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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preferred Care at Hamilton	1501 State Hwy 33 Hamilton Square, NJ 08690

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 40744 Based on interview and record review, it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASRR) level one assessment after a resident was newly diagnosed with a mental illness. This deficient practice was identified in 1 of 2 residents reviewed for PASRR (Resident #17) and was evidenced by the following: On 1/28/25 at 11:02 AM, during the initial tour the surveyor observed Resident #17 in bed with eyes closed. On 1/28/25 at 11:26 AM, the surveyor reviewed the medical Record for Resident #17. A review of the Admission Record face sheet (an admission summary) reflected the resident was initially admitted to the facility in 2021, with diagnoses which included but not limited to; failure to thrive, hypertension (high blood pressure), chronic pain, and anxiety. Further review showed a new diagnosis of psychosis in 12/2022. A review of Resident #17's PASRR level one in the Electronic Medical Record (EMR) dated 6/2021. A review of section one of the PASRR which asked if the resident had a mental illness diagnosis, no was marked. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 10/30/24, reflected the resident had a Brief Interview of Mental Status (BIMS) score of 4 out of 15, meaning the resident had severe cognitive impairment. A review of section I of the MDS titled active diagnoses revealed the resident had a diagnosis of anxiety and psychotic disorder. On 1/29/25 at 8:50 AM, the surveyor interviewed the Social Worker (SW) regarding the PASRR for Resident #17. The SW was able to provide the surveyor with the level one PASRR, completed prior to admission, but not a level two. The surveyor asked if a level two was completed when the resident developed a new mental illness diagnoses, and the SW stated she would complete it now because it was missed. The surveyor asked how a new diagnosis would be communicated to her, and she said that the psychiatrist told the nurse of a new diagnosis, and the nurse let the social worker know. On 2/3/25 at 12:30 PM, during a meeting with the Director of Nursing (DON), she acknowledged the PASRR should have been completed and told the survey team the SW was educated. (continued on next page)

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.

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: 315111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Resident Assessment-Coordination with PASRR Program policy dated 7/2024, included . any resident who exhibits a newly evident or possible serious mental disorder will be referred promptly to the state mental health or intellectual disability authority for a level two resident review . NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

33106

Complaint #175979

Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) implement interventions to prevent the development of a stage 3 (full thickness wound) facility acquired pressure injury; b.) ensure individualized comprehensive care plan interventions were implemented to prevent a facility acquired pressure injury wound from worsening; c.) ensure daily observation during wound care was documented according to professional standards of nursing practice to follow continuity of care; and d.) ensure that the physician evaluated and assessed the resident's medical issues related to skin care. This deficient practice occurred for 1 of 2 residents reviewed for pressure ulcers (Resident #167). Resident #167 was identified as having moisture associated skin damage (MASD) and dermatitis (inflammation of the skin) on the right buttocks measuring 2 centimeters (cm) x 1.5 cm x 0.1 cm on 5/29/24, which progressed to a stage 3 pressure injury on 6/5/24, of the right buttocks measuring 2.8 cm x 1. 5 cm x .2 cm and MASD on the sacrum measuring 2 cm x 0.7 cm x 0.1 cm.

The evidence was as follows:

A review of the Admission Record face sheet (admission summary) indicated that Resident #167 was admitted to facility with the diagnoses that included but not limited to; Parkinson's disease and protein calorie malnutrition.

A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 4/10/24, indicated that Resident #167 had moderate cognitive impairment and required partial to moderate assistance with activities of daily living (ADLs). The MDS also indicated that the resident was at risk for developing pressure ulcers/injuries.

A review of the Resident Evaluation-V2 dated 4/7/24, reflected that Resident #167's skin was intact at the time of admission to the facility and the Braden Scale (used to predict pressure ulcer risk) reflected that the resident's score was 15, which indicated that the resident was at risk for skin breakdown.

The surveyor was unable to interview or observe Resident #167 as the resident was longer a resident in the facility.

