STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	X1KYQQ	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HAMILTON	1660 WHITEHORSE-HAMILTON SQUARE ROAD HAMILTON TOWNSHIP, NJ 08619

(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
H 000	Initials Comments TYPE OF SURVEY: Complaint COMPLAINT #: NJ00168418 CENSUS: 74 SAMPLE SIZE: 3 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.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record.	H5790		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	X1KYQQ	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H5790	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint: NJ00168418 Based on interview and record review it was determined that the facility failed to retain a completed Universal Transfer Form (UTF) for 1 of 3 residents reviewed who was transferred to the hospital for evaluation, Resident #2. The deficient practice was evidenced by the following: On 10/19/2023 at 12:05 p.m., the surveyor reviewed Resident #2's medical record (MR) who moved in on NJ Ex Order 26.4b1, with diagnoses which include NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. According to the resident's MR, the resident was transferred to the hospital on NJ Ex Order 26.4b1 due to a "NJ Ex Order 26.4b1" and on NJ Ex Order 26.4b1, due to NJ Ex Order 26.4b1. On further review of Resident #2's MR, the surveyor did not observe documentation of a copy of the UTF when the resident was transferred to the hospital on either date. On 10/20/2023 at 9:00 a.m., the surveyor spoke with the Senior Administrator who indicated the UTF's dated NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 were missing and no copies were retained. On 10/23/2023 at 11:30 a.m., the surveyor spoke with the Director of Nursing who stated they were still looking for the missing UTF's. The facility failed to retain a copy of the UTF's in Residents #2's MR when he/she was transferred to the hospital on NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.	H5790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	X1KYQQ	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	Continued From page 2	A 000		
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00168418, NJ00161057, NJ00160756 CENSUS: 74 SAMPLE SIZE: 3 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.	A 000		
A 940	8:36-11.5(b)(2)(i-iv)(1-3),(v-vi) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 2. If an appropriate delegation is made, and in accordance with the facility's policies and procedures and all applicable State and Federal laws and regulations, the certified	A 940		

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	X1KYQQ	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HAMILTON	1660 WHITEHORSE-HAMILTON SQUARE ROAD HAMILTON TOWNSHIP, NJ 08619

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A 940	Continued From page 3	A 940		

medication aide may:

i. Administer medications through the routes of oral, ophthalmic, otic, inhalant, nasal, rectal, vaginal, topical, and by the percutaneous endoscopic gastrostomy (PEG) tube route of administration;

ii. Administer any prescription or OTC medications as described in (b)1 above;

iii. Administer regularly scheduled medications, including prescription, OTC, and Schedule II-V medications;

iv. Administer "prn" or as-needed prescription, OTCand Schedule II-V medications except that residents receiving the following medications shall be assessed by the registered professional nurse at least once every seven days:

1. Residents receiving prn Schedule II narcotic analgesics;

2. Residents receiving Schedule III-IV narcotic analgesics; and

3. Residents receiving Schedule III-IV central nervous system agents;

v. Administer medications that have been dispensed by a pharmacy, in accordance with N.J.S.A. 45:14 et seq., N.J.S.A. 24:21 et seq., N.J.A.C. 13:39, and the requirements of this chapter; or

vi. Administer experimental and/or research medications in accordance with 45 CFR

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 940	Continued From page 4 Part 46, Protection of Human Subjects, incorporated herein by reference, as amended and supplemented.	A 940		

This REQUIREMENT is not met as evidenced by:
Complaint: NJ00168418

Based on observation, interview, and record review, it was determined the facility's Director of Nursing (DON) failed to ensure the appropriate training was provided prior to the delegation of treatment of a NJ Ex Order 26.4b1 to a Certified Medication Aide (CMA) for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 10/19/2023 at 12:05 p.m., the surveyor reviewed Resident #2's medical records (MR) who moved in on NJ Ex Order 26.4b1, with diagnoses which include NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. On NJ Ex Order 26.4b1, an outside NJ Ex Order 26 care company documented Resident #2's NJ Ex Order 26.4b1 was reclassified as a NJ Ex Order 26.4b1. Further review of the Treatment Administration Record revealed the physician ordered, "NJ Ex Order 26.4b1 . Reference: NJ Ex Order 26. source. com, "NJ Ex Order 26.4b1 is intended for use in NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1." NJ Ex Order 26.4b with NJ Ex Order 26.4b1 then apply NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 then NJ Ex Order 26.4b1 " daily.

Post-survey on 10/23/2023 at 12:28 p.m., the

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	X1KYQQ	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 940	Continued From page 5 surveyor received the names of the staff members who performed treatment to Resident #2 in NJ Ex Order 26.4b1 via email from the DON. A review of facility staff list confirmed CMA #1 provided treatment to Resident #2's NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. On 10/26/2023 at 10:44 a.m., the surveyor requested NJ Ex Order 26.4b1 care training specific to Resident #2 that CMA #1 received prior to performing NJ Ex Order 26.4b1 care on Resident #2's NJ Ex Order 26.4b1 and the facility policy and/or process of delegation to certified NJ Ex Order 26.4b1. On 10/30/2023 at 8:31 p.m., the surveyor received an email from the DON with a policy titled, "Assisted Living: Practice Guidelines for CMA's Under RN Delegation" which states, "The registered professional nurse is responsible for the delegation of specific nursing tasks including medication administration to qualified, competent individuals in accordance with state guidelines and the New Jersey Nursing Standards of Practice. "An Employee Education Attendance Record was also received. The topic of the in-service was titled, "CMA NJ Ex Order 26.4b1 for Resident #2 dated, NJ Ex Order 26.4b1." There was no evidence that CMA#1 was trained on NJ Ex Order 26.4b1 care treatment for Resident #2's NJ Ex Order 26.4b1 prior to the survey.	A 940		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1073	Continued From page 6	A1073		

health care and service providers shall be entered according to the standards of professional practice.

