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
NAME OF PROVIDER OR SUPPLIER Preferred Care at Hamilton		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to promote and maintain resident dignity a.) while providing feeding assistance and b.) for a resident with a urinary catheter. This deficient practice was identified for 4 of 16 residents reviewed for dignified dining (Resident #11, #51, and #72) and 1 of 2 residents reviewed for urinary catheters (Resident #52). The evidence was as follows: 1. On 1/29/25 at 12:15 PM, the surveyor observed resident dining in the North Wing resident dining room. The surveyor observed a Licensed Practical Nurse (LPN) actively feeding Resident #72, while standing alongside the resident at the resident's table. There were five empty and available chairs near the LPN while she remained standing over the resident who was seated in a geriatric chair at the table. On 1/29/25 at 12:20 PM, the surveyor interviewed the Certified Nursing Aide (CNA) who was in the dining room, who stated that staff should have been seated alongside the resident while providing feeding assistance. On 1/29/25 at 12:23 PM, the surveyor observed the CNA replace the LPN with assisting Resident #72 with feeding. The LPN walked away from the table, and at that time the surveyor interviewed the LPN, who stated that the proper way to assist a resident with feeding was to sit alongside the resident to maintain eye contact and dignity. On 1/30/25 at 1:48 PM, the surveyor reviewed Resident #72's medical record. A review of the resident's Admission Record face sheet (an admission summary) indicated the resident was admitted to the facility with diagnosis which included but was not limited to; dementia and mood disorder. A review of the resident's physician's Order Summary Report indicated the resident had a ground texture regular diet. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool dated 1/7/25, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated severe cognitive impairment. A further review of the MDS reflected the resident required partial to moderate assistance with eating. (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:	(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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 12:00 PM, the surveyor interviewed the Director of Nursing (DON) and the Infection Preventionist (IP), who both stated that when assisting residents with feeding/eating, staff should be seated alongside the resident and not have been standing over them for dignity concerns. On 2/3/25 at 10:13 AM, the DON, in the presence of the survey team acknowledged that staff should always be seated when assisting residents with meals. 2. On 1/30/25 at 11:36 AM, during a follow-up kitchen inspection, the surveyor observed three meal trays being prepared by the kitchen staff with individual resident meal slips placed on them. Upon closer review of the meal slips, it was observed for each slip to have Resident #11, #51, and #72's names on each slip with the term Feeders printed below each resident's name. The surveyor continued to monitor and followed the meal trays which each still had the resident's meal slip on them as they were delivered to the main dining room. Staff then passed the trays out to the individual residents and the meal slips remained on the tray on the table in front of the residents. On 1/30/25 at 1:48 PM, the surveyor reviewed Resident #11's medical record. A review of the resident's Admission Record face sheet indicated the resident was admitted to the facility with diagnosis which included but was not limited to; dementia and dysphagia (difficulty swallowing). A review of the resident's quarterly MDS dated [DATE], indicated that the resident had a BIMS score of 5 out of 15, which indicated severe cognitive impairment. A further review of the MDS reflected the resident required substantial to maximal assistance with eating. On 1/30/25 at 1:48 PM, the surveyor reviewed Resident #51's medical record. A review of the resident's Admission Record face sheet indicated the resident was admitted to the facility with diagnosis which included but was not limited to; Alzheimer's Disease and dysphagia. A review of the resident's quarterly MDS dated [DATE], indicated that the resident had a BIMS score of 1 out of 15, which indicated severe cognitive impairment. A further review reflected the resident was dependent on staff for assistance with eating. On 1/30/25 at 1:48 PM, the surveyor reviewed Resident #72's medical record. A review of the resident's Admission Record face sheet indicated the resident was admitted to the facility with diagnosis which included but was not limited to; dementia and mood disorder. A review of the resident's quarterly MDS dated [DATE], indicated that the resident had a BIMS score of 1 out of 15, which indicated severe cognitive impairment. A further review reflected that the resident required partial to moderate assistance with eating On 1/31/25 at 9:35 AM, the surveyor interviewed the Regional Food Service Director (RFSD) and the Food Service Director (FSD), who stated that they were unsure as to how the term feeders was put on the meal slips. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 12:00 PM, the surveyor interviewed the DON and the IP, who both stated that staff and the facility should not refer to residents or use terms such as feeders because that would be considered undignified. On 2/3/25 at 10:13 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team acknowledged that the meal slips containing the term feeders was an error and should have been caught by the facility. A review of the facility's Dining and Meal Assistance policy with a last revised date of 6/2024, included all residents will be encouraged to eat in the dining room. facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: not standing over residents while assisting them with meals . avoiding the use of labels when referring to residents (e.g., feeders) . 49094 3. On 1/28/25 at 10:30 AM, during the initial tour of the facility, the surveyor observed Resident #52 lying in their bed awake. The resident stated they had a suprapubic catheter (type of indwelling catheter that drains urine from the bladder into a bag). The surveyor observed the indwelling catheter drainage bag secured to the bed frame, not placed in a privacy bag exposing the contents (urine) in the bag. The surveyor was able to observe the urine in the resident's catheter drainage bag from the hallway. On 1/29/25 at 10:45 AM, the surveyor reviewed the medical record for Resident #52. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included but not limited to; retention of urine, type two diabetes (body does not use insulin properly), neuromuscular dysfunction of bladder (nerves controlling bladder function are damaged), and cystostomy status (surgical creation of an opening into the bladder). A review of the most recent comprehensive MDS, an assessment tool dated 12/9/24, indicated the resident had a BIMS score of 15 out of 15, indicating a cognitively intact cognition. A review of the Order Summary Report included a physician's order (PO) dated 12/2/24, for a catheter: maintain 20 french (Fr; size of the indwelling catheter) catheter with a 10 cubic centimeter (cc) balloon (balloon inflated to keep catheter in place) for a diagnosis of neurogenic bladder (bladder function are damaged) and attach urinary drainage bag and maintain it below the level of the bladder every shift for catheter management. A review of the individual comprehensive care plan (ICCP) included a focus area dated 12/8/24, that the resident had a suprapubic catheter due to neurogenic bladder. Interventions included but not limited to; check and place catheter in privacy bag each shift and secure catheter per facility protocol. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1:44 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN), who stated that catheter drainage bags should be located below the resident's bladder, hooked on the resident's bed frame, and placed in a privacy bag. The UM/LPN further stated the importance of the catheter drainage bag to be in a privacy bag was for the resident's dignity. On 1/30/25 at 1:04 PM, the surveyor interviewed the Infection Preventionist (IP), who stated that catheter drainage bags should be placed in a privacy bag, positioned below the bladder, and should not be touching the floor. The IP also stated that privacy bags were used for the resident's dignity. On 1/31/25 at 10:30 AM, the surveyor presented the Director of Nursing (DON) and IP a picture of the resident's catheter drainage bag that was seen during initial tour. The DON and IP acknowledged that the catheter drainage bag was not in a privacy bag at that time. The DON stated it should have been in a privacy bag for dignity reasons. On 2/3/25 at 10:14 AM, the DON, in the presence of the ADON, Regional Director of Nursing, Licensed Nursing Home Administrator (LNHA) and the survey team, confirmed that the catheter drainage bags should be maintained in a privacy bag for dignity reasons. A review of the facility's Urinary Catheters policy dated reviewed 11/1/24, did not include storing Foley catheter bags in a privacy bag. NJAC 8:39-4.1(a)(12)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49094 Complaint # NJ 182108 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the resident's living environment in a clean, comfortable, homelike manner. This deficient practice was identified on 1 of 2 nursing units (South Side) reviewed for environmental concerns, and was evidenced by the following: On 1/28/25 at 10:30 AM, the surveyor observed the South side nursing unit and identified the following concerns: In Resident room [ROOM NUMBER]-B had one bag of dirty linen on the floor near the resident's dresser. In Resident room [ROOM NUMBER]-A had a cracked trash can with no liner. In the bathroom the surveyor observed the toilet which had a brown substance splattered in the toilet and around the rim. The surveyor also observed a clear bag tied to the handrail filled with used Foley catheter leg bags. On 1/20/25 at 12:57 PM, the surveyor observed in Resident #1's bathroom a clear bag tied to the hand grab bar. The surveyor observed used Foley catheter leg bags in the clear bag. At that time, the surveyor asked Resident #1 if they tied the clear bag to the handrail. Resident #1 stated no, the [facility]; the resident does not use it. At that time, the Unit Manager/Licensed Practical Nurse (UM/LPN) observed Resident #1's bathroom, and she acknowledged that the bag had used Foley catheter leg bags in it. The UM/LPN stated it should not be hanging on the handrail for infection control reasons, and she was not sure who tied it to the handrail and removed the bag and discarded it. Resident #1 then stated, It's just dirty. On 1/31/25 at 10:30 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Infection Preventionist (IP), who stated that soiled linen should be bagged and taken to the soiled utility room immediately. The DON further stated it should not be left on the resident's floor. The IP stated it should not be left in the resident's room for infection control purposes. The surveyor presented the photos of the soiled bagged linen, the trash can with no liner, and bathroom to the DON and IP. The DON and the IP acknowledged that the toilet should have been cleaned and the trash can should not be cracked and should have a liner in it. On 1/31/25 at 10:38 AM, the surveyor interviewed the Environmental Services Director (ESD), who stated that the housekeepers had a daily schedule that they followed. The ESD further stated that if a resident had an accident, the Certified Nursing Aide (CNA) should have notified the housekeeping department so that the toilet seat could have been cleaned right away. The ESD acknowledged the surveyor's concerns with the toilet seat, trash can, dirty linen, and the bag with used Foley catheter leg bags. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 10:14 AM, the DON, in the presence of the IP, Licensed Nursing Home Administrator (LNHA), Regional Director of Nursing, and survey team acknowledged the surveyor's environmental concerns. A review of the facility's Linen Handling policy dated revised 6/2024, included .It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection .linen can become contaminated with pathogens from contact with intact skin or body surfaces, or from environmental contaminants or contaminated hands . A review of the facility's Routine Cleaning and Disinfection policy dated created 1/2025, included .routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge .routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to .toilet seats . NJAC 8:39-31.4(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40744 Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to revise an individual comprehensive care plan for a resident with a history of falls who used a fall mat. This deficient practice was identified in 1 of 5 residents reviewed for falls (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. The resident had a fall mat on the floor next to the bed and the right side of the bed was pushed up against the wall. On 1/29/25 at 1:24 PM, the surveyor reviewed incidents and accidents for Resident #17. The report reflected that on 11/17/24, the resident was observed on the floor sitting with their back against the bed frame. It was documented that the resident sustained no injuries from the fall and on the following day an interdisciplinary team meeting was held. A review of the Admission Record face sheet (an admission summary) reflected Resident #17 was admitted to the facility with diagnoses which included but were not limited to; failure to thrive, hypertension (high blood pressure), chronic pain, and anxiety. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 10/30/24, reflected that 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 the individualized comprehensive care plan (ICCP) included a focus area initiated on 6/23/21, that the resident was at risk for falls. The care plan focus area was updated on 11/17/24, following a fall. Interventions included frequent room checks, side rails, encourage resident to ask for assistance, call light within reach, bed in low position, well lit room and a clutter free environment. Interventions did not include fall mats and bed against the wall. On 1/30/25 at 9:15 AM, the resident was observed in bed with eyes closed. The bed was against the wall and a fall mat on the floor next to the side of the bed. On 1/31/25 at 11:55 AM, the resident was observed in the bed. The bed was against the wall and a fall mat in place. There was a Certified Nursing Assistant (CNA) with the resident providing care. The surveyor asked the CNA if the resident had history of falls, and she said yes and pointed to the fall mat. On 2/3/25 at 10:45 AM, during a meeting with the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), the Regional Director of Nursing (RDON), and the Infection Preventionist (IP), the surveyor asked if the resident should have been care planned for fall mats and having the bed against the wall. The DON replied yes, it should have been on the care plan. A review of the facility's Fall Policy dated 1/2024, included .the care plan would be reviewed and updated following a resident fall . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Care Plan Process policy dated 9/2024, included the purpose was to ensure a care plan will be developed that is appropriate for each resident's needs and/or wishes based on the assessment and the reassessment process with required timeframes . NJAC 8:39-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 45208 Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident received care and services for the provision of dressing changes to a peripherally inserted central catheter (PICC) site consistent with professional standards of practice. The deficient practice was identified for 1 of 24 residents reviewed for professional standard of practice (Resident #12). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The evidence was as follows: On 1/28/25 at 10:26 AM, the surveyor observed that Resident #12 had a bag attached to intravenous tubing line. The resident revealed a PICC located in the left chest wall. The surveyor observed the dressing was not labeled or dated. On 1/29/25 at 10:10 AM, the surveyor observed the undated and unlabeled dressing on Resident #12. On 1/29/25 at 10:37 AM, the surveyor interviewed Resident #12, who stated that the dressing had not been changed since it was inserted. The resident continued that the medication bag was changed every eight (8) hours. On 1/29/25 at 10:57 AM, the surveyor reviewed the medical record for Resident #12. A review of the Admission Resident face sheet (an admission summary) reflected Resident #12 was admitted to the facility with medical diagnoses which included but was not limited to; acute and/or chronic congestive heart failure (CHF). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/8/24, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated a cognitively intact cognition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Order Summary Report included physician's orders (PO) with a start date of 1/17/25, for milrinone lactate in dextrose intravenous solution (IV) 40-5 milligrams (mg)/200 milliliter (ml), 16.85 micrograms (mcg) every shift continuous for heart failure. The PO did not reflect any orders for PICC line observation or dressing changes. A review of the corresponding Medication Administration Record (MAR) dated, 1/1/25-1/31/25, revealed the nurses were electronically for the milrinone lactate in dextrose IV three times a day at 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM) since 1/17/25. The Mar did not include orders for PICC line observation or dressing changes. A review of the Treatment Administration Record (TAR) dated, 1/1/25-1/31/25, did not reflect any orders for PICC line observation or dressing changes. A review of nursing progress notes from since the start of the PICC line did not include any documentation for the PICC line dressing changes or measurements of the external portion of the catheter. On 1/29/25 at 12:08 PM, the surveyor interviewed the Infection Preventionist (IP), who stated upon admission, the nurse conducted an initial assessment and contacted the physician for orders. The IP stated a PICC line data set should have been discussed with the physician and the orders should be placed in the electronic medical record (eMR) that distributed the orders to the correct forms (MAR or TAR). The IP stated the forms allowed the nurse to acknowledge, perform, and document accordingly. The IP acknowledged that the facility process was not followed and since the dressing was unlabeled and undated she could not tell me when it was last changed. On 1/31/25 at 12:35 PM, the surveyor interviewed the Director of Nursing (DON), who acknowledged the facility process was not followed by staff. On 2/3/25 at 10:16 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, IP, and the Regional Nurse, who all acknowledged the surveyor's concerns. A review of the facility's PICC /Midline/CVAD Dressing Change policy, dated 1/2025, which included a policy statement; .change peripherally inserted central catheter (PICC) .dressing weekly or if soiled in a manner to decrease the potential for infection or cross contamination .measure external length of catheter from hub to skin entry to ensure that it has not migrated .secure the catheter with engineered stabilization device .label the dressing with date and time and your initials. A review of the facility's Infection Control IV policy, dated 1/3/2025, change IV site according to physician orders or facility policy . 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49094 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a) label, date, and store respiratory equipment in a manner to prevent contamination for infection control and b) develop a individualized comprehensive care plan (ICCP) for use of oxygen. This deficient practice was identified for 2 of 3 residents reviewed for respiratory care (Resident #45 and #85), and was evidenced by the following: 1. On 1/28/25 at 10:30 AM, during the initial tour of the facility, the surveyor observed Resident #45 lying in their bed watching television. The surveyor observed an oxygen concentrator (device that delivers oxygen) with nasal cannula (device that delivers additional oxygen through the nose) tubing placed on the oxygen concentrator unbagged and exposed to the air. On 1/29/25 at 1:14 PM, the surveyor reviewed the medical record for Resident #45. A review of the Admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; anxiety disorder (feelings of worry and fear), acute embolism and thrombosis of unspecified deep veins of left lower extremity (blood clot forms and breaks off traveling to the lungs), and encephalopathy (impairment of brain function). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 1/6/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating a cognitively intact cognition. A review of the Order Summary Report included a physician's order (PO) dated 1/20/25, for oxygen at 3 liters per minute (lpm) via nasal cannula every shift. Further review revealed a physician's order for oxygen at 3 lpm via nasal cannula due to shortness of breath or decreased pulse oxygenation as needed to maintain oxygen saturation (SPO2; percent of oxygen in a person's blood) 90% or greater. A review of the ICCP did not include a focus area for respiratory. The ICCP did not include interventions to administer oxygen. On 1/29/25 at 1:44 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN #1), who stated that oxygen tubing should be stored in a bag when not in use. UM/LPN #1 further stated that the tubing should be stored in a bag for infection control purposes. On 1/30/25 at 1:04 PM, the surveyor interviewed the Infection Preventionist (IP), who stated that oxygen tubing was changed once a week and as needed. The IP further stated that oxygen tubing should be stored in a bag when not in use to ensure it does not become contaminated. On 1/31/25 at 10:30 AM, the surveyor presented the Director of Nursing (DON) and IP pictures of the oxygen concentrator with the oxygen tubing unbagged and exposed to air. The DON and IP acknowledged that oxygen tubing should be stored in a bag and not exposed to air when not in use for infection control purposes. (continued on next page)

