110:2010 Edition, Sections 8.4, 8.49, 8.49.1 o 8.4.9.7. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Manager or designee will ensure the vendor adds the diesel power generator 3 year 4 continuous hour load bank test to calendar and to the maintenance logs in accordance with NFPA 110:2010 Edition , Sections 8.4, 8.49, 8.49.1 o 8.4.9.7. Plant Operations Manager or designee will audit logs monthly to ensure load bank tests are scheduled when due. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager or designee will report findings of audits and the inspection results from the vendor to safety committee for 6 months and report to and Quality Assurance Performance Improvement Committee for 6 months.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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K0918 SS = F	Continued from page 10 monthly tests. There was no report of a 3-year 4-hour load bank test conducted in the last 3 years. No further documentation of a 4 continuous hour test was provided. In an interview at the time, the [US FOIA (b)] confirmed the record review and stated the generator does not run at 30% or greater of its nameplate rating during the monthly load tests. The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 110	K0918		
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.	K0923	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; These are the residents specified in the CMS-2567, Statement of Deficiencies. Boxes were removed immediately from storage area where oxygen cylinders stored. Oxygen bottle storage racks were ordered on 9/15/2025 and expected delivery is 9/25/25 and will be installed within 10 days from delivery. 2. How the facility will identify other residents having potential to be affected by the same deficient practices. All residents, staff, and visitors may be affected by not having oxygen storage area free of combustibles by 5 feet in a sprinklered area in accordance with NFPA 99. 2012 Edition, Sections 11.3.2.3 (2). 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Plant Operations Manager will add this storage area to his maintenance logs and will check area weekly to ensure the area clear of combustible material and oxygen cylinders stored appropriately. 4. How the facility will monitor its corrective actions	10/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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K0923 SS = F Bldg. 01	Continued from page 11 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/27/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to ensure oxidizing gases were separated from combustibles by 5 feet in a sprinklered area in accordance with NFPA 99: 2012 Edition, Sections 11.3.2.3 (2). This deficient practice had the potential to affect all 52 residents and was evidenced by the following: An observation at 9:15 AM of the oxygen storage room revealed the room had E cylinders stored within 5 feet of a metal 4 shelf rack containing combustible boxes. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 4:46 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 99	K0923	Continued from page 11 to ensure that the deficient practice is being corrected and will not recur. Plant Operations Manager will audit Maintenance logs and report findings to resident safety committee for 6 months and to the Quality Assurance Performance Improvement Committee for 6 months.	

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HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/27/25 and 8/28/25. Hamilton Place at The Pines was found to be in substantial compliance with CFR 483.73, Requirements for Long Term Care Facilities.	E0000		09/12/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315347	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/14/2025

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HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 , WHITING, New Jersey, 08759

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K0000 Bldg. 01	INITIAL COMMENTS An onsite revisit was conducted on 11/14/2025 to verify the facility's Plan of Correction for the 8/29/2025 Life Safety Code survey. The facility was found to be in compliance 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.	K0000		

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 reverse for further 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.

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