STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		6/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 05/10/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
E 037	Continued From page 1	E 037		

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
E 037	Continued From page 2 (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation, it was determined that the facility failed to maintain documentation of initial training in Emergency Preparedness (EP) and consistently train new and existing staff and individuals providing services under arrangements. This deficient practice was identified facility wide for 155 of 179 staff training reviewed and was evidenced by the following: The surveyor reviewed the facility EP and environmental safety training logs which revealed that multiple staff members in the facility did not complete the EP training. On 04/26/24 at 10:10 AM, the surveyor	E 037	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were adversely affected on the specific date noted. Initial training of the Emergency Preparedness policies and procedures has been provided to all new and existing team members including all volunteers and individuals providing resident services at Pines Village by arrangement, consistent with their expected roles. Documentation of this training includes each team member□s successful completion of a post-test to demonstrate appropriate knowledge of the policies and procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
E 037	Continued From page 5 interviewed the US FOIA (b)(6)) regarding EP training and education. The US FOIA (b)(6) stated that the education was not completed for all staff. The US FOIA (b)(6) further stated that it should have been done and that she NJ Ex Order 26.4b1 the job, but it was "no excuse." On 04/26/24 at 09:07 AM, the surveyor interviewed the US FOIA (b)(6)) who stated the facility updated almost everything in the EP manual to be more organized. The US FOIA (b) confirmed that not all the staff members in the facility completed the mandatory education for EP and that going forward the administration will assure that staff complete the training on EP, and it will be monitored through a group effort. The facility policy titled, "Emergency Preparedness Training and Testing Program" with a revised date of 02/05/24, indicated that all team members and individuals providing services under this arrangement, volunteers will be trained on emergency preparedness plan and procedures, consistent with their expected roles. The policy indicated that training shall be provided upon hire, annually and when changes to the EP plan or procedures were made. NJAC: 8:39-31.6 (a)	E 037	2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Emergency Preparedness Training and Testing policy was revised to reflect that training of the Emergency Preparedness policies and procedures will be scheduled for all new and existing team members including volunteers and individuals providing resident services consistent with their expected roles, upon hire and at least every two (2) years after initial training, respectively. The policy also includes that training will be scheduled for all team members when emergency preparedness policies and procedures are significantly updated. The Human Resources and Maintenance Directors, and Education Coordinator designee will create and concurrently update a shared Emergency Preparedness training log that identifies all new and existing team members along with their training due dates, completion dates, and post test results. The log will serve as the basis for ensuring all team members are scheduled for, receive, and demonstrate training in accordance with the Emergency Preparedness Training and Testing policy and E-037. Any issues of non-compliance will be immediately reported and acted upon by the Administrator. The Administrator will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
E 037	Continued From page 6	E 037	identify the requirement for training if the emergency policies and procedures are significantly modified, and the log will be updated with the additional training dates, and training will be completed and documented accordingly. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Emergency Preparedness Training log will be audited by the Administrator monthly for accurate and timely completion. The Administrator will present a report of audit results to the QAPI Committee on a quarterly basis. The audits may be discontinued when 100% compliance is achieved for two years.	
F 000	INITIAL COMMENTS Complaint NJ #169725, 169992, and 171013 STANDARD SURVEY: 04/22/24 to 04/26/24 CENSUS: 52 SAMPLE SIZE: 13 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
F 656	Continued From page 7 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 656	Continued From page 8 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to develop person-centered comprehensive care plans for 2 of 13 residents (Resident #34 and #38) reviewed. This deficient practice was evidenced by the following: 1. According to the Face Sheet, Resident #34 was admitted to the facility with diagnoses which included, but were not limited to, Ex Order 26.4B1 The admission Minimum Data Set (MDS), an assessment tool, dated Ex Order 26.4B1 and required NJ Exec Order 26.4b1 assistance with activities of daily living. The MDS also indicated that the resident received Ex Order 26.4B1 . The surveyor reviewed the resident's electronic medical records (EMR) which revealed the following information: The Physician Order Sheet (POS) dated Ex Order 26.4B1 reflected a physician's order Ex Order 26.4B1 Ex Order 26.4B1, give at hours of Ex Order 26.4B1.	F 656	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plans for residents #34 and #38 were updated to comply with CFR: 483.12(b)(1)(3) upon identification of the deficient practice. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. 3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. An audit was completed of the comprehensive care plan of each resident and the care plans were confirmed to be compliant with CFR 483.12 (b)(1)(3). All interdisciplinary team members were re-educated on 4.29.2024 about the Comprehensive Care Plan policy and procedure and the requirement and their responsibilities to develop and document a person-centered, comprehensive care plan for each resident in accordance with CFR 483.12 (b)(1)(3). 4.How the facility will monitor its corrective actions to ensure that the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

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

F 656

Continued From page 9

The Ex Order 26.4B1 consult evaluation and NJ Exec Order was ordered by the physician on Ex Order 26.4B1 for Ex Order 26.4B1 was currently pending.

On 04/23/24 at 09:49 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that the resident's Ex Order 26.4B1 consult was pending, however the resident was on the schedule for the Ex Order 26.4B1 to evaluate the resident for the use of Ex Order 26.4B1 medications.

The surveyor reviewed the resident's Care Plan (CP) which didn not include the use of Ex Order 26.4B1 medication nor related interventions.

On 04/23/24 at 01:27 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the initial CP was developed when the resident was admitted to the facility. She explained that by day 14 of admission, the CP was fully developed and updated continuously. She stated that Ex Order 26.4B1 medications should be included on the CP due to risk factors of taking the medication and that behaviors associated with NJ Exec Order 26.4b1 should be included in a separate CP with interventions to NJ Ex Order 26.4b1. She stated that the CP was important for goal development and risk factors. She stated that the CP directed resident care was developed by the interdisciplinary team. She continued to add that the family and resident was also involved in care planning process.