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

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 10:14 AM, the DON, in the presence of the IP, Regional Director of Nursing, Licensed Nursing Home Administrator (LNHA), and the survey team, confirmed that oxygen tubing should be stored in a bag and not exposed to air when not in for infection control purposes. The DON also confirmed that Resident #45's ICCP did not include oxygen and it should have. 33106 2. On 1/28/25 at 10:26 AM, during the initial tour, the surveyor observed Resident #85 sitting up in the wheelchair (w/c) with oxygen (O2) being infused via a nasal cannula at 4 lpm. The O2 tubing and the humidification bottle (add moisture to the breathing gases for administration of O2) was not labeled or dated. The resident was pleasant and had no complaints. Resident #85 when asked, was unsure when the O2 tubing was changed or when the humidification bottle was changed. On 1/29/25 at 10:00 AM, the surveyor reviewed the medical record for Resident #85. A review of the Admission Record face sheet reflected that Resident #85 was admitted to the facility with the diagnoses which included but not limited to; chronic respiratory failure and diabetes mellitus (DM). A review of the most recent comprehensive MDS indicated that the resident had a BIMS score of 7 out of 15, which indicated severely impaired cognition. The MDS also indicated that the resident received O2. A review of the physician Order Summary Sheet reflected a physician's order (PO) dated 7/30/24, for the resident to be administrated O2 at 4 lpm via nasal cannula. A review of Resident #85's ICCP did not include the administration of the resident's oxygen. On 1/29/25 at 12:49 PM, the surveyor observed Resident #85 sitting up in the w/c and O2 was infusing via nasal cannula at 4 lpm. The resident was pleasant and stated they were having a good day. The surveyor observed the O2 nasal tubing had a piece of tape on it with illegible writing and the humidification bottle was not labeled or dated. On 1/30/25 at 11:38 AM, the surveyor was accompanied by LPN #1 to Resident #85's room to observe the O2 tubing and the humidification bottle. LPN #1 confirmed that there was no labeling on the humidification bottle and the date on the O2 tubing was illegible. LPN #1 stated that the tubing should be changed weekly and that the 11:00 PM-7:00 AM (11-7) nurse was responsible to date the O2 nasal cannula and humidification bottle but must have forgotten. On 1/30/25 at 11:42 AM, the surveyor interviewed UM/LPN #1, who stated that the 11-7 nurse had just changed all the respiratory tubing on the South unit on Tuesday (1/25/24). UM/LPN #1 stated that she was not sure if the humidification bottles should be labeled with a date or initialed, but the date written on the O2 tubing must have smeared. The surveyor reviewed the Treatment Administration record (TAR) that included a PO dated 7/30/24, for oxygen tubing to be changed and to date the tubing and respiratory bag weekly every night shift on Tuesday. The TAR indicated that the tubing was changed 1/28/25, but the date on the tubing was illegible. There was no physician's order to change or date the humidification bottle. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 10:14 AM, the surveyor interviewed the DON, who stated that the O2 nasal cannula and the humidification bottle should be dated and initialed and confirmed that a ICCP was not developed for Resident #85 when the physician ordered Resident #85 to be administered O2. A review of the facility's Oxygen Administration policy dated revised 7/1/24, included oxygen tubing would be dated and initialed when started each week .humidification bottle needed to be changed weekly or when empty if it was a week before it was completed .The policy did not include labeling or dating the humidification bottle of the storage of oxygen tubing when not in use. A review of the facility's Care Plan Process policy dated revised September 2024, included .that the resident's CP (care plan) 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 .CP would include problem statements to include medical problems for which the resident was on significant medications (i.e., hypertension, diabetes etc.) .a CP would include identified problem, onset date, related risk factors, build on the resident's strengths, reflect treatment goals and objectives, and interventions and approaches . NJAC 8:39-27.1 (a)