This REQUIREMENT is not met as evidenced by:
Complaint: NJ00168418

Based on interview and record review, it was determined that the facility failed to maintain documentation of services provided according to the standards of professional practice and provide documented evidence that the facility's nursing staff performed [redacted] care for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 10/19/2023 at 12:05 p.m., the surveyor reviewed Resident #2's medical record (MR) who moved in on [redacted], with diagnoses which include [redacted], [redacted] and [redacted]. According to the resident's Progress Notes by the Director of Nursing on [redacted], the resident exhibited, "[redacted] to [redacted] of [redacted] noted. No [redacted]. No [redacted]. [redacted]. No [redacted]. [redacted] team consulted and currently following." In addition, Resident #2's MR showed a consultation with an [redacted] care agency on [redacted], which indicated the resident had a [redacted], [redacted] [redacted] daily and [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	X1KYQQ	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1073	Continued From page 7 NJ Ex Order 26.4b1 recommended. On 10/20/2023 at 8:15 a.m., the surveyor interviewed the RN Supervisor who stated once per week an outside NJ Ex Order 26 care agency Nurse comes to the facility to perform treatments on the residents; otherwise, a facility Nurse or Certified Medication Aide will perform treatments. At 9:00 a.m., upon exit of the survey, the surveyor requested copies of Resident #2's Treatment Administration Record (TAR) be sent via email. At 4:15 p.m., the surveyor received an email from the Director of Nursing (DON) which indicated that the facility was unable to locate the TAR for NJ Ex Order 26.4b1 and only provided the TAR for NJ Ex Order 26.4b1. Post-survey on 10/23/2023 at 11:30 a.m., the surveyor interviewed the DON via telephone who stated she was still unable to locate the NJ Ex Order 26.4b1 TAR for Resident #2. On 11/02/2023 at 11:55 a.m., the surveyor reviewed the policy on Retention of Medical Records which states medical records shall be retained by the facility in accordance with current applicable laws.	A1073		

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 940	Director of Wellness has in serviced CMAs/LPNs on appropriate RN delegation. CareOne Hamilton has obtained outside [NJ Ex Order 26.4b] care services and homecare services to assist with residents [NJ Ex Order 26.4] care. Resident #2 event reported to the Department of Health. Followed by Kane [NJ Ex Order 26.4b] care until resident moved to another Assisted Living facility per family request.	All residents with wounds have the potential to be affected by this practice.	DOW will delegate wound care to RN supervisor or LPNs within the community with assistance of homecare and weekly outside wound care services.	Director of Wellness in-serviced LPN's on proper documentation. DOW or RN designee will audit TARs every week for 4 weeks and monthly moving forward. The results of the audit will be reviewed monthly at the communities QA meetings for further review and recommendations as needed.	12/15/2023 and monthly thereafter. [NJ Ex O]
A1073	DOW or designee will audit at end of month, documentation and/or	All residents have the potential to be affected by this	DOW or designee will ensure at end of month, documentation and/or notes from all health care and service	Director of Wellness has in serviced RNs and LPN's on appropriate record keeping and end of month	11/30/2023

POC accepted 12/07/2023 [NJ Ex Order 26]

	notes from all health care and service providers, MARS and TARs from prior month are filed into resident record. Resident #2 event reported to the Department of Health. Moved to another Assisted Living facility per family request.	practice.	providers, MARS and TARs from prior month are filed into resident record.	MAR/TARs reconciliation. RN or designee will audit resident files monthly. The results of the audit will be reviewed monthly at the communities QA meetings for further review and recommendations as needed.	
H5790	Director of Wellness has in serviced RNs, LPN's, CMA'S on Universal Transfer Form. RN on call is informed of any resident transfers and RN will monitor residents medical record to ensure copy of the Universal Transfer Form is on file. Resident #2 event reported to the Department of Health. Moved to another Assisted Living facility per family request.	All residents have the potential to be affected by this practice.	Director of Wellness has in serviced RNs, LPN's, CMA'S on Universal Transfer Form.	Director of Wellness has in serviced RNs, LPN's, CMA'S on Universal Transfer Form. RN on call is informed of any resident transfers and RN will monitor residents medical record to ensure copy of the Universal Transfer Form is on file 1x a week for 4 weeks, 1x a month for 3 months. The results of the audit will be reviewed monthly at the communities QA meetings for further review and recommendations as needed.	11/30/2023

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
X1KYQQ		12/7/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HAMILTON	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 11/30/2023	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
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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	
10/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
X1KYQQ		12/7/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HAMILTON	1660 WHITEHORSE-HAMILTON SQUARE ROAD HAMILTON TOWNSHIP, NJ 08619

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0940 Reg. # 8:36-11.5(b)(2)(i-iv)(1-3),(v-vi) LSC	Correction Completed 12/15/2023	ID Prefix A1073 Reg. # 8:36-15.6(b) LSC	Correction Completed 11/30/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
10/20/2023	