On 04/24/24 at 08:32 AM, the surveyor interviewed LPN #2 who stated that if a resident was on a Ex Order 26.4B1 medication, it should be

F 656

practice is being corrected and will not recur.
The ADON/Nurse designee will review the comprehensive care plan of each newly admitted resident via the care planning audit tool to ensure compliance with CFR 483.12 (b)(1)(3). This audit will be completed weekly for 4 weeks, and if 100% compliance is achieved, then monthly for 3 months. Any compliance issues will be immediately reported to the Administrator and Director of Nursing and acted upon to ensure adherence to CFR 483.12 (b)(1)(3). The audit results and trends will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly. The weekly and monthly audits will be discontinued when 100% compliance is achieved for 4 weeks and 3 months, respectively. The QAPI Committee will subsequently determine the timeframes for periodic audits of the comprehensive care plans on an ongoing basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
F 656	Continued From page 10	F 656		

documented on the CP with interventions to include any behaviors and important for the team members to know that the resident was on this medications and to communicate to the staff how to NJ Ex Order 26.4b1 according to the interventions. LPN #2 reviewed Resident #34's CP and confirmed that there was no documentation that the resident was on Ex Order 26.4B1 medications and there were also no behaviors or interventions documented on the CP.

On 04/24/24 at 08:36 AM, the surveyor interviewed the U.S. FOIA (b)(6) U.S. FOIA (b)(6) who stated that she had been employed in the facility for Ex O years. The U.S. FOIA (b)(6) stated that the registered nurses (RNs) usually update the CP with any resident changes. She stated that the CP was interdisciplinary and was important so the staff knew what type of care the resident wanted and needed. She stated that the CP should include use of Ex Order 26.4B1 medication and Ex Order 26.4B1 wellbeing. She explained that the interventions should include interventions for Ex Order 26.4B1 symptoms and emotional support and diversional activities and monitor their appetite. She stated that the family should also be involved in CP interventions. She confirmed that a CP was not developed for Resident #34 to include the use of Ex Order 26.4B1 medications.

2. The surveyor further reviewed the Resident #34's EMR which revealed the following information:

Review of the POS, dated Ex Order 26.4B1 reflected an order from the physician for a Ex Order 26.4B1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 656	Continued From page 11 Ex Order 26.4B1 Further review of the POS reflected a physician's order for Ex Order 26.4B1 check every shift and NJ Ex Order 26 as needed. Review of the POS, dated Ex Order 26.4B1, reflected that the resident required Ex Order 26.4B1 care every shift. The surveyor reviewed the resident's CP which did not include the resident's Ex Order 26.4B1 or Ex Order 26.4B1. On 04/24/24 at 09:49 AM, the surveyor interviewed the US FOIA (b) (6) who stated that a CP should have been developed with interventions for the Ex Order 26.4B1 and the Ex Order 26.4B1. The U.S. FOIA (b) stated that a CP was essential to address the resident needs and so that the staff knew what care the resident was to receive. She stated that the staff would be responsible to update that CP to address all the resident's needs and should be comprehensive for all residents. 3. According to the Detailed Summary, Resident #38 had diagnoses which included, but were not limited to, Ex Order 26.4B1 Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26.4B1 included the resident had Brief Interview for Mental Status score of Ex Order 26 which indicated the resident's Ex Order 26.4B1 was Ex Order 26.4B1. Further review of the MDS included the resident was Ex Order 26.4B1 Review of the admission progress note, dated Ex Order 26.4B1, included the resident was taught to NJ Exec Order 26.4b1 intake due to being on an	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 656	Continued From page 12 Ex Order 26.4B1 for a NJ Exec Order 26.4b1 Further review of a progress note, dated Ex Order 26.4B1 , included the resident was Ex Order 26.4B1 Ex Order 26.4B1 . Review of the care plan, dated Ex Order 26.4B1 , did not include the resident was Ex Order 26.4B1 with a history of Ex Order 26 nor related interventions. During an interview with the surveyor on 04/24/24 at 9:45 AM, the Certified Nursing Assistant, (CNA), stated that she performed Ex Order 26.4B1 rounds every two hours or as needed in order to prevent Ex Order 26.4B1 . She further stated that Resident #28 wore Ex Order 26.4B1 for periods of Ex Order 26.4B1 During an interview with the surveyor on 04/24/24 at 9:50 AM, the Licensed Practical Nurse (LPN #3) stated Ex Order 26.4B1 residents were NJ Exec Order 26.4b twice a shift and as needed to prevent Ex Order 26 and Ex Order 2 breakdown. She further stated that the US FOIA (b)(6) was responsible for initiating care plans and that it was important for the care plan to be comprehensive "for proper care of the resident." During an interview with the surveyor on 04/24/24 at 10:00 AM, the U.S. FOIA (b)(6) stated Ex Order 26.4B1 residents were NJ Exec Order 26.4b1 every two hours and as needed. The U.S. FOIA (b)(6) further stated that the interdisciplinary team initiated the care plan upon admission "so staff know how to care for the resident." During an interview with the surveyor on 04/24/24 at 10:07 AM, the U.S. FOIA (b)(6) stated interventions to prevent Ex Order 26.4 included	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING _____ B. WING _____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
F 656	Continued From page 13 NJ Exec Order 26.4b1. The U.S. FOIA (b) further stated the US FOIA (b)(6) initiated the resident care plans within 24 hours and the comprehensive care plan was completed within 14 days of admission. The U.S. FOIA (b) added that it was important that the resident's care plan was comprehensive because "it is available to all those involved in the care of the resident," and, "the care plan is an overview of the resident's needs." Review of the facility's Comprehensive Care Plans policy, dated 01/09/24, included, "The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment," and, "The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." NJAC8:39-11.2 (f)	F 656		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was	F 695	1.How the corrective action will be accomplished for those residents found to	6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 695	Continued From page 14 determined that the facility failed to obtain a physician's order for Ex Order 26.4B1 and develop a care plan for Ex Order 26.4B1 care. This deficient practice was identified for 1 of 1 resident (Resident #43) reviewed for Ex Order 26.4B1 care. This deficient practice was evidenced by the following: On 04/22/24 at 07:37 AM, during the initial tour the surveyor observed Resident #43 lying in bed sleeping receiving Ex Order 26.4B1. On 04/23/24 at 11:01 AM, the surveyor observed Resident #43 lying in bed watching TV. At that time, the surveyor interviewed the resident who stated that she receive Ex Order 26.4B1 and that the staff change the Ex Order 26.4B1 but was not sure how often it was changed. The surveyor reviewed the medical record for Resident #43. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included Ex Order 26.4B1 A review of the significant change in status Minimum Data Sheet (MDS), an assessment tool, dated Ex Order 26.4B1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exe out of 15, which indicated the resident was	F 695	have been affected by the deficient practice. Upon identification of this deficient practice,, physician□s orders for Ex Order 26.4B1 therapy and equipment management were obtained, and an individualized care plan for Ex Order 26.4B1 therapy and Ex Order 26.4B1 care was developed for resident #43 in accordance with CFR 483.25 (i). 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who require oxygen have the potential to be affected by this practice. 3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. An audit of each resident□s record and suite was completed to identify those residents who had oxygen equipment in their suite; and, or oxygen therapy documented in the physician□s plan of care, and, or the physician□s orders. An audit of the physicians□ orders and care plan for each identified resident requiring oxygen was subsequently completed and confirmed that the physician□s orders and care plans are in compliance with CFR 483.25 (i). All nurses were educated by the Nurse Educator designee on 5.10.24 about the requirement for obtaining oxygen therapy orders and developing and updating the resident□s individualized care plan accordingly to comply with the Comprehensive Care Plan and Care Plans-Updating for Status Change policies and procedures, and CFR 483.25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
F 695	Continued From page 15 Ex Order 26.4B1 A further review of the MDS in Section O: Special Treatments, Procedures and Programs reflected the resident received continuous Ex Order 26.4B1. A review of the Ex Order 26.4B1 physician's orders (PO) did not include any orders for Ex Order 26.4B1. A review of the discontinued PO indicated, as of Ex Order 26.4B1, the following orders were discontinued: -Change and date NJ Exec Order 26.4b1 every Tuesday night. -Change and date NJ Exec Order 26.4b1 to resident) every Tuesday night. -NJ Exec Order 26.4b1 continuously; NJ Exec Order A review of the individualized Care Plan revealed there was no developed care plan for Ex Order 26.4B1 care. On 04/23/24 at 01:00 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated they had POs for Ex Order 26.4B1 to ensure they administered the appropriate amount of Ex Order 26.4B1 She further stated they checked every shift to ensure the NJ Exec Order matched the order. The LPN stated that the Ex Order 26.4B1 was changed during the 11 PM to 7 AM shift and that she never had to change it but believed the Ex Order 26.4B1 was changed every 72 hours. The LPN stated that there were POs in the electronic medical record (EMR) for the NJ Exec Order to be changed, for how many Ex Order 26 and if continuous or PRN (as needed). The LPN emphasized there should be an order for Ex Order prior to administering to ensure the resident was properly assessed. When asked if Ex Order 26.4B1 care should be on the care plan, the LPN stated	F 695	(i). 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. An audit will be completed 3 times weekly to validate that each resident who requires oxygen therapy has accurate, corresponding orders, and an individualized care plan for oxygen therapy and respiratory care in accordance with the Comprehensive Care Plan and Care Plans-Updating for Status Change policies and procedures and CFR 483.25 (i). Any issues with compliance will be immediately reported to the Administrator and Director of Nursing and acted upon to ensure adherence to the policies and procedures and CFR 483.25 (i). The audit results will be reported to and reviewed by the QAPI Committee quarterly. The weekly audit will be discontinued when 100% compliance is achieved monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ____ B. WING ____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
F 695	Continued From page 16 that "most of the time it would be on the care plan." She further stated that when she completed her new admissions, she updated the care plan to reflect if the Ex Order 26.4B1 was continuous, PRN, and how many NJ Exec O. The LPN stated that the care plan was important so that staff was aware on how to care for the resident. On 04/23/24 at 01:10 PM, the surveyor interviewed the Registered Nursed (RN) who stated that everyone who received Ex Order 26.4B1 had an order for it. She further stated that Ex Order 26.4B1 should also be on the care plan. The RN stated that the U.S. FOIA (b)(6)) was responsible for entering the POs in the EMR. She stated that the importance of an order was so it could be administered. The RN emphasized, "you can't administer Ex Order 26.4B1 without an order." She further stated that the order also indicated how many NJ Exec Ord the Ex Order 26.4B1 should be set to and if it was continuous or PRN. The RN stated that the CN or the U.S. FOIA (b)(6) was responsible for updating the care plan. She stated that the care plan "tells the resident's plan of care, interventions, and goals" for that specific resident. The RN concluded that there should be a PO for Ex Order 26.4B1 and that it should be on the care plan so everyone knew what to do. On 04/24/24 at 11:29 AM, the surveyor conducted a follow up interview with the RN who showed the surveyor the Ex Order 26.4B1 Nurse's Flow Sheet which indicated Resident #43 was on Ex Order 26.4B1. She stated that the flow sheet did not indicate the number of NJ Exec Ord because "it could change." The U.S. FOIA reviewed the orders in the EMR with the surveyor which revealed that all the Ex Order 26.4B1 orders were entered as new and to start that day Ex Order 26.4B1	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 695	Continued From page 17	F 695		