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe, appropriate pain management for a resident who requires such services.

44833

Based on observation, interview, and record review, it was determined that the facility failed to ensure appropriate monitoring of pain with adequate assessment prior to administration for a resident who was prescribed pain medication. This deficient practice was identified for 84 of 131 doses administered for pain management to Resident #42, and was evidenced by the following:

On 1/28/25 at 11:25 AM, during initial tour of the facility, the surveyor observed Resident #42 resting in bed wearing a back brace belt and watching television. The resident told the surveyor that they were dealing with back pain.

On 1/29/25 at 12:27 PM, the surveyor observed the resident as they had completed their lunch in the main dining room and were walking out of the dining room, wearing a back brace belt and using a cane. The resident stated they were being managed for pain.

On 1/29/25 at 1:10 PM, the surveyor reviewed Resident #42's medical record.

A review of the Admission Record face sheet (an admission summary) indicated that the resident was admitted to the facility with diagnosis which included but was not limited to; thoracic discitis (inflammation of the spinal discs) and cervical spondylopathy (disease or disorder of the spine in the neck region).

A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/12/24, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating an intact cognition. The MDS further indicated that the resident received regularly scheduled pain medication.

A review of the resident's Individualized Comprehensive Care Plan (ICCP) included a care focus with initiated 10/22/24, for pain. Interventions included but not limited to: administer pain medications as ordered.

A review of the resident's physician's orders (PO) included an order with a start date of 10/22/24, and end date of 11/7/24, for morphine sulfate half a tablet (a controlled pain medication) of 15 milligrams (mg) to be given as needed every six hours for moderate to severe pain ranging from 4-10 on a scale of 0-10. A second PO dated 11/20/24, for morphine sulfate tablet 15 mg to be given as needed every six hours for moderate to severe pain ranging from 4-10.

A review of the November 2024, December 2024, and January 2025 Medication Administration Record (MAR) indicated morphine sulfate was administered as ordered with no documented pain level assessment conducted prior to administering the following doses:

November: 11/20 (one dose), 11/21 (two doses), 11/22 (one dose), 11/23 (two doses), 11/24 (two doses), 11/25 (one dose), 11/26 (three doses), 11/27 (two doses), 11/28 (two doses), 11/29 (two doses), 11/30 (two doses). There were a total of 20 doses administered with no pain level assessments.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December: 12/1 (two doses), 12/2 (two doses), 12/3 (one dose), 12/4 (two doses), 12/5 (two doses), 12/6 (one dose), 12/7 (two doses), 12/8 (two doses), 12/9 (two doses), 12/10 (two doses), 12/11 (two doses), 12/12 (two doses), 12/13 (two doses), 12/14 (one dose), 12/15 (two doses), 12/16 (two doses),12/ 17 (two doses), 12/18 (two doses), 12/19 (two doses), 12/20 (one dose), 12/21 (two doses), 12/22 (two doses), 12/23 (two doses), 12/24 (two doses), 12/25 (two doses), 12/26 (one dose), 12/27 (one dose), 12/28 (two doses), 12/29 (one dose), 12/30 (two doses), and 12/31 (two doses). There were a total of 55 doses administered with no pain level assessments. January: 1/1 (one dose), 1/2 (one dose), 1/3 (one dose), 1/4 (two doses), 1/5 (two doses), 1/6 (two doses). There were a total of nine doses administered with no pain assessment. On 1/30/25 at 1:56 PM, the surveyor interviewed the Director of Nursing (DON), who reviewed the MAR for the resident's pain medication and confirmed that a pain level assessment was not documented for each pain medication administered. The DON further stated there was a separate order for a pain level assessment every shift, but acknowledged that the pain level at the time of the assessment may not have been the same pain level at the time the pain medication was administered. The DON acknowledged that a pain level assessment should have been documented at the time the pain medication was administered. On 1/31/25 at 11:21 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that when administering pain medication, nurses were expected to assess the resident's level of pain on a scale from 0-10, and document that level on the MAR at the time the medication was administered. The LPN reviewed Resident #42's MAR with the surveyor, and confirmed that the portion requiring a pain level assessment for each administered dose of pain medication was marked with an X, which indicated there was no pain level assessments documented for those doses. On 1/31/25 at 11:31 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM), who reviewed the MAR with the surveyor for Resident #42 and stated based on the documentation provided, there were no pain assessments done for the doses administered that had an X indicated for the pain level. On 2/3/25 at 10:13 AM, in the presence of the survey team, the DON acknowledged that Resident #42 received pain medication without properly documented pain assessments. A review of the facility's Pain Management policy with a most recent created date of 11/2024, included .the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences .pain management .recognition, assessment, treatment and monitoring of pain . 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45208 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a) provide pharmaceutical services in accordance with professional standards of practice and b) accurately document the administration of controlled medications. This deficient practice was identified on 2 of 3 medication carts reviewed for medication storage. This was evidenced by the following: On 1/30/25 at 1:03 PM, the surveyor in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM #1), reviewed the Middle Cart North medication cart. A review of the cart revealed the Individual Patient Controlled Substance Administration Record sheet (declining inventory) for Resident #21's morphine extended release (ER) 60 milligram (mg) tablets was not signed by the nurse who administered the medication on 1/30/25. The declining inventory sheet revealed there should be a tablet count of 10 and the medication card revealed 9 tablets. A review of the cart revealed the declining inventory sheet for unsampled Resident #47's morphine ER 100 mg tablet was not signed by the nurse who administered the medication on 1/30/25. The declining inventory sheet revealed there should be a tablet count of 30 and the medication card revealed 29 tablets. At the time of observation, the surveyor interviewed LPN/UM #1, who stated, there should be no missing signatures and acknowledged that there were missing signatures on the narcotic declining inventory sheet. LPN/UM #1 acknowledged the narcotic tablet count was incorrect. On 1/30/25 at 11:45 AM, the surveyor in the presence of LPN/UM #2, reviewed the A-Hall South medication cart. A review of the cart revealed the declining inventory sheet for unsampled Resident #71's oxycodone immediate release, (IR) 10 mg tablet was not signed by the nurse who administered the medication on 1/30/25. The declining inventory sheet revealed there should be a tablet count of 30 and the medication card revealed 29 tablets. At the time of observation, the surveyor interviewed LPN/UM #2, who stated, there should be no missing signatures and acknowledged that there were missing signatures on the narcotic declining inventory sheets. LPN/UM #2 acknowledged the narcotic tablet count was incorrect. On 2/3/25/25 at 9:48 AM, the surveyor interviewed the Director of Nursing (DON), who acknowledged that the individual declining inventory sheets should be completed and filled out for each narcotic dose dispensed immediately at the time the medication was removed from inventory. A review of the facility's Medication Administration policy dated revised 1/2025, included .Medications are administered by licensed nurses .in accordance with professional standards of practice .if medication is a controlled substance, sign narcotic book . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-29.7(c)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 33106 Based on observation, interview, review of the medical records and other facility documentation, it was determined that the facility failed to provide adequate monitoring for the use of psychoactive medication. This deficient practice was identified for 1 of 5 residents reviewed for psychoactive medication used (Resident #85), and was evidenced by the following: On 1/30/25 at 12:07 PM, the surveyor observed Resident #85 sitting up in the wheelchair reading a book. The resident was very pleasant and stated they were having a good day and had no complaints. The surveyor reviewed the medical records for Resident #85. A review of the Admission Record face sheet (an admission summary) reflected that Resident #85 was admitted to the facility with the diagnoses which included but not limited to; chronic respiratory failure and diabetes mellitus (DM). A review of the comprehensive Minimum Data Set (MDS), an assessment tool, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated moderate cognitive impairment. The MDS further reflected the resident was dependent on staff for activities of daily living (ADLs) and received psychoactive medications. A review of the Medication Administration Record (MAR) revealed that the resident was on the following psychotropic medications: A physician's order (PO) dated 7/26/24, for trazodone hydrochloride (HCl) oral tablet 150 milligrams (mg); give 75 mg by mouth at bedtime for depression targeting insomnia. A PO dated 12/24/24, for lorazepam oral tablet 0.5 mg; give 1 tablet by mouth two times a day for anxiety. A PO dated 1/29/24, for buspirone HCl oral tablet 7.5 mg; give 1 tablet by mouth two times a day for anxiety. A PO dated 9/11/24, valproic acid oral solution 25 mg/5 milliliters (ml), anticonvulsant, give 5 ml by mouth every 12 hours for mood disorder. A review of the individual comprehensive Care Plan (ICCP) which included the following focus areas: A focus area dated initiated 4/19/24, that Resident #85 had the potential to express mood issues related to recent admission to the facility and history of depression. Interventions included: monitor, record, report to the medical doctor (MD) as needed (prn) acute episode feelings or sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite/eating habits, change in sleep patterns, diminished ability to concentrate; change in psychomotor skills; and monitor, record, report to MD prn mood patterns signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A focus area dated initiated 4/19/24, that the resident had the potential to be verbally abusive (i.e. screams/curses at staff/residents) related to (r/t) cognitive impairment, dementia, ineffective coping skills, and delusional behaviors. Resident #85 was noted to be incontinent of bowel and bladder and refused frequently to allow incontinence care, refused frequently to get out of wheelchair and sit and/or lie down in bed, refused labs, refused to sleep in the bed often despite verbalization of understanding with continuous education. Interventions included to: monitor behaviors every shift; document and observed behavior and attempted interventions. A focus area dated initiated 4/18/24, Resident #85 used antidepressant medication trazodone r/t depression and anxiety, delusions, anxiousness, verbally aggressive with staff. Interventions included to: administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness; monitor, document, report prn adverse reactions to antidepressant therapy: change in behavior, mood, or cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt. loss, nausea and vomiting, dry mouth, dry eye. A Review of Resident #85's MAR and the Treatment Administration Record (TAR) did not include documentation that the facility was monitoring the resident's behavior for the use of psychotropic medications. On 1/31/25 at 9:50 AM, the surveyor interviewed the Certified Nursing Assistant (CNA), who stated that Resident #85 required complete care with ADLS. The CNA stated that the resident was incontinent of bladder and bowel and wore incontinent briefs. The CNA stated that the resident was able to feed themselves and became anxious at times. The CNA stated that the resident became very confused and thought they were leaving the facility. The CNA stated that the resident did not become verbally or physically aggressive when she provided them care. On 1/31/25 at 9:55 AM, the surveyor interviewed Resident #85's Licensed Practical Nurse (LPN), who stated the resident required complete care with activities of ADLs. The LPN explained that Resident #85 could be sweet one minute and then could be cursing and screaming at the staff the next minute. The LPN explained that the resident usually exhibited behaviors during the evening shift and during sundown hours. She stated that the resident usually calmed down on their own and apologized for the behaviors. The LPN stated that if the resident had behaviors, the behaviors were documented in the Progress Notes. The LPN reviewed Resident #85's medical record, and confirmed that the resident did not have physician's orders for behavior monitoring or monitoring for side effect from psychotropic medication use. The LPN stated that she had seen other residents that had orders for that, and she was not sure why some residents on psychotropic medications had orders for side effects and behavior monitoring and some did not. On 1/31/25 at 10:14 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who explained that when residents started a new psychotropic medication or any changes in medications, the resident was monitored for 14 days. The LPN/UM stated that medication monitoring was documented in the Progress Notes. The LPN/UM stated that behavior monitoring and side effect monitoring for the use of psychotropic drugs was done on a case-by-case bases. The surveyor and the LPN/UM reviewed the resident's ICCP which specified that the resident's behavior was to be monitored every shift for the use of psychotropic medications, and the LPN/UM stated that she did not know the facility's behavior monitoring protocol. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/31/25 at 10:37 AM, the surveyor attempted to call the Resident's Representative (RR), but the phone number documented in the medical record was the wrong number. A review of the facility's policy Behavior Management, Intervention and Monitoring policy dated 7/1/24, indicated that the facility was to monitor specific behavior for resident's receiving psychotropic medications and that a licensed nurse would monitor and document drug side effects of all psychotropic use daily and will note in the resident medical record for behavior and side effects observed. On 2/3/25 at 10:14 AM, the surveyor interviewed the Director of Nursing (DON), who stated that behaviors were documented by exception, meaning only when the resident exhibited behaviors. The DON stated that the facility only documented and monitored the resident when a resident was being gradually dose reduced (GDR) from a psychoactive medication. The DON stated that monitoring was only done daily if the resident was started on a new psychotropic medication or if there was a change in the psychotropic medication. The DON could not speak to why the policy specified that a licensed nurse would monitor and document drug side effects and all psychotropic medication used daily and would note in the medical records for behavior and side effects. NJAC 8:39-27.1(a)