A review of Resident #167's individual comprehensive Care Plan (ICCP) dated 4/7/24, reflected that the resident was at risk for skin breakdown related to bladder incontinence and immobility. Interventions included to: turn and reposition every two to four hours; inspect skin during provision of care and bathing activities; labs as ordered; limit out of bedtime to two hours per session; provide pressure relieving cushion; report any skin breakdown to the nurse; suspend or float heels as able; apply moisture barrier cream and needed for protection after each incontinent episode.

(continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the Treatment Administration Record (TAR) dated 4/7/24, reflected a physician's order to apply peri-guard external ointment (skin protectants, miscellaneous) to the coccyx (tailbone) topically every shift for skin protection and/or healing. The order was subsequently discontinued on 4/8/24. The ICCP was not updated to reflect that the resident was not receiving a moisture barrier cream for preventive protective skin care. On 1/29/25 at 10:34 AM, the surveyor interviewed the Licensed Practical/Nurse Unit Manager (LPN/UM #1), who stated that Resident #167's skin was assessed on admission to the facility and was intact. LPN/UM #1 stated that skin checks were ordered on admission and were scheduled to be conducted on the resident's shower days. LPN/UM #1 added that skin checks were documented on the Medication Administration Record (MAR) and the nurses assigned to the resident were required to sign that the skin check was performed. LPN/UM #1 stated that he thought the condition of the resident's skin was documented in the resident's progress notes but was not sure. A review of the MARs for April, May, and June of 2024, included a physician's order dated 4/7/24, for skin checks to be done on shower days every evening shift on Tuesday and Friday for monitoring. There was no weekly documentation of skin checks describing the resident's skin condition until the resident developed moisture associated skin damage on 5/29/24. A review of the Wound Observation Progress Note (WOPN) dated 5/29/24 at 5:30 AM, indicated that the resident had developed a facility acquired skin injury on the right buttocks measuring 2 cm x 1.5 cm x 0.1 cm. The wound was described as moisture associated skin damage (MASD) and dermatitis (inflammation of the skin). A review of the resident's ICCP revealed that the ICCP was not updated to reflect that the resident had developed actual skin impairment, and no new interventions were initiated to prevent further deterioration of the skin after the resident developed an impairment on 5/29/24. A review of the Wound Care Consultant Report (WCR) dated 5/29/24, reflected that the resident developed MASD on the right buttocks. The WCR indicated that the Wound Care Consultant (WCC) recommended honey gel with a border foam dressing as the treatment to the resident's right buttocks. According to the report, the WCC performed a treatment to the wound using honey gel with a border foam dressing on 5/29/24. The WCC also recommended preventative interventions to promote wound healing such as: alternating pressure mattress with turning and repositioning; a specific type of gel (roho) cushion to be applied to the resident's wheelchair (to reduce pressure); and to encourage the resident to perform seat lifts every 15 minutes. The ICCP was not updated to reflect these interventions. A review of the Physician Order Report (POR) dated 5/30/24, reflected a wound treatment to start on 5/31/24, and to cleanse the area with normal saline solution (NSS), apply Medihoney wound/burn dressing external gel (wound dressings) to the right buttock topically everyday shift for wound care and to cover with a bordered foam dressing daily. The treatment was started two days after the WCC recommended the treatment to start on 5/29/24. A review of the May 2024 TAR revealed that Resident #167 did not have a treatment done on 5/30/24. The TAR revealed that the treatment was not performed until 5/31/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the MAR dated 5/31/24, had a nursing signature indicating that a skin check was performed for Resident #167. There was no further documentation regarding the condition of the resident's skin. A review of the Nurse Practitioner Note (NPN) dated 6/2/24, indicated that the Nurse Practitioner (NP) documented that the resident had no wounds, rash, or lesions and that the skin turgor/texture was within normal limits (wnl). A review of the NPN dated 6/4/24, indicated that the NP documented that the resident had no wounds, rash, or lesions and that skin turgor/texture was wnl. A review of the primary care physician (PCP) notes dated 5/31/24 at 5:01 PM, 6/2/24 