On 04/24/24 at 11:48 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that one of the nurses had just entered the Ex Order 26.4B1 orders to start today. The U.S. FOIA (b)(6) stated that she reviewed the PO as well as another nurse, but they could not find any Ex Order 26.4B1 orders. When asked if there should be orders for Ex Order 26.4B1, the U.S. FOIA (b)(6) stated, "absolutely there should be an order for Ex Order 26.4B1 She further stated that it was important to have orders, so everyone was aware that the resident was on Ex Order 26.4B1. The U.S. FOIA (b)(6) stated, "I'm just disappointed." She explained the resident was sent out to the emergency room in Ex Order 26.4B1 and was on Ex Order 26.4B1 then and returned to the facility Ex Order 26.4B1 on Ex Order 26.4B1. She further explained that everything should be checked on the 11 PM to 7 AM shift to ensure that all the orders were entered. Upon further review, the U.S. FOIA (b)(6) stated that the order did not indicate how many Ex Order 26 and stated that the order would have to updated to include the number of NJ Exec Or.

On 04/24/24 at 11:56 AM, the U.S. FOIA (b)(6) and surveyor reviewed the Care plan in the EMR. The U.S. FOIA (b)(6) stated she did not see anything related to Ex Order 26.4B1 care. She stated that the care plan told the story of the resident, why they were there, what care should be provided and what they were at risk for. She further stated that all departments such as nursing, dietary, therapy, and activities could update the care plan because everyone was involved in the care. The U.S. FOIA (b)(6) acknowledged that Ex Order 26.4B1 should be on the care plan that there should have been POs for Ex Order 26.4B1 prior to surveyor inquiry.

