

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>X1KYQQ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARE ONE AT HAMILTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 WHITEHORSE-HAMILTON SQUARE ROAD HAMILTON TOWNSHIP, NJ 08619</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00168379</p> <p>CENSUS: 73</p> <p>SAMPLE SIZE: 3</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00168379</p> <p>Based on interview and record review, it was determined that the facility's administrator failed to implement and enforce the facility's policy and procedure titled " Assisted Living: Alarm System for Wandering Resident" for 2 of 3 residents reviewed for [redacted], Resident #2 and Resident #3. This deficient practice is evidence by the following:</p> <p>On 10/18/2023 at 11:21 a.m., the surveyor conducted an interview with a care giver who stated there was a resident [redacted] on [redacted]. The certified home health aide (CHHA) reported that Resident #2 was seen [redacted] by another CCHA who was eating lunch in [redacted]. The CHHA who was sitting in her car was able to [redacted] resident [redacted] without issue.</p> <p>Resident #2 moved in on [redacted] with diagnoses which included [redacted] and [redacted]. The surveyor reviewed an unnamed facility document which revealed that Resident #2 was an [redacted] and had a [redacted] on his/her [redacted] which was placed [redacted].</p> <p>Resident #3 moved in on [redacted] with diagnoses which included [redacted]. The surveyor reviewed a facility document which revealed that Resident #3 has</p>	A 310		

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A 310	<p>Continued From page 2</p> <p><b>NJ Ex Order 26.4b1</b> and was an <b>NJ Ex Order 26.4b1</b>. On 10/18/2023, the surveyor reviewed "Progress Notes" dated <b>NJ Ex Order 26.4b1</b> which revealed that Resident #3 had a <b>NJ Ex O</b> applied to his/her <b>NJ Ex Order 26.4b1</b>.</p> <p>On 10/18/2023 at 2:15 p.m., the surveyor conducted an interview with the Director of Nursing who stated that there was no documentation for Resident #2 or Resident #3 ensuring that the <b>NJ Ex O</b> was checked every shift and <b>NJ Ex Order 26.4b1</b> properly.</p> <p>The surveyor reviewed the facility's policy titled "Assisted Living: Alarm System for Wandering Residents" which revealed:                      "7. Assigned Nursing Staff will check and document every shift that the wanderguard bracelet is in place on the resident."                      8. Assigned Nursing Staff will check and document once daily that the wanderguard bracelet functions appropriately. IF not, the wanderguard bracelet will be replaced immediately."</p>	A 310		
A 749	<p>8:36-7.3(a) Resident Assessments and Care Plans</p> <p>(a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p>	A 749		

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A 749	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: C#: NJ00168379</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that the General Service Plan (GSP) was updated or revised to include interventions in order to reduce the <b>NJ Ex Order 26.4b1</b> for 1 of 3 residents, Resident #3. This deficient practice is evidenced by the following:</p> <p>On 10/18/2023 the surveyor reviewed the medical record of Resident #3 who moved into the facility on <b>NJ Ex Order 26.4b1</b> with diagnoses which <b>NJ Ex Order 26.4b1</b>. The surveyor reviewed an unnamed facility document which revealed that Resident #3 had <b>NJ Ex Order 26.4b1</b> and was an <b>NJ Ex O</b>. On 10/18/2023, the surveyor reviewed "Progress Notes" dated <b>NJ Ex Order 26.4b1</b> which revealed that Resident #3 had a <b>NJ Ex Order 26.4b1</b> applied to his/her <b>NJ Ex Order 26.4b1</b>.</p> <p>Continued surveyor review of Resident #3's medical record failed to contain additional documentation regarding the <b>NJ Ex O</b>. Resident #3's GSP dated <b>NJ Ex Order 26.4b1</b> identified that Resident #3 was an <b>NJ Ex Order 26.4b1</b>, without mention of the <b>NJ Ex O</b> to alert staff of the intervention in place. The surveyor interviewed the Director of Nursing who confirmed that the only documentation regarding the <b>NJ Ex O</b> was the initial note written on <b>NJ Ex Order 26.4b1</b>.</p> <p>The facility failed to update the GSP when Resident #3 was assessed as an <b>NJ Ex Order 26.4b1</b> and a <b>NJ Ex Order 26.4b1</b> was implemented.</p>	A 749		
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## Plan of Correction

ID Prefix Tag	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.	Completion Date
A 310	<p>Residents #2 was immediately <b>NJ Ex Order 26.4b1</b> by a CHHA.</p> <p>Resident #3 with <b>NJ Ex Order 26.4b1</b> placed to her <b>NJ Ex Order 26.4b1</b> was checked for function and placement. Order to monitor function and placement was immediately entered in the TAR.</p>	<p>All residents with a wander guard have the potential to be affected by this practice.</p>	<p>On 10/19/2023, Staff completed a review of documentation and monitoring for residents at risk for elopement, and education was conducted of all nurses on:</p> <ul style="list-style-type: none"> <li>a.) Nursing risk assessment to exit-seeking residents.</li> <li>b.) Monitoring/checking of wander guard for function and placement every shift, and ensuring orders are in the treatment administration record (TAR).</li> <li>c.) Policy review of elopements.</li> </ul>	<p>The DON or designee will audit residents' treatment administration record (TAR) once a week for 1 month, then every two weeks for two months, then monthly thereafter.</p> <p>The DON or designee will audit nursing risk assessment completion and service plan to exit-seeking residents with wander guard monthly.</p> <p>The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.</p>	<p>10/31/2023</p>

A 749	<p>Resident #'s general service plan was immediately updated on NJ Ex Order 26.4b1</p>	<p>All residents with a wander guard have the potential to be affected by this practice.</p>	<p>On 10/19/2023, The DON and designee conducted an education of all nurses on:</p> <ul style="list-style-type: none"> <li>a. Policy elopement, risk assessment and general service plan completion.</li> <li>b. Documentation of interventions put in place in the service plan.</li> </ul>	<p>The DON or designee will audit the general service plan of residents identified for elopement risk and with wander guard once a week for 1 month, then every two weeks for two months, then monthly thereafter.</p> <p>The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.</p>	<p>10/31/20 23</p>
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**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER X1KYQQ	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing		DATE OF REVISIT 11/6/2023	Y3
NAME OF FACILITY CARE ONE AT HAMILTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1660 WHITEHORSE-HAMILTON SQUARE ROAD HAMILTON TOWNSHIP, NJ 08619		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix A0310	Correction	ID Prefix A0749	Correction	ID Prefix _____	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-7.3(a)	Completed	Reg. # _____	Completed
LSC _____	10/31/2023	LSC _____	10/31/2023	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/18/2023

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