at 10:12 PM, and 6/4/24 at 10:29 PM, did not address the resident's MASD that developed on their right buttocks. A review of the TAR dated 6/4/24, included a nursing signature that indicated a skin check was performed for Resident #167. There was no further documentation regarding the condition of the resident's skin. A review of the WOPN dated 6/5/24 at 8:38 PM, reflected that Resident #167 had developed a stage 3 pressure ulcer of the right buttocks measuring 2.8 cm x 1.5 cm x .2 cm and MASD of the sacral area measuring 2 cm x 0.7 cm x 0.1 cm. The resident had a weekly skin check done on 6/4/24, and there was no documentation regarding the resident's skin condition. A review of the WCR dated 6/5/24, indicated that the resident's skin condition had worsened. The documentation reflected that the resident's right buttocks wound had deteriorated to a stage 3 pressure injury measuring 2.8 cm x 1.5 cm x 0.2 cm and developed MASD of the sacral area measuring 2 cm x 0.7 cm x 0.1 cm. The WCR indicated that the resident had a bedside sharp debridement (a surgical procedure used to remove dead (necrotic) tissue from wounds) of the right buttocks wound and the resident tolerated the procedure well. The WCR specified that the resident was to be offloaded (method applied to reduce pressure) utilizing an alternating pressure mattress. The resident's ICCP did not reflect that the resident was utilizing the mattress as recommended by the WCR. A review of the subsequent PCP note dated 6/8/24 at 4:30 PM, the physician did not address that the resident had a new stage 3 pressure injury on the right buttocks. The NP nor the PCP documented and addressed that the resident had developed a facility acquired stage 3 pressure ulcer until 6/11/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/29/25 at 11:27 AM, the surveyor interviewed the Infection Preventionist (IP), who stated that weekly skin assessments were ordered on admission and performed on the resident's shower days. The IP explained that skin checks were ordered weekly as a preventative measure to prevent skin breakdown and the checks were documented on the MAR when it was completed. The IP stated that she was not sure where the actual skin check was documented regarding the condition of the residents' skin. At that time, the IP reviewed the resident's medical record and stated that she could not locate where the nurses were writing what the resident's skin actually looked like, but would find out where the information was located. The IP stated that the facility completed a RMS (Risk Management System-incident) report which was the WOPN when a resident developed a wound. The IP reviewed the resident's ICCP with the surveyor and confirmed that the ICCP was not updated to include actual skin breakdown with interventions after the resident developed skin breakdown on 5/29/24. On 1/30/25 at 10:01 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the nurses were required to sign the MAR after completing a weekly skin check. The DON stated that weekly skin checks were documented by exception, meaning that the nurses only documented if there was an issue with the resident's skin. The DON stated that she would have expected the nurses to write a description of the resident's skin when they performed a weekly skin check after the resident had developed a skin impairment on 5/29/24. The DON did not have an explanation as to why the treatment order was not obtained when the resident developed skin breakdown on 5/29/24. The DON reviewed the TAR in the presence of the surveyor and confirmed that the treatment order was not received until 5/30/24, but was not completed until 5/31/24. The DON did not have an explanation as to why Resident #167's ICCP was not updated to reflect the WCR recommendations for additional offloading interventions after the wound development on 5/29/24. The DON explained that the facility did not need an order for periguard ointment because the Certified Nursing Aide (CNA) applied it to the resident's buttock during care for skin protection. On 1/30/25 at 1:20 PM, the surveyor interviewed the WCC, who stated that he saw Resident #167 on 5/29/24, and that treatment recommendations and offloading interventions were given to the nurse on the that day. The WCC stated that the nurses were responsible to get the treatment orders from the providing physician and to update the ICCP with the new offloading interventions to aid in skin healing. On 2/3/25 11:44 AM, the surveyor conducted a telephone interview with the resident's PCP, who stated that he left the recommendations for wound care up to the wound care team. The PCP stated that he did not write the notes on 6/2/24 or 6/4/24, that Resident #167's skin was intact. The PCP stated a Nurse Practitioner (NP) documented those notes, and that he did not work with the NP. The PCP added that the NP was hired by the facility and he did not follow-up or supervise the NP. The PCP did not have a response as to why there was no documentation from the PCP or NP that addressed that the resident developed a facility acquired stage 3 pressure ulcer until 6/11/24. On 2/3/25 at 12:01 PM, the surveyor interviewed the Medical Director (MD), who stated that there were two groups of NPs that came to the facility and saw the residents. The MD stated that the NPs were contracted and they had their own physicians. The MD also stated that the NP should have been reporting to the attending physician (PCP) and the MASD wound should have been reported to and addressed by the physician. The MD stated that the NP who documented that the resident's skin was intact when in fact it was not, did not work at the facility anymore, but he would have to address with the PCP that it was not documented until 6/11/24, that the resident had a new wound. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's Skin Assessment Policy dated 1/3/25, included it was the policy to perform a full body assessment as part of our systematic approach to pressure injury prevention and management . documentation of skin assessments with any skin impairment will be noted in the patients' medical record . A review of the facility's Pressure Ulcer/Wound Treatment Management policy dated 2/1/24, included that the facility was to provide evidence-based treatments in accordance with current standards of practice and physician's orders .wound treatments will be provided in accordance with physician's orders and in the absence of treatment orders, a licensed nurse will notify the physician to obtain treatment orders . A review of the facility's Care Plan Process policy dated September 2024, included that the resident's care plan (CP) will be developed was appropriate for each resident's needs and/or wishes based on the assessment and reassessment process with the required timeframes .the plans of care have key areas, may include but were not limited to health maintenance and daily care needs .the CP would include problem statements to include medical problems for which the resident was on significant medications (i.e., hypertension, diabetes etc.). The policy indicated that a CP would include: identified problem; onset date; related risk factors; build on the resident's strengths; reflect treatment goals and objectives; interventions and approaches. A review of the facility's Pressure Ulcer/Wound Treatment Management policy dated 2/1/24, included the facility was to provide evidence-based treatments in accordance with current standards of practice and physician's orders .wound treatments will be provided in accordance with physician's orders and in the absence of treatment orders, a licensed nurse will notify the physician to obtain treatment orders . A review of the facility's Resident Care Consultants and Referrals policy dated June 2024, included the nurse would inform the attending physician of the consulting physician recommendations for appropriate follow-up and physician orders if indicated . A review of the facility's Service Agreement - Advance Practice Nursing dated 6/5/18, included the facility had a contract with [name redacted] to provide advanced practice nurses (APN). The APNs were expected to follow all facility policies and procedures. NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44833 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 1/28/25 at 10:00 AM, during initial tour of the kitchen, the surveyor, accompanied by the Food Service Director (FSD) and the Licensed Nursing Home Administrator (LNHA) observed the following: Upon entering the kitchen, the FSD washed her hands at the hand washing sink, and lathered with soap outside the flow of running water for 14 seconds. The LNHA then washed his hands lathering with soap prior to rinsing for a total of 13 seconds. The surveyor used a digital stopwatch to record the time. The [NAME] had a long beard with a beard net that was worn under his chin and not covering his beard hair while he actively worked in the kitchen. At that time, the FSD confirmed it should not have been worn that way. A plastic bin of powdered mashed potatoes and a bin of flour both had the scooper stored inside the bin hanging off the edge. The scoopers caused the lids to remain slightly open. At that time, the FSD confirmed it should not have been stored that way and could allow rodents to get in. One 16-ounce (oz.) container of dried parsley flakes, one 16 oz container of bay leaves, and one 16 oz container of dried thyme which were opened and not dated with an opened date. The ice scooper bin was mounted