On 04/24/24 at 12:05 PM, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ____ B. WING ____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 695	Continued From page 18 interviewed the U.S. FOIA (b)(6)) who confirmed that the resident did not have any Ex Order 26.4B1 orders prior to surveyor inquiry. The U.S. FOIA (b)(6) stated, "of course the resident should have orders for Ex Order 26.4B1." She stated they completed an audit on Ex Order 26.4B1 and care plans last week. She further stated that the resident "slipped through the cracks." She acknowledged the nurses entered the orders today Ex Order 26.4B1 for changing the Ex Order 26.4B1 and the continuous Ex Order 26.4B1. She explained it should be in the EMR and the nurses should be signing it off. On 04/24/24 at 12:13 PM, the surveyor continued to interview the U.S. FOIA (b)(6) who stated that a care plan addressed specific problems that the resident may have or the potential problems as well as interventions put into place to resolve those problems. She explained for example Ex Order 26.4B1 care is the problem, and the intervention would be Ex Order 26.4B1 which should be on the care plan. The U.S. FOIA (b)(6) stated that the care plan should be implemented on admission and updated whenever there was a change. The U.S. FOIA (b) acknowledged the orders and care plan should have been updated prior to surveyor inquiry. On 04/26/24 at 09:14 AM, the U.S. FOIA (b)(6) acknowledged in the presence of the U.S. FOIA (b)(6) and the survey team that the care plan and the orders should have been updated prior to surveyor inquiry. A review of the facility's Oxygen Administration policy, dated reviewed 12/23/2019, included, "A practitioner's order is required to initiate oxygen,	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
F 695	Continued From page 19 except in an emergency situation, when oxygen therapy is ordered an order will also be entered to change all disposable components weekly." A review of the facility's Comprehensive Care Plans policy dated revised 1/9/24, included, "to develop and implement a comprehensive person-centered care plan for each resident ...to meet a resident's medical, nursing ...needs that are identified in the resident's comprehensive assessment." A review of the facility's Care Plans - Updating for Status Change policy dated revised 1/9/24, included, "1. The comprehensive care plan will be reviewed, and revised or updated as necessary, when a resident experiences a status change. 2. C. The care plan will be updated with the new or modified interventions accordingly. F. The Charge Nurse/Nurse designee and, or other team member who updated the care plan will coordinate that all care plan intervention updates are communicated to team members involved in the resident's care." NJAC 8:39- 19.4(a); 27.1(a)	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced	F 730		6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 730	Continued From page 20 by: Based on interview and record review, it was determined that the facility failed to evaluate the performance of all Certified Nursing Assistants (CNAs) on an annual basis. This deficient practice occurred with 2 of the 5 CNAs whose personnel records were reviewed and was evidenced by the following: On 04/24/2024 at 10:48 AM, the surveyor reviewed the employee files of 5 randomly selected CNAs which were provided by the facility. The surveyor identified the following: CNA #1 had a hire date of Ex Order 26.4B1. According to CNA #1's personnel record, the last documented performance appraisal was Ex Order 26.4B1 There were no annual performance reviews conducted within the past year. CNA #2 had a hire date of NJ Exec Order 26.4b1. According to CNA #2's personnel record, the last documented performance appraisal was Ex Order 26.4B1. There were no annual performance reviews conducted within the past year. During an interview with the surveyor on 04/24/24 at 12:05 PM, the U.S. FOIA (b)(6) stated she had been employed at the facility for the last four months. The U.S. FOIA (b)(6) stated that performance appraisals should be done annually. The surveyor then showed the U.S. FOIA (b)(6) the personnel records of CNA #1 and CNA #2 and confirmed that their performance appraisals were not completed annually. During a follow up interview with the surveyor on 04/25/2024 at 10:02 PM, the U.S. FOIA (b)(6) stated that the	F 730	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were adversely affected. Upon identification of this deficiency, the annual performance reviews for CNAs #1 and #2 were completed by the Interim Director of Nursing in accordance with CFR 483.35(d)(7) 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents assigned to CNAs #1 and # 2 had the potential to be affected. 3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The current system of providing the Director of Nursing written notification of CNA performance review due dates at least one month in advance will be continued by the Human Resources Director. Subsequent reminder notices will be sent at least weekly until the performance review is completed. Upon receipt of the first notification, the Director of Nursing will schedule dates with the CNAs for completion of the performance reviews and document them on a calendar to ensure timely compliance. This schedule will be updated with any changes and be accessible to the Human Resources Director and Administrator. The Director of Nursing will also assign performance evaluations on the schedule	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 730	Continued From page 21 Ex Order 26.4B1) was responsible for performance appraisals and the Ex Order 26.4B1 U.S. FOIA (b)(6) was responsible to send a list of performance appraisals that were due to the U.S. FOIA (b). During an interview with the surveyor on 04/25/24 at 10:10 AM, the U.S. FOIA (b)(6) stated that the performance appraisals should be completed on the anniversary date of the date of hire. The U.S. FO stated he had sent the US FOIA (b) (6) several email reminders to complete the performance appraisals. A review of the facility policy titled, "Performance Appraisal", undated, indicated that a performance appraisal measures and evaluates an individual team member's performance and accomplishments over a period of time. Typically, supervisors will complete performance appraisals as follows: a) at the end of the orientation period, b) annually, and c) when considering a team member for promotion. The policy further revealed that a performance appraisal system should be "on-going", and in no case should evaluations be given less than once a year. NJAC 8:39-43.17(b)	F 730	to the Nurse Manager designee, as necessary, to ensure the due dates are met. US FOIA (b)(6) were educated about this protocol on 5.6.2024. The Administrator will immediately act upon any potential compliance issues. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A monthly audit of timely completion of the CNA performance reviews will be completed by the Director of Human Resources for 6 months. The audit results will be reported to and reviewed by the QAPI Committee on a quarterly basis. This audit may be discontinued when 100% compliance is achieved for 6 months.	
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards.	F 836		6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 836	Continued From page 22 The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following:	F 836	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this deficient practice. A CMS 855 application was submitted and received by CMS on 4.25.24 to address compliance with F Tag 836. 2.How the facility will identify other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

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

F 836 Continued From page 23

According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program:
"(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements:

(1) Compliance with title XVIII of the Act and applicable Medicare regulations.
(2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare.
(3) Not employing or contracting with individuals or entities that meet either of the following conditions:
(i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act.
(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76......
(d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the

F 836

residents having the potential to be affected by the same deficient practice. The facility has determined that no residents have the potential to be affected.