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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)

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

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

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

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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)

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 44833 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to properly dispose and maintain waste in garbage dumpster areas. This deficient practice was identified in 1 of 1 kitchen garbage dumpster areas, and was evidenced by the following: On 1/28/25 at 10:38 AM, during initial tour of the kitchen, the surveyor, in the presence of the Food Service Director (FSD) and the Licensed Nursing Home Administrator (LNHA) observed the kitchen's garbage dumpster area. The surveyor observed food debris including: bread slices and other unidentifiable disposed food and disposable gloves scattered on the ground. The surveyor also observed a half full garbage compactor which had the door wide open and was not actively being used by staff. At that time, the FSD stated that the dumpster area should have been maintained and cleaned; that leaving the garbage compactor open and having food debris on the ground was disgusting and could promote rodents. On 2/3/25 at 10:13 AM, in the presence of the survey team, the LNHA acknowledged that the dumpster area should have remained clean, and the garbage containers should have remained closed when not in use. A review of the facility's Dumpster Area policy with a revised date of 11/2024, included .the trash area should be clean, odor-free, and free from pest infestation. Trash containers should be sealed, leak proof, and covered at all times to prevent exposure to waste .all trash shall be placed inside the dumpster . NJAC 8:39-19.3(c)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Complaint # NJ 182108 Based on observation, interview, and review of other pertinent facility documentation it was determined that the facility failed to: a) ensure that soiled linen and soiled incontinent briefs were properly stored in a sanitary manner and b) ensure soiled medical equipment was sanitized prior to storage to prevent cross contamination and the spread of infection. This deficient was identified on 1 of 2 nursing units observed (South Unit) and 1 of 2 medication storage rooms observed (North Unit), and it was evidenced by the following: 1. On 1/28/25 at 12:00 PM, the surveyor was conducting a dining observation on the South Unit. The surveyor entered Resident room [ROOM NUMBER] and observed one bag of dirty linen and one bag of trash which contained dirty protective briefs, on the floor in the room. On 1/28/25 at 12:30 PM, the surveyor returned to Resident room [ROOM NUMBER] on the South Unit and observed a Certified Nursing Assistant (CNA #1) feeding the resident in bed B (near window). There were two bags of dirty linen and trash now moved in the front of the resident's bed while the CNA #1 continued to feed the resident. The surveyor interviewed CNA #1 at that time, and asked the CNA what the two bags were, and the CNA stated that the one bag contained resident dirty incontinent briefs, and the other bag contained dirty linen. CNA #1 then revealed that she utilized the same bags of dirty linen and briefs going from resident room to resident room because she did not want to waste bags so used the same bag for all residents she cared for. On 1/28/25 at 12:35 PM, the surveyor interviewed the License Practical Nurse (LPN #1) for the South Unit, who stated that CNA #1 should not be taking bags of dirty linen and briefs room to room after she performed resident care. LPN #1 stated that after resident care, CNA #1 should be utilizing individual bags for each resident for dirty briefs and dirty linen. LPN #1 stated that after caring for the resident, the linen and trash should immediately be removed from the resident's room and placed in the soiled utility room. LPN #1 accompanied the surveyor to Resident room [ROOM NUMBER] and observed the dirty linen in front of the residents' bed while CNA #1 was feeding the resident. LPN #1 stated that this should not have occurred and that if was an infection control issue. LPN #1 stated that going room to room with dirty briefs and linen could cause cross contamination. On 1/28/25 at 12:37 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM #1), who went to Resident room [ROOM NUMBER], and immediately removed the bag of linen and briefs. LPN/UM #1 stated that this was gross and a dignity issue. LPN/UM #1 stated, If I was a resident I would not want to eat in my own toilet. LPN/UM #1 then stated that this was an infection control issue and dirty bags of linen and briefs should not be going from resident room to resident room. On 1/30/25 at 08:27 AM, the surveyor interviewed the Infection Preventionist (IP), who stated that during meal service, dirty linen and briefs should be bagged and taken to the soiled utility room. The IP stated that the staff should never be taking dirty trash or linens from room to room; that it could pose an infection control issue related to cross contamination. The IP stated that the staff should never be feeding residents with dirty linen and dirty briefs in bags in the resident's rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/2025 at 9:30 AM, the Director of Nursing (DON) stated that the facility took this matter seriously and education was provided to the staff regarding proper handling and disposal of soiled linens, particularly during resident care activities. A review of the facility's Linen Handling policy dated 6/2024, included it was the policy of the facility to handle, store, process and transport clean linen and sanitary method to prevent contamination of the linen which could lead to infection .contaminated linen was linen that was soiled with blood or other potentially infectious materials .clean linen should be stored separately from soiled and that linen could become contaminated with pathogens from contact with intact skin or body substance, or from environmental contaminants or contaminated hands . 45208 2. On 1/30/25 at 8:49 AM, the surveyor, in the presence of LPN/UM #1, toured the North Medication Storage Room. The surveyor observed; one soiled oxygen (O2) concentrator with a humidification bottle that was half-way filled with a liquid substance that was still attached and three soiled tube feeding pumps stored in the medication room. At that time LPN/UM #1 stated, the soiled equipment should have been placed in the soiled utility room so housekeeping could process the equipment. LPN/UM #1 acknowledged that the soiled equipment should not be in the medication room; it could cause cross contamination to the sterile supplies and medication preparation area. On 1/30/25 at 9:31 AM, the surveyor interviewed the IP, who stated that soiled equipment should never be placed in the medication room; there was a soiled utility room that used equipment should be placed in. The IP stated it ensured housekeeping cleaned it, and when equipment was cleaned, a clear bag was placed on the equipment so that staff were aware, and it could go back into circulation. On 1/31/25 at 12:35 PM, the surveyor interviewed the DON, who stated that the facility's process for soiled equipment was to remove the equipment from the resident's room when it was no longer needed and placed it in the dirty utility room. The DON stated housekeeping cleaned the item and covered it with a clear plastic bag signifying it had been cleaned. A review of the facility's Cleaning and Disinfection of Nursing Equipment policy with a revised date of 3/2024, included .Policy; Equipment are to be free of soil and contamination with infectious organisms and product . clean and disinfect all highly technical/sensitive equipment (pumps, etc) per manufacturer's recommendations . NJAC 8:39-19.4