on the wall above seven uncovered racks of clean coffee mugs and soup bowls. The mugs and bowls had water on them. The FSD stated that the ice scooper bin had been there forever meaning above the spot where racks of clean supplies were stored. In the walk-in freezer was one pie, identified by the FSD as an apple pie, covered with plastic wrap and not labeled or dated. Next to the walk-in refrigerator were two racks of clean dessert bowls that were uncovered with an exterior exhaust fan cage above it. The fan was covered with a thick layer of gray dust-like material. Next to the two racks of clean dessert bowls was the refrigerator's cooling system/motor which was also covered in a thick layer of gray dust. On the drying rack were two red and two white cutting boards which were pitted and had deep cut marks. On 1/30/25 at 11:15 AM, during a follow-up tour of the kitchen, the surveyor observed the following: The [NAME] went to the hand washing station, wet his hands, dispensed foam soap into his hands, and immediately began to rinse his hands with no lather time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Following the Cook, a Dietary Aid (DA #1) washed his hands lathering with soap for 16 seconds prior to rinsing The usrveyor used a digital stopwatch to record the time. DA #2 was observed at the steam table leaning over a large tray of mashed potatoes as he used a large whisk to mix the potatoes. The surveyor observed DA #2 with a large amount of sweat drops on his face and running down his nose, dripping into the tray of mashed potatoes as he mixed. At that time, the surveyor approached the Regional Food Service Director (RFSD) and informed him of that observation. The RFSD approached DA #2, observed the sweat on his face, and acknowledged the concern. On 1/31/25 at 11:46 AM, the surveyor interviewed the Infection Preventionist (IP) in the presence of the LNHA and the Director of Nursing (DON). The IP stated that she provided infection control education including hand hygiene to all facility staff including kitchen staff and administration. The IP stated that the required minimum time for lathering with soap when washing hands for infection control was 20 seconds. At that time, the LNHA added that he was also educated on the proper amount of time to lather with soap when washing his hands and acknowledged the surveyor's observation of him not meeting the minimum 20 seconds. The IP further stated that anyone who entered the kitchen was required to wear proper hair and beard nets appropriately and that those items were readily available at the kitchen entrance. The IP stated that having beard hair and any other hair outside of the hair net posed an infection control risk. On 2/3/25 at 10:13 AM, in the presence of the survey team, the LNHA acknowledged that personal hygiene when preparing food, appropriate hand hygiene, and proper use of hair and beard nets should have been followed appropriately in the kitchen. The LNHA also acknowledged that kitchen supplies and equipment should have been maintained in a sanitary manner, and that all items should have been labeled and dated appropriately. A review of the facility's Hand Hygiene policy with a most recent created date of 8/1/24, included all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, resident, and visitors. This applies to all staff working in all locations within the facility .hand hygiene technique when using soap and water: a. wet hands with water. avoid using hot water to prevent drying of skin. b. apply to hands the amount of soap recommended by the manufacturer. c. rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. rinse hands with water . A review of the facility's dietary Dating policy with a reviewed date of 8/2023, included all fresh and frozen foods must be dated with the date it was received into the kitchen, unless it has a purveyor shipping label on it. Make sure to not date over or cover up the manufacturer's expiration date on the product . A review of the facility's Personal Hygiene policy with a reviewed date of 8/2024, included cover hair and facial hair with restraint (hairnet, cap, beard net or hat). Mustaches and beards must be well trimmed . A review of the facility's Kitchen Supplies: Storage policy with a most recent created date of 6/2024, included all food service equipment should be cleaned, sanitized, air-dried, and reassembled after each use. Plastic-ware or dishware that has lost its glaze or is chipped or cracked must be disposed of . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's Food Prep Hygiene policy with a last revised date of 6/2024, included during food preparation, maintain appropriate distance and body posture from food prep area to avoid possible contamination . NJAC 8:39-17.2(g)