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
In the event of a business name change, the Administrator and or designee will verify that CMS is notified and sent authorization for a change in the facility□s name by submitting CMS form 855A 30 days in advance of the name change and obtaining documentation of this submission receipt. To ensure compliance, the facility will allow 45 days for Novartis/Medicare approval and then 90 days for approval from the NJDOHSS after the Novartis/Medicare approval is obtained. The Name Change for the Entity policy and procedure was revised to reflect the Administrator□s responsibility to ensure the CMS form 855A is submitted 30 days in advance of the change and the submission receipt is maintained in the Business Office. The Business Office Manager was educated about this policy on 5.6.2024.

4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
In the event of a name change, the Administrator and or designee will monitor that CMS is notified and sent authorization for a change in the facility□s name via

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
F 836	Continued From page 24 specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (2) All other changes in enrollment must be reported within 90 days." On 04/23/24 at 9:00 AM, the surveyor reviewed the facility's Long-Term Care Facility Application for Medicare and Medicaid (form CMS-671) which reflected under name of facility as "Skilled Nursing Home at Pines Village". At that time, the surveyor requested additional information and the US FOIA (b)(6)) provided the New Jersey Department of Health (NJDOH) Division of Certificate of Need & Licensing documents which indicated Skilled Nursing at Pines Village; Effective: July 31, 2023; Expired July 31, 2024, and Issued: September 12, 2023. The US FOIA (b)(6) stated that she knew it used to be named Hamilton Place at the Pines at Whiting prior to the name change. On 04/24/24 at 9:52AM, the US FOIA (b)(6) stated she started at the facility NJ Exec Order 26.4b1 ago and to her knowledge the facility was named Skilled Nursing at Pines Village. She stated in her files she had where an application was submitted but needed to look for the approval letter. At that time, the US FOIA (b)(6) provided a letter which indicated the NJDOH confirmed they were in receipt of the documents reflecting 7/31/23 as the completion date for the final transfer of ownership of Hamilton Place at the Pines at Whiting. It further included the new facility name was Skilled Nursing at Pines Village and that the transfer of ownership approval was in transaction. The surveyor asked if there was any additional	F 836	submission of CMS form 855A 30 days in advance of the name change.. To ensure compliance, the facility will allow 45 days for Novartis/Medicare approval and then 90 days for approval from the NJDOHSS after the Novartis/Medicare approval is obtained. The Administrator will also monitor that the submission receipt for CMS 855A was obtained 30 days in advance and is kept on file in the Business Office per the revised policy. The monitoring results will be reported to the subsequent, quarterly QAPI Committee meeting and will be discontinued if 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
F 836	Continued From page 25 information of the approval from CMS and not just from the NJDOH and the U.S. FOIA (b)(6) stated she would continue to look it in her files. On 04/24/24 at 10:23 AM, the surveyor inquired if the Medicare Enrollment Application for institutional Providers application (form CMS 855A) was completed and submitted and the US FOIA (b)(6) stated she would have to find out. On 04/24/24 at 12:51 PM, the surveyor followed back up with the U.S. FOIA (b)(6) who stated that she was still waiting to hear back from the corporate office regarding the licensing. On 04/25/24 at 09:54 AM, the U.S. FOIA (b)(6) confirmed that the CMS 855A application was not submitted. She stated that the business office was in the process of completing it today 4/25/24. The U.S. FOIA (b)(6) acknowledged that the CMS 855A application should have been done prior to surveyor inquiry. On 04/26/24 at 09:06 AM, the U.S. FOIA (b)(6) provided an email from the business office that the Medicare Enrollment Application was submitted on 4/25/24. On 04/26/24 at 09:14 AM, the U.S. FOIA (b)(6) acknowledged in the presence of the Ex Order 26.4B1 , and the survey team that the application should have been completed and received approval from CMS prior to the name change. A review of the facility's Name Change for the Entity policy, dated 7/1/23, included, "Notify the state in which your business operated and any other agencies. File the official name change with the IRS [Internal Revenue Service]. Update	F 836		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
F 836	Continued From page 26 permits and licenses with regulatory agencies." NJAC 8:39-5.1 (a)	F 836		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656000	A. BUILDING: ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/10/24

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315347 Y1	A. Building B. Wing Y2	6/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 06/10/2024	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 06/10/2024	ID Prefix F0730 Reg. # 483.35(d)(7) LSC	Correction Completed 06/10/2024
ID Prefix F0836 Reg. # 483.70(a)-(c) LSC	Correction Completed 06/10/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315347		6/11/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0037 Reg. # 483.73(d)(1) LSC	Correction Completed 06/10/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING **01** B. WING ______	**04/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/22/24 and 4/23/24, Hamilton Pines was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Hamilton Place at the Pines is a two (2) story, Type I Fire Resistant building that was built in 1/1/85. The facility is divided into 5-smoke zones. The facility provided plans that indicated the building is constructed of precast concrete and block with metal studs. The #2 exterior 150 KW Cummins diesel generator does approximately 40% of 2nd floor LTC facility. The facility is licensed for 66 beds and is currently occupying 52.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of	K 222		6/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 05/10/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 222	Continued From page 1 locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 222	Continued From page 2 accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interviews on 4/23/24, in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b)(6), it was determined that the facility failed to ensure that the 15-second delayed egress feature on 2 of 4 exit discharge doors (with this feature), would activate properly when tested in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1. This deficient practice was identified for 2 of 4 exit/egress discharge doors observed and had the potential to affect 52 residents who resided on the second floor at the facility and was evidenced by the following: 1.) At 10:21 AM, the surveyor and U.S. FOIA (b)(6) observed that the exit/egress door br resident room 2224 was provided with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." The US FOIA tried to activate the doors delayed device as indicated on the sign, but the door opened immediately with no delay. 2.) At 10:45 AM, the surveyor and U.S. FOIA (b)(6) U.S. FOIA (b)(6) observed that the exit/egress door br resident room 2240 was provided with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." The US FOIA tried to activate the doors delayed device as indicated on the sign, but the door opened immediately with no delay.	K 222	(1) Residents affected by the deficient practice All residents were not directly affected as they did not exit the egress doors. Immediately following the surveyors finding, the facility contacted the vendor in charge of the maglocks and it was discovered that there was a faulty circuit board and relay in the identified doors. The parts were replaced on 4/25/2024. (2)Identifying other residents who could be affected by the deficient practice All residents had the potential to be affected. (3)Measures or systemic changes to ensure that this deficient practice will not occur To actively spot this deficiency in the future, the Plant Operations team has created a bi-weekly preventative maintenance (PM) checklist for each door throughout the skilled nursing community. Effective immediately, this PM checklist will be completed on a daily basis for 1 month and then continued bi-weekly. The Plant Operations Director in-serviced the Plant Operations team on proper inspection and documentation of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ____	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 222	Continued From page 3 An interview was conducted with the U.S. FOIA (b)(6) U.S. FOIA (b)(6) during the observations. The US FOIA indicated he was not sure why the delayed devices were not working. The US FOIA (b)(6) was notified of the findings at the Life Safety Code exit conference on 4/23/24. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222	egress doors on 04/26/2024. Additionally, an in-service training for the Plant Operations and nursing team regarding the egress doors was completed on 04/26/2024 and will be repeated annually and included in the new hire orientation. The in-service includes notifying the direct supervisor who will inform the Plant Operations Director when any problems with door function are observed. Team members have also been instructed to complete a work order if an egress door problem is observed, and the Plant Operations team will have it repaired within 24 hours of its finding. If the repair cannot be done the same day, security and the skilled nursing team will round every half hour in the affected area and document this accordingly until the repair is completed. (4)Monitoring the effectiveness of the systemic change The Plant Operations Director and the Service Coordinator will be responsible for monitoring compliance with completion of the PM checklist on a daily basis for 1 month and bi-weekly thereafter. All corrective and preventative maintenance work orders will be audited for egress door problems daily for 1 month. This auditing will include that any egress door problems are corrected by maintenance within 24 hours. If an egress door problem is identified and cannot be repaired the same day, an audit for compliance with the egress door rounding will be done twice every shift by the Plant Operations Director or Service Coordinator. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING **01** B. WING ______	**04/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 222	Continued From page 4	K 222	Plant Operations Director will report these audit results to the quarterly QAPI Committee for review. The audit of work orders, timeliness of egress door repairs, and egress door rounding, as applicable, will be continued monthly until 100% compliance is achieved for 1 month. A report of the bi-weekly audit results of PM checklist completion will be submitted to the QAPI Committee quarterly on an ongoing basis.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review on 4/23/24, in the presence of : U.S. FOIA (b)(6) the facility failed to ensure smoke detection sensitivity testing of 40 of 40 smoke detectors observed was completed in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to effect 52 residents and was observed by the following: A document review of the facility fire alarm vendor	K 345	(1)Residents affected by the deficient practice Residents were not adversely affected by this practice. Immediately following the findings on 4/23/2024, we notified our contractor about the finding and scheduled the sensitivity testing. Sensitivity Testing of 40 smoke detectors was scheduled and completed Friday 04/26/2024 in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. The Sensitivity Testing completion record and	6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ____	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
K 345	Continued From page 5 semi-annual inspections dated: 1/19/24 and 6/22/23, had no reference to a smoke detection sensitivity test. At the time of observations, the U.S. FOIA (b)(6) U.S. FOIA (b)(6) indicated he was not sure why a smoke detector sensitivity test inspection was not included in the current fire alarm testing contract. The US FOIA (b)(6) was notified of the findings at the Life Safety Code exit conference on 4/23/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	results of no issues detected have been added to our Life Safety Book. (2)Identifying residents that could be affected by the deficient practice All residents were potentially affected by this practice. (3)Measures to ensure that this deficient practice will not occur The Plant Operations Director added to the scope of services in the vendor contract the annual completion of the Sensitivity testing of all (40) smoke detectors. In the event, there is a deficiency reported by the vendor, the Plant Operations Director will immediately act upon resolving this through the vendor services. (4)Monitoring the continued effectiveness of the systemic change The Plant Operations Director will audit, annually, the facility□s compliance with fire alarm testing including Sensitivity Testing of all smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. A report of the audit results will be submitted to the QAPI Committee annually and may be discontinued when 100% compliance is achieved for 2 years.	
K 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a	K 352		6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING **01** B. WING ______	**04/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 352	Continued From page 6 signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review on 4/23/24, in the presence of the U.S. FOIA (b)(6) (US FOIA (b) it was determined that the facility failed to maintain the fire sprinkler system in accordance with NFPA 13, 25, & 72, by failing to ensure that the water supply valves were provided with tamper alarms. This deficient practice was identified for 1 of 1 post indicator valve's observed and had the potential to affect 52 residents who resided on the second floor at the facility and was evidenced by the following: At 12:30 PM, the surveyor observed on the outside of the facility, by generator #2, that the red unlocked post indicator valve was not monitored. The red post indicator valve window that indicates open or closed was missing, and the clarity of the letters was comprimised from weather. The US FOIA indicated the post indicator valve was not monitored and did provide water to the 2nd floor of the LTC fire sprinkler system. The red exterior valve was observed to have no monitor wires indicating the control valve was electronically supervised by a device connected to the fire alarm system. The US FOIA (b)(6) was notified of the finding at the Life Safety Code exit conference on 4/23/24. NJAC 8:39-31.1(c), 31.2(e)	K 352	(1)Residents affected by the deficient practice Residents were not adversely affected by this finding. Immediately following the surveyor□s findings, the Plant Operations Director notified the facility□s fire sprinkler contractor about this finding and finalized a quote for the installation of a tamper alarm switch to the fire alarm system□s water supply valve for Skilled Nursing to comply with NFPA 72, National Fire Alarm and Signaling Code and NFPA 13 and 25.The vendor has ordered all necessary equipment and will install the tamper alarm switch as soon as parts are received. (2)Identifying residents that could be affected by deficient practice All residents were potentially affected by this finding. (3)Measures or systemic changes to ensure that the deficient practice will not occur The Plant Operations Director arranged installation of a tamper switch by allowing the fire alarm system to monitor the flow of water to our suppression system and to ensure there is no tampering of the PIV. The Plant Operations Director will also in-service all Plant Operations team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
K 352	Continued From page 7 NFPA 13, 25, 72 NFPA 101 2012 edition Life Safety Code 9.7.2.1* (Supervisory Signals)	K 352	members by June 10th , 2024 regarding the requirement for a tamper alarm switch to the fire alarm system□s water supply valve for continuous monitoring in accordance with NFPA 72, National Fire Alarm and Signaling Code and NFPA 13 and 25 by . The facility□s vendor for fire alarm testing will be responsible for checking, annually, that the functional integrity of the tamper alarm switch is intact. Any integrity issues will be reported to the Plant Operations Director and addressed as a priority. (4)Monitoring the continued effectiveness of the systemic change The Plant Operations will check monthly for two months that the functional integrity of the tamper alarm switch is intact. The Plant Operations Director will annually audit compliance with the completion of the functional integrity checks of the tamper alarm switch by the fire alarm system vendor. A report of the results for these two audits will be submitted to and reviewed by the QAPI Committee quarterly and may be discontinued when 100% compliance is achieved for 2 months and 1 year, respectively.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363		6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING **01** B. WING	**04/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 363	Continued From page 8 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/23/24, in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition,	K 363	(1)Residents affected by deficient practice All residents were not adversely affected by this finding. Upon performing a root cause analysis, it was determined that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 363	Continued From page 9 Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 2 of 38 resident rooms observed and had the potential to affect 52 residents who resided on the second floor at the facility and was evidenced by the following: During the building tour on 4/23/24, from 9:15 AM to 12:45 PM, the surveyor, in the presence of the US FOIA toured the facility and observed the following compromised resident room doors in the following areas: # 2212: door rubs onto its frame # 2216: door rubs onto the floor At the time of observations, the surveyor interviewed the U.S. FOIA (b)(6), who confirmed the above findings. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/23/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	problem was a minor door hinge alignment for the 2 identified, resident suite doors to the corridor. Immediately after the finding, the Plant Operations team was able to successfully fix the doors using a door hinge alignment tool. (2) Identifying residents that could be affected by deficient practice Residents in the identified suites were potentially affected by this finding. (3)Measures or systemic changes to ensure that the deficient practice will not occur The Plant Operations Director has created a monthly preventative checklist to check all resident suite doors to the corridor and their hardware for compliance. This monthly preventative checklist will be completed by a Plant Operations team member, and a work order will immediately be created and completed for any issue identified during the inspections. (4)Monitoring the continued effectiveness of the systemic change The Plant Operations Director will audit, monthly, the completion of the preventive checks of resident suite doors to the corridor and their hardware. The audit will also include that any deficient findings had a work order completed and was addressed the same day. A report of the results of this audit will be submitted to and reviewed by the QAPI Committee quarterly. This audit may be discontinued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING **01** B. WING ______	**04/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 363	Continued From page 10	K 363	when 100% compliance is achieved for 6 months.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 4/23/24, in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to maintain smoke barrier doors to resist fire for a minimum of 20 minutes as per NFPA 80 & 101. This deficient practice was identified for 2 of 6 smoke barrier door sets observed and had the potential to affect 52 residents who resided at the facility and was evidenced by the following: 1.) At 10:11 AM, the surveyor observed that the set of smoke barrier doors by resident room 2212 and the staff lounge were provided with a fire resistive label. The label was observed to be painted and the set of doors could not be	K 374	(1)Residents affected by deficient practice Residents were not adversely affected by this finding. The fire rating labels on the identified, smoke barrier doors were addressed by the vendor painter so that they are free of paint and allow the labels to be clearly read so that the door materials and fire rating are clearly visible. (2)Identifying residents that could be affected by the deficient practice All residents were potentially affected by this finding. (3)Measures or systemic changes to	6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530 WHITING, NJ 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
K 374	Continued From page 11 identified with a material that resists fire for a minimum of 20 minutes. 2.) At 10:38 AM, the surveyor observed that the set of smoke barrier doors by the bistro were not labeled. The set of doors could not be identified with a material that resists fire for a minimum of 20 minutes. The U.S. FOIA (b)(6) , confirmed the findings above during the observations. The US FOIA (b)(6) was informed of the findings during the Life Safety Code survey exit conference on 4/23/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 101- 2012 edition 19.3.7.6(4) NFPA 101-2012 edition 19.3.6.3.1*(12)	K 374	ensure the deficient practice will not occur The Plant Operations Director has completed an in-service for the maintenance team and painting vendors regarding the requirement to ensure that all door, fire rating labels are free of paint and can be read clearly. (4)Monitoring the continued effectiveness of the systemic change The Plant Operations Director will audit that all fire rated, door labels are free of paint on a monthly basis for 3 months. A report of the audit results will be submitted to and reviewed by the QAPI Committee quarterly. The audit may be discontinued when 100% compliance is achieved for 3 months.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced	K 761		6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING **01** B. WING ______	**04/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 761	Continued From page 12 by: Based on observation and interview on 4/23/24, in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b), it was determined that the facility failed to ensure that the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice was evidenced for 8 of 8 doors observed and had the potential to affect 52 residents who resided on the second floor at the facility and was evidenced by the following: At 9:00 AM, document review indicated that the fire door assemblies were not inspected and tested annually in accordance with NFPA 80 Standard for fire doors. The US FOIA was interviewed at the time of the document review and he confirmed the fire doors were not inspected annually and could not provide a log indicating so. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/23/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 80, section 5.2.1	K 761	(1)Residents affected by the deficient practice Residents were not adversely affected by this finding. Immediately following the surveyor□s findings, the Plant Operations team tested and inspected all fire barrier doors in the health center to be in compliance with 2012 NFPA 101 LSC Section 7.2.1.15 (2)Identifying residents that could be affected by deficient practice All residents were potentially affected by this finding. (3)Measures or systemic changes to ensure that the deficient practice will not occur The Plant Operations Director created an annual preventative maintenance checklist and logbook. The Plant Operations Director will also in-service all Plant Operations team members regarding the requirement for proper testing and inspections of fire doors in accordance with 2012 NFPA 101 LSC Section 7.2.1.15 by June 10th, 2024. The Plant Operations team will be responsible for checking, annually, that the function of all fire barrier doors are intact. Any integrity issues will be reported to the Plant Operations Director and addressed as a priority. (4)Monitoring the continued effectiveness of the systemic change The Plant Operations will check monthly for two months that the functional integrity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
K 761	Continued From page 13	K 761	of the fire barrier doors are intact. The Plant Operations Director will annually audit compliance with the completion of the annual preventative checklist and logbook. A report of the results for the audit will be submitted to and reviewed by the QAPI Committee quarterly and may be discontinued when 100% compliance is achieved for 2 months and 1 year, respectively.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and	K 914	(1)Residents affected by the deficient	6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 914	Continued From page 14 documentation review on 4/23/24, in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was identified for 30 of 30 resident rooms observed and had the potential to affect 52 residents who resided on the second floor at the facility and was evidenced by the following: During record review on 4/23/24, the surveyor reviewed documentation provided by the U.S. FOIA (b)(6) which included the facility's electrical inspection report, dated 10/20/23, from the facility's vendor, which did not indicate that the rooms with non-hospital grade electrical outlets were annually inspected for grounding, polarity, and blade tension in accordance with NFPA 99. In an interview during the observations, the US FOIA indicated he will have the non-hospital grade outlets tested for grounding, polarity, and blade tension in accordance with NFPA 99 as soon as possible. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/23/24. NJAC 8:39-31.2(e) NFPA 99	K 914	practice Residents were not adversely affected by this finding. Immediately following the surveyor□s findings, and upon receiving the previously ordered tension tester, the Plant Operations team initiated testing and inspections of all non-hospital grade outlets for grounding, polarity, and blade tension in accordance with NFPA 99. All outlets will be completed and any issues will be reported to the Plant Operations Director and addressed as a priority. (2)Identifying residents that could be affected by deficient practice All residents were potentially affected by this finding. (3)Measures or systemic changes to ensure that the deficient practice will not occur The Plant Operations Director created a logbook for annual testing and preventative checklist documenting all non-hospital grade outlets for grounding, polarity, and blade tension in accordance with NFPA 99. The Plant Operations Director will also in-service all Plant Operations team members by June 10th, 2024 regarding the requirement for proper testing and inspections of non-hospital grade outlets in accordance with NFPA 99 by . The Plant Operations team will be responsible for checking, annually, the function of all non-hospital grade outlets. Any integrity issues will be reported to the Plant Operations Director and addressed as a priority.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
K 914	Continued From page 15	K 914	(4)Monitoring the continued effectiveness of the systemic change The Plant Operations Director will check monthly for two months the functional integrity of all non-hospital grade outlets in accordance with NFPA 99. The Plant Operations Director will annually audit compliance with the completion of the annual preventative checklist and logbook. A report of the results for these audits will be submitted to and reviewed by the QAPI Committee quarterly and may be discontinued when 100% compliance is achieved for 2 months and 1 year, respectively.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	**507 ROUTE 530** **WHITING, NJ 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
K 918	Continued From page 16 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 REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/23/24, in the presence of the U.S. FOIA (b)(6) U.S. FOIA), it was determined that the facility failed to a.) ensure a remote manual stop station for their exterior 150 KW diesel generator #2 providing emergency power to approximately 40% of the Health Care facility was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.; and b.) certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice had the potential to affect 66 residents who resided at the facility and was evidenced by the following: 1.) At 10:40 AM, the surveyor and US FOIA observed the 150 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location.	K 918	(1)Residents affected by the deficient practice Residents were not adversely affected by this finding. Immediately following the surveyor□s finding of no emergency generator stop, the Plant Operations Director notified the facility□s generator service company about this finding and received a quote for installation of an emergency generator stop for generator number 2, that will be completed in accordance with 2010 NFPA 110 section 5.6.5.6. Additionally, the Plant Operations Director immediately completed and documented the generator load test for generator number 2 and compliance was demonstrated in accordance with NFPA 99 for emergency electrical generator systems. (2)Identifying residents that could be affected by deficient practice All residents were potentially affected by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
K 918	Continued From page 17 An interview was conducted during the time of the observation with the US FOIA (b) who stated and confirmed that the generator did not have a remote manual stop station to prevent inadvertent or unintentional operation, that was located outside the area of the enclosure housing the prime mover for the current generator in service. 2.) At 11:44 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the #2 generator would start and transfer power to the building within ten seconds. The current log provided, was on a generator daily fuel consumption register form. The dates on the form did not indicate weekly and monthly load transfer times as required by NFPA 99. An interview was conducted with the US FOIA during document review, where he stated that currently he was not putting the transfer time on the provided generator monthly load test log. He indicated the form used for the last 4 months was a fuel form. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/23/24. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	this finding. (3)Measures or systemic changes to ensure that the deficient practice will not occur The Plant Operations Director arranged installation of an emergency generator stop by allowing the remote stoppage of the generator in accordance with 2010 NFPA 110 section 5.6.5.6. The Plant Operations Director will also in-service all Plant Operations team members by June 10th, 2024 regarding the requirement for and location of the emergency generator stop. The Plant Operations Director has implemented the generator test form and logbook for generator number 2 in accordance with NFPA 99 for emergency electrical generator systems. An in-service for all Plant Operations team members was completed regarding the proper documentation and testing for generator number 2. Any integrity issues will be reported to the Plant Operations Director and addressed as a priority. The Plant Operations Director will annually audit the generator testing log book for compliance of checks for functionality and integrity of the emergency generator stop for generator number 2 and completion of the proper documentation of testing generator number 2. (4)Monitoring the continued effectiveness of the systemic change The Plant Operations Director will arrange for the vendor to complete a check of the functionality and integrity of the emergency generator stop for generator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315347	A. BUILDING 01 B. WING ______	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 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
K 918	Continued From page 18	K 918	number 2 for 1 month. The Plant Operations Director will audit the proper documentation of testing generator number 2 for 2 months. A report of the results for these audits will be submitted to and reviewed by the QAPI Committee quarterly and may be discontinued when 100% compliance is achieved for 1 month and 2 months, respectively. The Plant Operations Director will, on an ongoing basis, annually audit the generator testing log book for compliance of checks for functionality and integrity of the emergency generator stop for generator number 2 and completion of the proper documentation of testing generator number 2. The audit results will be reported and reviewed by the QAPI Committee annually.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315347 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE AT THE PINES AT WHITING	507 ROUTE 530 WHITING, NJ 08759

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 06/10/2024	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 06/10/2024	ID Prefix Reg. # NFPA 101 LSC K0352	Correction Completed 06/10/2024
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 06/10/2024	ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 06/10/2024	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 06/10/2024
ID Prefix Reg. # NFPA 101 LSC K0914	Correction Completed 06/10/2024	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 06/10/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO