

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to complete a.) reference checks on employees before their start date for 38 of 77 employee files reviewed; b.) a check of the appropriate licensing boards and registries for 8 of 77 employee files; and c.) a criminal background checks for 6 of 77 employee files. The deficient practice was evidenced by the following: From 1/7/26 through 1/12/26, the survey team reviewed the facilities' new employee files and identified the following: a.) Employee #1 was hired as a Certified Nursing Assistant (CNA) on 2/10/25; there was no evidence of a reference check prior to the start of employment. Employee # 4 was hired as a Certified Nursing Assistant (CNA) on 8/26/24; there was no evidence of a reference check prior to the start of employment. Employee #5 was hired as an Activities Aide on 9/11/25; there was no evidence of a reference check prior to the start of employment. Employee #6 was hired in the Nursing Department on 3/10/25; there was no evidence of a reference check prior to the start of employment. Employee #7 was hired in the Nursing Department on 2/11/25; there was no evidence of a reference check prior to the start of employment. Employee #8 was hired as a Certified Nursing Assistant on 11/12/25; there was no evidence of a reference check prior to the start of employment. Employee #9 was hired in the Nursing Department on 5/1/25; there was no evidence of a reference check prior to the start of employment. Employee #10 was hired as a Registered Nurse on 2/19/25; there was no evidence of a reference check prior to the start of employment. Employee #11 was hired in Administration on 11/24/25; there was no evidence of a reference check prior to the start of employment. Employee #12 was hired as a Licensed Practical Nurse on 11/18/25; there was no evidence of a reference check prior to the start of employment. Employee #13 was hired as a Certified Nursing Assistant on 11/10/25; reference checks were identified as being completed on 9/12/25 Employee #25 was hired as a Registered Nurse on 11/25/24; there was no evidence of a reference check prior to the start of employment. Employee #26 was hired in Dietary on 11/21/24; there was no evidence of a reference check prior to the start of employment. Employee #29 was hired in Social Services on 8/25/25; there was no evidence of a reference check prior to the start of employment. Employee #33 was hired in Staffing on 11/13/25; there was no evidence of a reference check prior to the start of employment. Employee #34 was hired in Maintenance on 10/16/24; there was no evidence of a reference check prior to the start of employment. Employee #37 was hired in Housekeeping on 10/13/25; there was no evidence of a reference check prior to the start of employment. Employee #39 was hired in Dietary on 4/2/25; there was no evidence of a reference check prior to the start of employment. Employee #40 was hired in Dietary on 7/6/25; there was no evidence of a reference check prior to the start of employment. Employee #41 was hired in Dietary on 10/30/25; there was no evidence of a reference check prior to the start of employment. Employee #44 was hired in Dietary on 5/15/25; there was no evidence of a reference check prior to the start of employment. Employee #45 was hired in Dietary on 11/13/24; there was no evidence of a reference check prior to the start of employment. Employee #46 was hired in Activities on 2/17/25; there was no evidence of a reference check prior to the start of employment. Employee #47 was hired as a Licensed Practical Nurse on (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
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	before the applicant was to be hired. When the surveyor asked how the criminal background checks, reference checks, and licensures/registry checks applied to the facilities' abuse policy, the [NAME] further acknowledged that they were to be completed according to the facility's abuse policy. On 1/9/25 at 2:19 PM, the survey team interviewed the Licensed Nursing Home Administrator (LNHA), who acknowledged the employee files were a mess and that they would be better next year. A review of the facility provided Abuse Policy, Revised 12/2022, under the title Screening included: 1. All potential employees, contracts, consultants who will have access to residents are screened for a history of abuse, neglect, or mistreating residents/patients during the hiring process. Screening will consist of, but not limited to: inquiries into State licensing authorities, inquiries into state nurse aid registry, reference checks from previous and/or current employers, criminal background checks [.] 2. Record the results of the screening. Include the data, name and the title of the person contracted for reference and name the person obtaining the title.N.J.A.C. 8:39-13.4(c)2i		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 1/5/2026 at 9:30 AM the surveyor, accompanied by the Assistant Director (AD) and the Assistant Licensed Nursing Home Administrator (ALNHA), observed the following in the kitchen: Upon entry to the kitchen the surveyor observed that the baseboard tile molding was missing from the diet office doorway and extending into the kitchen area towards the service line. Observation of the juice box temperature log revealed that temperatures had been recorded daily, up to and including the AM temperature on 1/5/2026. Observation of the interior of the juice box revealed that there was not an internal thermometer to measure temperature. When interviewed, the AD told the surveyor that he was not aware that they needed an internal thermometer and that they used the digital thermometer on the exterior of the juice box. Prior to entry of the walk-in refrigerator, the surveyor reviewed the January 2026 temperature log. The log revealed that the temperatures had been recorded daily in the AM and PM up to and including the AM temperature on 1/5/2026. Observation of the interior of the walk-in refrigerator revealed that there was no interior/internal thermometer to measure the refrigerator temperature. The AD told the surveyor when interviewed that the thermometer had broken, and they he did not have a replacement. The ALNHA provided a new internal thermometer on site. On a rear middle rack of a multi-tiered wire rack in the walk-in refrigerator, a sheet pan contained four white plastic, round bags. The sheet pan was filled to the top edge with what appeared to be a reddish liquid from defrosting meat. The pan and bags were undated. On the shelf/rack directly above, a previously opened deli turkey was wrapped in plastic wrap. The plastic wrap was dated 12-19-26 in black marker. The surveyor questioned the AD how long the deli meat was good for after opening. The AD responded, I am not sure about things like that. It was pulled on the third. It is ground turkey. It is on the menu for tomorrow for turkey meat loaf. The surveyor observed an additional environmental concern under the rear shelf/rack that the defrosting ground turkey meat was observed. The floor beneath the storage rack was covered in a reddish/brown unidentified liquid. When interviewed on how often the walk-in refrigerator was cleaned the AD told the surveyor that they deep cleaned the refrigerator on the weekend and it was to be cleaned daily. The AD agreed that the refrigerator was in need of deep cleaning. In addition to the reddish brown on the rear floor of the walk-in, the surveyor observed individual portion control creamers, plastic wrappers, cardboard and other unidentifiable debris throughout the walk-in refrigerator. The AD was observed to instruct a dietary staff to clean the walk-in refrigerator in the surveyor's presence. The supplement refrigerator had an up-to-date January 2026 temperature log, and the last temperature was recorded on 1/5/2026 in the AM. The surveyor opened the refrigerator and observed frost on the inside. The refrigerator contained portion control butter, Mighty Shakes and creamers. There was no internal thermometer. The AD and ALNHA put a new internal thermometer in the fridge in the presence of the surveyor and agreed that there was no internal thermometer prior to surveyor observation. On 1/7/2026 at 11:17 AM the surveyor, accompanied by the Licensed Practical Nurse (LPN #3), observed the following in the First Floor Pantry, which was used to store foods brought from home for residents in the facility. 1. In the freezer, a frozen 8 oz 2% reduced fat milk on the freezer door shelf had a sell by date of [DATE]. Two (2) clear plastic containers contained unknown frozen contents. The containers had no name, dates or room numbers, as required by facility policy. 2. In the refrigerator on an upper door shelf, a container of Activia yogurt had a manufacturer's date of [DATE]. On the same door and a shelf below a container of Tropicana Pure Premium orange juice had a manufacturer's date of [DATE] for Use By. On a lower shelf in the interior of the refrigerator a clear 4 oz portion control container with a plastic (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lid contained an unknown orange substance. The container had no name, date or room number. In addition, a plastic storage container with a red plastic lid contained unknown food contents. The container had a name, but no dates and a plastic container covered in aluminum wrap had unknown contents. The container had no name, date or room number. When interviewed, LPN #3 told the surveyor that the facility infection preventionist rounded and checked the refrigerator and freezer for expired foods. In addition, she stated that all staff were responsible for removing undated and expired foods from the refrigerator and freezer. On 1/7/2026 at 11:48 AM the surveyor, accompanied by LPN #4, observed the following on the Second Floor Pantry: 1. On an upper shelf of the refrigerator, a white plastic bag contained two (2) plastic containers with green plastic lids with unknown food contents. The 2 plastic containers had no dates, names, or room numbers. The plastic bag had no date, name or room number. 2. In the freezer a clear, plastic container contained an orange unknown food substance that was frozen. The container had no name, date or room number. When interviewed concerning the unmarked foods the LPN stated, No name, no dates. It goes in the trash. On 1/9/2026 at 10:38 AM the surveyor, accompanied by the AD, observed the following in the kitchen: 1. Upon entry to the kitchen the surveyor observed that the dish machine was in use and actively washing dishware from the breakfast meal at 10:41 AM. The AD told the surveyor that the dish machine was a low temperature machine. Review of the Low Dish Machine Temperature Log, dated January 2026, revealed that on 1/9/2026 in the AM no temperatures had been recorded for the wash cycle and final rinse. In addition, the log also revealed that the sanitizer level in ppm (parts per million) had not been recorded in the AM. The surveyor observed three dietary staff operating the low temperature dish machine. The surveyor asked the dietary aide (DA) if he had tested the sanitizer level prior to initiating dish washing. The DA told the surveyor, No. He further stated that he did not test the sanitizer level prior to washing any dishes and that they had started to wash dishes approximately an hour ago. The surveyor asked the AD if staff should monitor and record dish machine temperatures and sanitizer level prior to initiating the dish washing process. The AD agreed that the temperatures and sanitizer level should be monitored prior to dish washing to ensure that the minimum temperatures and sanitizer level were met. 2. A white plastic bulk storage container with a clear plastic lid contained an opened bag of all-purpose flour used to prepare resident meals. Inside the opened bag the surveyor observed a metal ladle used to scoop flour from the bag. The AD removed the metal ladle from the bag of flour and agreed that it could cause cross contamination. The surveyor reviewed the facility policy titled FOOD STORAGE, last date revised: 5/10/2024. The following was revealed under the POLICY: Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry and free from contaminants. Food will be stored, at appropriate temperatures and by methods designed to prevent contamination. In addition, the following was revealed under PROCEDURE:6. Scoops must be provided for bulk foods (such as sugar, flour, and spices). Scoops are not to be stored in food or ice containers but are kept covered in a protected area near the containers. Scoops are to be washed and sanitized on a regular basis.7. (d) Date marking to indicate the date or day by which a ready-to-eat, time/temperature control for safety food (formerly known as PHF) should be consumed, sold, or discarded will be visible on all high-risk food.13. Refrigerated Food Storage: (a) All refrigerator units will be kept clean and in good working condition at all times.(c) Every refrigerator must be equipped with an internal thermometer.(e) Cooked foods must be stored above raw foods to prevent contamination. Raw animal foods will be separated from each other and stored on lower shelves (below cooked foods or raw fruits and vegetables) and in drip proof containers.(h) Safe thawing: Frozen meat, poultry, and fish should be defrosted in a refrigerator within 3-5 days and should be used after thawing. The surveyor reviewed the facility policy titled DISH WASHING AND STORAGE POLICY, last revised date: 11/08/2024.The following was observed under POLICY:Dishwashing guidelines will be carried out in compliance with the state and local health codes. Dishes, pots, pans utensils and flatware will be washed, sanitized and air-dried following procedures to assure proper (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	function, temperature, and/or chemicals appropriate for cleaning and sanitizing are applied. The following was revealed under PROCEDURE:Personnel1. Prior to use, verify temperatures and machine function. Confirm that soap and rinse dispensers are filled and have enough cleaning products for the shift. Dish Machine Washing:5. Dish machine temperatures are logged at each meal on the Dish Machine Temperature Log.6. Staff will monitor dish machine temperatures throughout the dishwashing process. 10. Employees are trained in proper dishwashing and drying procedures. Staff will be trained to report any problem with the dish machine to the director of food and nutrition services as soon as they occur. The surveyor reviewed the facility policy titled FOOD - FROM OUTSIDE, current revision date: 7/12/2023. The following was revealed under POLICY: Residents have the right to have foods brought in by family and friends. Due to the potential for foodborne illness or interference with nutritional treatment, family members and/or visitors who bring food in from the outside will be educated on safe food handling practices and the importance of diet order compliance. Food or beverage that is brought in from the outside will be monitored by nursing staff for spoilage, contamination and safety.The following was observed under PROCEDURE:12. Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. (Label will identify resident name, room number, item, date received and discard date).13. All refrigerated food will be discarded within 48 hours. 14. Nursing staff will monitor resident's room, unit pantry, and refrigeration units for food and beverage disposal.15. The nursing staff will discard perishable foods on or before the discard date. Review of the Daily Cleaning Schedule revealed that the AM Dietary Aide #2 was responsible for cleaning of the walk-in refrigerator weekly. NJAC 8:39-17.2(g)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interviews and review of other pertinent facility documentation, it was determined that the facility failed to ensure the implementation of the antibiotic stewardship program, including ongoing monitoring and surveillance for 12 of 12 months and utilization of the infection assessment tool for 3 of 5 residents (Resident #106, #144, #175) reviewed for antibiotics This deficient practice was evidenced by the following:On 1/7/2026 at 1:15 PM, the surveyor interviewed the Infection Preventionist (IP), during the interview, a request was made for evidence of the antibiotic tracking log for January 2025 through January 2026.At that time, the IP provided the surveyor with the Infection Control Binder, which did not include any evidence that the antibiotics were being tracked for all twelve months of 2025 to present. She then confirmed that she did not have the tracking logs for 2025. The IP stated that she assumed the role of IP in October of 2025, and she was not doing the tracking, and had no knowledge of any tracking being completed prior to October 2025. The IP confirmed that the tracking log should have been updated when an antibiotic was initiated and kept in the binder. The IP explained that the infections should be tracked by completing a log that should include if the antibiotic was started in-house, the date of onset, any testing and sensitivity that was done, and date the antibiotic was completed. She further stated that tracking was also important to ensure that the resident was placed on the right precautionary measures, if applicable.The surveyor reviewed the infection control binder, which included the Order Listing Reports (OLR -a list of residents and the antibiotic that was prescribed) for June, July, September, October, November, and December 2025. A random review of the OLR for the month of December 2025 revealed that seven residents received antibiotics. At that time, the surveyor requested that the IP identify the residents who started antibiotics at the facility and provide evidence that the infection assessment tool (used for monitoring and feedback) was completed. The IP stated that Resident #106 was started on antibiotics in-house. The resident was ordered Bactrim 800-160 milligrams (MG) on 12/8/205 at 6:11 PM for five days for a urinary tract infection (UTI). She pulled up their medical record, and there was no documented evidence that the infection assessment tool was completed.The IP also noted that Resident #144 was started on antibiotics in-house. The resident was started on Macrobid 100 MG on 12/1/2025 at 11:46 AM for a UTI for fourteen days. She pulled up their medical record, and there was no documented evidence that the infection assessment tool was completed.The IP stated that Resident #175 was started on antibiotics at the facility. The resident was started on vancomycin 1.5 gram, on 12/5/2025 at 6:04 PM, to be infused for a total of two hours. She pulled up the medical record. There was no documented evidence that the infection assessment tool was completedOn 1/8/2026 at 2:03 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the IP should be tracking all infections and doing surveillance for the antibiotic usage. She further stated that there should be a spreadsheet completed with all pertinent information.01/12/2026 8:06 AM, the surveyor interviewed the Regional Clinical Director (RCD) who stated that the IP should have been able provide evidence of the surveillance and the Antibiotic Stewardship Program should have been implemented. A review of the facility's Antibiotic Stewardship policy, revised 6/25/2025 included: This facility will adhere to the principles of Antibiotic Stewardship as defined and described in the Centers for Disease Control and Prevention.Develops and implements protocols to optimize the treatment of infections by ensuring residents who require an antibiotic are prescribed the appropriate antibiotic.Develops, promotes, and implements a facility-wide system to monitor the use of antibiotics. The Facility Administrator and the Director of Nursing are committed to the implementation of an effective Antibiotic Stewardship Program meeting the needs of the facility.NJAC 8:39-19.4(c) (d)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to a.) provide services consistent with professional standards of practice by failing to document weekly skin assessments for a resident with a history of pressure ulcers; b.) consistently implement pressure relieving interventions in accordance with the facility policy and professional standards of nursing practice. This deficient practice was identified for 2 (two) of three (3) residents reviewed for pressure ulcers (Resident #8 and #199) and was evidenced by the following: a.) A review of the admission Record (admission summary) reflected that Resident #199 was admitted to the facility with diagnoses which included, but were not limited to: unspecified dementia, anxiety and major depressive disorder. A review of the annual Minimum Data Set (MDS), an assessment that facilitates a resident's care, dated 9/30/25, included the resident was dependent with all aspect of activities of daily living (ADL's). Further review of the MDS indicated that the resident had long and short-term memory deficits and was severely impaired with decision making. Further review of the MDS reflected that the resident was at risk of developing pressure ulcers but did not have an unhealed pressure ulcer during this assessment. The MDS assessment also indicated that the resident had a pressure reducing device to the chair and to the bed. On 01/08/2026 at 10:08 AM, the surveyor observed Resident #199 lying in bed on an air mattress. The resident was non-verbal at the time of observation, and the surveyor was unable to conduct an interview. The surveyor reviewed the resident's electronic medical records (EMR) which revealed the following: A review of a Physician's Order (PO) dated 12/25/23, indicated that weekly skin assessments were to be conducted on Monday during the 7:00 AM-3:00 PM shift for skin monitoring. The order specified that skin monitoring must be completed in the UDA (utilization data assessment) within the EMR. A review of the PO dated 3/5/25, indicated that the resident was admitted to hospice services for a diagnosis of senile degeneration of brain. A review of the Progress Note (PN) dated 8/18/25 at 16:14 (4:14 PM), indicated a nursing clinical evaluation was performed and the resident had a new skin alteration to the sacrum (a small triangular bone at the base of the spine) measuring 0.5 cm (centimeters) x 2.0 cm. The medical doctor was made aware, and a new treatment was ordered. The wound care interventions were reviewed, and the implementation of the interventions were verified. A review of Resident #199's EMR revealed the resident had a sacral wound on and off since August of 2025. Preventive /Protective skin care measures were in place prior to wound development. The documentation revealed that the resident's skin breakdown was unavoidable secondary to: Comorbidities', malnutrition, immobility and incontinence. A review of the Treatment Administration Record (TAR) for September 2025 contained a treatment order dated 9/93/25, to cleanse the sacrum with NNS (normal saline solution), pat dry, and apply Duoderm (dressings create a moist healing environment that aids in the healing process) during the day shift on Tuesdays for wound treatment. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the weekly skin assessment dated [DATE] and 9/27/25 indicated that the resident's skin was intact. There was no documented evidence that the resident had any changes in the skin on the sacral area. A review of the IDT (interdisciplinary team) note dated 9/24/25 at 19:22 (7:22 PM), indicated that the resident remained on hospice services with notable emaciation, advanced illness despite no loss of appetite. The note indicated that the resident's sacral wound had resolved however, continued to apply Duoderm to the sacral area for skin protection. A review of the physician PN dated 10/3/28, indicated that the resident did not have any rashes or evidence of skin breakdown. A review of the TAR indicated there was an order dated 12/25/23, for a weekly skin evaluation to be completed on 10/6/25, 10/13/25 or 10/20/25. Nursing signatures were present on these dates, which indicated skin assessments were performed; however, the surveyor was unable to locate documentation detailing the condition or appearance of the resident's skin during those assessments. A review of the PN dated 10/27/25 at 16:39 (4:39 PM), indicated that skin monitoring was completed and the residents previously noted reddened area being treated with Duoderm was now opened and measured 2.0cm x 2.3 cm. Evaluation of Wound Pain: Resident showed no signs or symptoms of pain, the hospice Registered Nurse (RN) assessed the wound and new recommendations were made to cleanse the area with NSS, pat dry, apply Medihoney (sterilized medical grade honey used for promoting wound healing) to the site and cover clean dry dressing, until healed. A review of the facility form titled, Facility Acquired Pressure Ulcer Investigation Tool dated 10/27/25, which indicated that the ulcer was a previously healed ulcer and upon discovery it was a stage two wound. The form indicated that the pressure ulcer was unavoidable related to chronic incontinence and that the resident was actively declining. A review of TAR contained a physician order dated 10/27/25, for wound care as follows: to cleanse area w/ NSS, pat dry, apply Medihoney at site and cover with clean dry dressing (CCD) every shift for wound care until healed. A review of Resident #199's Care Plan dated 10/28/25, contained a focus area: Alteration in skin integrity - resident had an actual pressure injury r/t: generalized decline/end of life. Sacral Pressure Injury stage II (involves partial thickness skin loss). On 01/08/2026 at 10:11 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that the resident had severe cognitive impairment and was nonverbal. He further reported that the resident was incontinent of bladder and bowel and required total care with all aspects of activities of daily living (ADLs). He confirmed that the resident had a wound on the sacral area, identified as a stage 4 and that treatments were being completed once a day as ordered. He stated that all residents in the facility had weekly skin assessments completed. LPN #1 explained that the documentation included initials on the TAR to indicated completion of skin assessments and further documentation was entered on the skin assessment form describing whether the skin was intact or if impairment was identified. Upon review of the resident's electronic medical record (EMR), the surveyor was unable to locate the documented skin assessments for the month in question. LPN #1 confirmed that he was also unable to locate the skin assessment documentation on 10/6/25, 10/13/25 and 10/20/25. LPN #1 acknowledged that skin assessments should have been completed and documented (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but he was unable to explain why the assessments were not documented in the EMR. He then confirmed that he signed the TAR on 10/13/25 that he completed the skin assessment, however, he could not explain why he had not actually completed the skin assessment in the EMR. He further added that he should have completed the skin assessment or should have documented the condition of the resident's skin in the progress notes. He stated that it would have been important to document the condition of the resident's skin because the resident had a history of skin breakdown. On 01/08/2026 at 10:25 AM, the surveyor interviewed the LPN #2 who documented on the TAR 10/6/25 and 10/20/25 that she completed the resident's skin assessments. She stated that although she completed the assessments, documentation describing the resident's skin condition was not entered into the electronic medical record. She further stated that she performed a PRN (as needed) skin assessment on 10/27/25 after being notified by the hospice nurse of a repeated opening on the resident's sacral area. On 01/08/2026 at 10:41 AM, the surveyor interviewed the Assistant Director of Nursing # 2 (ADON) #2 who stated that all residents in the facility were seen weekly by a nurse for skin assessments. She explained that documentation included initialing the TAR to confirm the completion of the assessment, with findings documented in the weekly UDA (utilization data assessment) within the EMR. She emphasized the importance of documenting a detailed skin description in the assessment so that the facility could track the condition of a resident's skin over time. ADON #2 stated that if the UDA was not completed in the EMR and the nurse signed the TAR to indicate the skin assessment was completed, it would be difficult to verify completion of the assessment. She further added that a secondary confirmation of skin monitoring was documented by the Certified Nursing Assistants (CNAs) in the resident's Point of Care (POC) records located within the EMR. In the presence of the surveyor, ADON #2 reviewed Resident #199's POC for October 2025 and confirmed that the CNAs documented that there was no skin impairment from 10/1/25 until 10/26/25. She added that according to the documentation in the progress notes on 10/27/25, the hospice nurse notified the nurse on duty that the resident had a skin alteration requiring a PRN skin assessment. Further review of the PN indicated that the hospice nurse recommended discontinuation of the protective Duoderm treatment to the resident's sacral area and a change in treatment to Medihoney. On 01/09/2026 at 10:52 AM, the Regional Clinical Director (RCD) provided the surveyor with completed skin assessments for the month of October 2025. The RCD confirmed that she could not provide any documentation that skin assessments were performed on 10/6/25, 10/13/25 and 10/20/25. She stated that the only skin assessment she could provide was dated 10/27/25. A review of the facility policy dated 3/13/23 and titled, Skin and Pressure Injury Prevention indicated that the purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. The policy indicated that a risk assessment would be performed on admission/re-admission for existing pressure/injury risk factors utilizing the Braden Risk Assessment. The facility would also conduct a comprehensive skin assessment on admission/re-admission and would perform weekly skin assessment by a Licensed Nurse. Once the assessment is conducted and risk factors were identified and characterized, a resident centered care plan would be developed to address the risks for pressure injuries and skin protection interventions. NJAC 8:39-27.1(a) b.) On 1/5/26 at 12:40 PM, the surveyor observed Resident #8 who was fully dressed and was seated (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in a wheelchair at the bedside. The resident stated that they had a wound on their left foot that may have resulted from their boot. On 1/7/26 at 12:50 PM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated that she was assigned to Resident #8. When the surveyor asked if the resident had any wounds she stated that the resident had no wounds. On 1/7/26 the surveyor reviewed the medical record for Resident #8. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: nontraumatic intracerebral hemorrhage, unspecified (bleeding from a blood vessel in the brain), monoplegia (paralysis of one side of the body) of upper limb following nontraumatic intracerebral hemorrhage affecting left non-dominant side, muscle weakness (generalized), and dysphasia (impaired speech resulting from brain injury) following nontraumatic intracerebral hemorrhage. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 12/29/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was fully intact. Further review of the MDS revealed the resident had one unstageable deep tissue injury that was not present upon admission/entry or reentry to the facility. Further review of the MDS Section M1040 Other Ulcers, Wounds and Skin Problems designated for Foot Problems, and Other Problems revealed that none of the above (infection of the foot (e.g., cellulitis, purulent drainage), Diabetic foot ulcer (s), other open lesion (s) on the foot, open lesion (s), other than ulcers, rashes, cuts (e.g., cancer lesion), surgical wound (s), burn (s) (second degree or third degree), skin tear (s), or Moisture Associated Skin Damage (MASD).were present. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 6/26/25, which revealed a focus area dated 7/24/25, which indicated the resident had an alteration in skin integrity, resident has an actual pressure injury r/t (related to): Right heel DTI (deep tissue injury, pressure-induced damage to underlying tissue). The interventions included: .Apply treatment per order, Weekly assessment of wound, by LN (licensed nurse) or Provider, including length: width, depth, tissue type, drainage, odor, pain, s/sx (signs and symptoms) of infection, monitor daily for signs and symptoms of infection Further review of the ICCP revealed a focus area dated 6/26/25, which indicated the resident was at risk for pressure injury development r/t (related to) impaired mobility. Interventions included an entry dated 10/13/25, for Heel (s) protection: Offload with pillows or (Specify Heel Boots or Heel Suspension Boot) as tolerated. A review of the Order Summary Report (OSR), dated as of 1/8/26, included the following physician orders (PO): A PO, dated 10/10/25, for Weekly skin evaluation done on Wednesday during the 7-3 shift. Every day shift every Wednesday for Weekly Skin Monitoring Must Complete LN: Weekly Skin Monitoring UDA (Utilization Data Assessment). A review of a Wound Assessment Detail dated 12/18/25, that was documented by the Wound Consultant Advanced Practice Nurse (APN) revealed the resident had one wound described as a right heel pressure ulcer, deep tissue injury that was persistent non-blanchable, with deep red, maroon or purple discoloration, that measured 1.0 cm (centimeter) x 1.0 cm x 0.1 cm. Wound status: not healed. A review of the Wound orders included: Cleanse wound with betadine OTA (open to air), change daily, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	change prn (as needed), Pressure Relief/Offloading: Facility Pressure Ulcer Prevention Protocol and Offload heels per facility policy. A review of a Podiatry Consult dated 9/29/25 at 10:13 AM, revealed: Resident was seen at bedside on consult for podiatric evaluation and at-risk foot care. Physical Exam (PE): on b/l (bilateral, both sides) offloading boots. A review of the January 2026 Treatment Administration Record (TAR) revealed an entry dated 10/22/25, for Weekly skin evaluation done on Wednesday during the 7-3 shift. Further review of the TAR revealed that on Wednesday 1/7/26, the entry was charted and was signed out as administered to indicate that the skin evaluation was completed. Further review of the medical record failed to include a corresponding Weekly Skin Monitoring UDA assessment that described the resident's skin condition. On 1/8/26 at 10:05 AM, the surveyor observed Resident #8 lying in bed asleep with their left heel on the bed and their right foot crossed over the left lower leg with the right heel elevated off the bed. On 1/8/26 at 10:30 AM, the surveyor noted that there were two pair of padded heel boots on top of the resident's wardrobe closet. When the surveyor asked the resident if they used the heel boots the resident stated, They used to put them on me, but it has been a while. On 1/8/26 at 11:01 AM, the surveyor interviewed CNA #2 who stated that she was not the resident's regular assigned aide, but she knew the resident. The surveyor asked CNA #2 if the resident used the heel boots that were on top of the wardrobe closet and the CNA #2 stated, I did not see them on the resident today. CNA #2 further stated, They will be on today. On 1/8/26 at 11:01 AM, the surveyor interviewed LPN/UM #1 who stated that the resident had a DTI (deep tissue injury) , and weekly assessments should be documented in detail in the assessments. The LPN/UM #1 stated the assigned nurse should have documented a full assessment yesterday, but after reviewing the documentation, she did not. The surveyor questioned LPN/UM #1 regarding Resident #8's heel booties in which LPN/UM #1 stated that she did not see them on the resident when she initially came in today. On 1/9/26 at 11:55 AM, the surveyor interviewed the Regional Clinical Director (RCD) who stated that the resident's right heel DTI was facility acquired, and it was identified on the skin assessment by a facility LPN on 7/23/25. The RCD further stated that an incident report was not completed upon the identification of the DTI, but it should have been done. On 1/12/26 at 9:12 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) #2. The surveyor asked ADON #2 if a head-to-toe assessment were completed on 1/7/25, should the wound on the resident's left great toe and the resident's elongated toenails have been documented on a weekly skin assessment, rather than just documenting completion of a skin assessment on the TAR? ADON #2 stated, some nurses do the assessment, but they do not document it, or some agency people do not care. ADON #2 further stated, I saw the resident's feet on Friday, and it was an ingrown toenail. The resident definitely could have used some foot care. ADON #2 stated that the aides are obviously not looking at the resident's feet if they have not identified that there was an alteration in the lower extremities. ADON #2 further stated, sometimes you do not see an ingrown toenail until it breaks through the skin. ADON #2 further stated that staff should assist the resident to turn as tolerated every one to two hours and off load the heels and any pressure prone areas. ADON #2 stated (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that staff could use heel boots or pillows to elevate the heels off the bed. ADON #2 stated that the Unit Manager was responsible to ensure that the Care Plan interventions were implemented. A review of the facility's Skin and Pressure Injury Prevention policy, revision date 6/27/24, included: The facility will assess residents for risk in the development of pressure injuries and implement preventative measures in accordance with current standards of practice. Weekly Skin Monitoring by Licensed Nurse; Staff inspect the skin when performing or assisting with personal care or ADLS (activities of daily living). Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan shall be developed to address the modifiable risks for pressure injuries and skin protection interventions. A review of the facility's Health Care Provider (HCP) Consultations policy, revision date 7/30/25, included: Consultants may provide recommendations that must be reviewed and approved by the attending HCP. A review of the facility's Care Plans Comprehensive policy, revision date 10/19, included: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39-27.1 (e), 27.2 (g)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to provide the correct menu items in accordance with their weekly cycle menu for 5 residents observed during the lunch meal on 1/6/2026 as indicated on a meal ticket. This deficient practice was identified for 5 (five) of 12 residents (Resident #22, #46, #92, #179, #214) reviewed during the dining observation and was evidenced by the following: A review of Resident #22's admission Record (AR-an admission summary) indicated that the resident was admitted to the facility with diagnoses which included but were not limited to, Parkinson's disease and cerebral palsy. A review of the quarterly Minimum Data Set (MDS), an assessment that facilitates a resident's care, dated 11/1/25, indicated that the resident was on a mechanically altered diet. A review of the physician's orders reflected an order dated 9/25/25, indicated the resident was to receive an Advanced Mechanical soft diet, soft texture. A review of Resident #92's AR indicated that the resident was admitted to the facility with the diagnoses that included but was not limited to, arthritis and dementia. The annual MDS dated [DATE], indicated that the resident was on a mechanically altered diet. A review of the physician's orders reflected an order dated 2/5/24, indicated the resident was to receive an Advanced Mechanical soft diet, soft texture, small bites. A review of Resident #179's AR indicated that the resident was admitted to the facility with the diagnoses that included but was not limited to; anemia, dementia and adult failure to thrive. The quarterly MDS dated [DATE], indicated the resident was on a mechanically altered diet. A review of the physician's orders reflected an order dated 7/16/24, indicated the resident was to receive an Advanced Mechanical soft diet, soft texture, small bites with nectar thick liquids. A review of Resident #214's AR indicated that the resident was admitted to the facility with the diagnoses that included but was not limited to; heart failure, mood disorder and dysphagia (difficulty swallowing). The quarterly MDS dated [DATE], indicated the resident was on a mechanically altered diet. A review of the physician's orders reflected an order dated 5/13/25, indicated that the resident was to receive an Advanced Mechanical soft diet with small bites. On 1/6/2026 at 12:52 PM, the surveyor observed dining room service in the A-B dining room on the second floor of the facility. The surveyor observed that three residents, Resident #179, Resident #22, Resident #214 were on advanced mechanical soft diets and received bite size chicken instead of Salisbury steak that was written on their food tickets. On 1/6/2026 at 12:56 PM, the surveyor interviewed a Certified Nursing Assistant (CNA). The CNA explained that if the meal tickets indicated that the residents were supposed to have a specific item and they did not receive the correct item on the food ticket, then the employee who noticed the discrepancy would notify the kitchen to find out why the resident did not receive the correct food item. The CNA then proceeded to the phone the kitchen to find out why the residents were given (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chicken instead of Salisbury steak. The surveyor was present during the phone call. The CNA explained to the surveyor that the person she spoke from the kitchen did not give her an explanation regarding the menu discrepancy but said that they would send up the right food menu item for the residents. On 1/6/25 at 1:02 PM, the surveyor observed dining in the C-D dining room on the 2nd floor. The surveyor observed that Resident #92 received bite sized chicken instead of bite sized Salisbury steak that was written on the resident's food ticket. On 1/6/2026 at 1:07 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who reviewed Resident #92's meal ticket and confirmed that the resident should have received bite sized Salisbury steak instead of chicken, and she notified the kitchen to find out why. LPN #1 stated that the kitchen did not have a response as to why the meal ticket did not match the meal that was served. He explained to the surveyor that the kitchen staff stated to him that they would send up the correct meal for resident #92. On 1/13/26 at 11:22 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and they did not provide any additional information. According to the admission Record, Resident #46 was admitted to the facility with the following but not limited to diagnoses: malignant neoplasm of prostate, senile degeneration of brain, anxiety disorder, major depressive disorder, and muscle weakness. On 1/6/2026 at 12:46 PM, the surveyor observed the lunch meal on the 2nd floor C/D dining room. The surveyor observed the meal ticket for Resident #46. The observation of the meal ticket dated 1/6/2026 revealed the following diet: Regular, advanced mechanical soft, thin liquids. According to the meal ticket, Resident #46 was to receive the following menu items at the lunch meal: BITE SIZE 3 oz (ounce) Salisbury Steak, 2 fl. oz (fluid ounce) Beef gravy for dipping, 1/2 C (cup) mashed potatoes, 1/2 C yellow squash, 1/2 C cinnamon applesauce, 6 fl. oz beverage, 1 ea. (each) salt, 1 ea. pepper, 2 ea. sugar packet and 1 ea. creamer. Upon observation, Resident #46 received the following items at the lunch meal: 1/2 C mashed potatoes w/gravy, 1/2 C yellow squash, approximately 3oz chopped/diced chicken, 8oz lemonade, 6 oz cranberry juice, 2 sugars and 4oz plain applesauce. No Salisbury steak was provided, and Resident #46 did not receive salt and pepper. On 1/6/2026 at 1:04 PM, the surveyor conducted an interview with the Assistant Director of Dietary (ADOD) who was assigned to the facility for the day from a sister facility. The surveyor questioned why Resident #46 was provided diced chicken at the lunch meal when the 16/2026 Week 2, Tuesday Day 10 [facility name redacted] - Extension sheets indicated that residents receiving an advanced mechanical soft diet were to receive 3 oz of bite sized beef Salisbury steak. The ADOD responded that there was a mix up. The cook gave diced chicken instead of Salisbury steak. I do not know why. I diced up some Salisbury steak and it's fixed now. The surveyor observed Salisbury steak and rice on the tray line in the main kitchen during the lunch meal service to ensure that the Salisbury steak had been prepared and was available. The surveyor then conducted an interview with the Director of Dietary Services (DOD) also in the facility from a sister facility on that day. The surveyor asked the DOD why residents were provided diced chicken instead of Salisbury steak, as per the Week 2 cycle menu for Tuesday Day 10 at lunch. The DOD told the surveyor that the AM cook should not have provided diced chicken. He further stated that when we found out that diced chicken was being served, we chopped Salisbury steak. (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the facility policy titled MEAL IDENTIFICATION AND DIET ORDER COMMUNICATION, current revision date: 12/15/2025. The following was revealed under POLICY: The facility provides a safe and accurate meal identification and delivery system that supports the resident's individual needs and preferences. The following was observed under Policy Implementation: 5. Meal tickets will be used to identify the resident and validate the diet order, food allergy, food and fluid consistency, and adaptive devices. NJAC 18:39-17.2(b)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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. Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean, sanitary, and home-like environment for 1 of 4 nursing units (1C), reviewed for environment. This deficient practice was evidenced by the following: On 1/12/2026 at 9:02 AM, the surveyor went to Resident #180's room to conduct an interview with them. When the resident sat upright, a large brown embedded stain was noted on the resident's fitted sheet. At that time, the resident stated that the stain was there when they received the fitted sheet. They further stated that on occasions, they received linens with holes. On 1/12/2026 at 9:19 AM, the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 observed the first floor, C-hall clean linen cart. The surveyor observed there a washcloth with multiple large red stains and two reddish-brown particles on it stored on the clean linen cart. There was also a fitted sheet with a golf ball-sized hole in it. LPN/UM #1 immediately removed the items from the cart. It was further observed that all three shelves on the clean linen cart had a build-up of a brown residue on multiple areas of the cart. At that time, the surveyor interviewed LPN/UM #1 who stated that about once or twice per week, bed linen would come up torn and/or a washcloth would have brown stains on it. She further stated that once identified, the stained and damaged linens should be removed promptly, placed in a bag and sent back to the laundry room. LPN/UM #1 also stated that the cart should be kept clean. On 1/12/2026 at 9:26 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that the linen cart should be kept clean, neat, and orderly, and the linen should be without stains, rips, or holes. She further stated that if the linen was found to be stained or torn, it should be taken off the cart and sent back to laundry for infection control purposes and to maintain the resident's dignity. On 1/12/2026 at 9:35 AM, the surveyor interviewed the Laundry Technician (LT) who stated that the linen should be white, intact, and in good condition when it goes up to the units. She further stated that any damaged linen should be removed from the inventory. On 1/12/2026 at 9:38 AM, the surveyor interviewed the Environmental Service Director (EVSD) who stated that the linen should be intact and clean when it leaves the laundry area, for both infection control purposes and the dignity of the residents. He also stated that the linen carts should be wiped down daily. On 1/12/2026 at 9:43 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the linen carts should be kept clean. He stated that they did not have a cleaning schedule for the linen carts, but they were cleaned as needed, and they should be checked quite often. He further stated that once the linen got too stained, it should be pulled from production. The surveyor showed the LNHA a picture of Resident #180's stained fitted sheet. The LNHA confirmed the findings. A review of the facility's Environmental Services policy, revised 5/18, included, Bring emptied linen cart to the linen room. If cart cover and cart are soiled, place cover in area to be washed and sanitize the cart. Linen cart and covers are scheduled for cleaning on a weekly basis. N.J.A.C. 8:39-31.4 (c)(F)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to accurately complete a Minimum Data Set (MDS), an assessment tool, for 1 of 56 residents (Resident #184) reviewed. This deficient practice was evidenced by the following: On 1/5/2026 at 10:26 AM, the surveyor observed Resident #184 in the bed with a C-PAP (Continuous Positive Airway Pressure machine that helps treat sleep apnea (a sleeping disorder in which temporary cessation of breathing occurs) on their nightstand next to them. The C-PAP mask was uncovered and touched the surface of the nightstand. At that time, Resident #184 stated that they last used their C-PAP machine one day last week, and they also used it a couple of times per week. A review of the admission Record, an admission summary, revealed the resident had a diagnosis which included, but was not limited to, anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood). The admission summary did not include a diagnosis of obstructive sleep apnea (when you stop breathing during sleep). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/28/2025, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. A further review of the MDS did not reflect that the resident used a C-PAP. A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 10/22/2025, that the resident was at risk for alteration in respiratory system related to shortness of breath. Interventions included but were not limited to: elevate the resident's head of bed to help alleviate shortness of breath. A further review of the ICCP did not include the use of the C-PAP. A review of the Order Summary Report (OSR), dated as of 1/6/2026, did not include a physician's order for a C-PAP. A review of the Consultant Pulmonologist Progress Note dated 12/31/2025 at 2:58 PM, revealed that the resident had obstructive sleep apnea and was on a C-PAP and should continue using the C-PAP at night. A further review of the Consultant Pulmonologist progress note (CPPN) dated 10/28/2025 at 8:50 AM, also revealed that the resident should continue using the C-PAP at night. A review of the Physician's Progress Note dated 10/23/2025 at 8:50 AM, reflected that the resident had obstructive sleep apnea (OSA) and should continue using the C-PAP. On 1/8/2026 at 12:33 PM, the surveyor interviewed the MDS coordinator who stated that when she completed the resident assessments, she looked at the admitting doctor's orders and would speak with the resident if she had to. She further stated that the end goal was to create a person-centered care plan on how to care for the resident. She also stated that the MDS should be an accurate reflection of the resident. On 1/12/2026 at 10:57 AM, in the presence of the survey team, the Regional Clinical Director (RCD) stated that the MDS coordinator should also interview the resident to gather information when assessing the resident. NJAC 8:39-11.1		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a resident received proper foot care that included treatment to prevent complications, including but not limited to, following up with podiatry (foot doctor) recommendations. This deficient practice was identified for 2 of 2 residents (Resident #8 and Resident #164) reviewed for Activities of Daily Living (ADLs) and was evidenced by the following: 1. On 1/5/26 at 12:40 PM, the surveyor observed Resident #8 who was fully dressed and was seated in a wheelchair at the bedside. The resident stated that they had a wound on their left foot that may have resulted from their boot. On 1/7/26 at 12:50 PM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated that she was assigned to Resident #8. When the surveyor asked if the resident had any wounds she stated that the resident had no wounds. CNA #1 further stated that the resident needed help to dress and when transferred required total assistance from staff. On 1/7/26 the surveyor reviewed the medical record for Resident #8. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: nontraumatic intracerebral hemorrhage, unspecified (bleeding from a blood vessel in the brain), monoplegia (paralysis of one side of the body) of upper limb following nontraumatic intracerebral hemorrhage affecting left non-dominant side, muscle weakness (generalized), and dysphasia (impaired speech resulting from brain injury) following nontraumatic intracerebral hemorrhage. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 12/29/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was fully intact. Further review of the MDS revealed the resident had one unstageable deep tissue injury that was not present upon admission/entry or reentry to the facility. Further review of the MDS Section M1040 Other Ulcers, Wounds and Skin Problems designated for Foot Problems, and Other Problems revealed that none of the above (infection of the foot (e.g., cellulitis, purulent drainage), Diabetic foot ulcer (s), other open lesion (s) on the foot, open lesion (s), other than ulcers, rashes, cuts (e.g., cancer lesion), surgical wound (s), burn (s) (second degree or third degree), skin tear (s), or Moisture Associated Skin Damage (MASD). were present. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 6/26/25, which indicated resident had an alteration in skin integrity, resident has an actual pressure injury r/t (related to): Right heel DTI (deep tissue injury, pressure-induced damage to underlying tissue). The interventions included: .Apply treatment per order, Weekly assessment of wound, by LN (licensed nurse) or Provider, including length: width, depth, tissue type, drainage, odor, pain, s/sx (signs and symptoms) of infection, monitor daily for signs and symptoms of infection. A review of the Order Summary Report (OSR), dated as of 1/8/26, included the following physician orders (PO): A PO, dated 10/10/25, for Podiatry Consult as needed. A review of a Podiatry Consult dated 9/29/25 at 10:13 AM, revealed: Proper feet and shoe hygienic strongly recommended. Walk with socks and proper shoe gear at all times. Monitor pressure areas. Recommend larger and bigger shoes to accommodate painful digital deformities. Poor vascular supply to both feet-Podiatry will continue to monitor. Further review of a Podiatry Consult dated 10/23/25, revealed the following: Recommend larger and bigger shoes to accommodate painful digital deformities. Poor vascular supply to both feet-Podiatry will continue to monitor; Poor vascular supply to both feet-Podiatry will continue to monitor. On 1/12/26 at 9:12 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) #2. The surveyor asked ADON #2 if the facility was responsible to ensure that the Podiatry Consultant recommendations for larger and bigger shoes to accommodate painful digital deformities? ADON #2 stated we should contact the family to bring the shoes in. Then if the family did not bring larger shoes in, the facility would provide new shoes on behalf of the resident and get reimbursed for them. On 1/12/2026 at 1:17 PM, the surveyor interviewed the Director of Nursing (DON) who provided the surveyor with a copy of a Charting By Exception Note dated 10/24/25, which specified that the facility notified the resident's (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brother, and daughter, regarding the resident who required bigger shoes. The DON further stated that the resident had a tendency to refuse, but that was not care planned. The DON further stated that the facility failed to close the loop, and did not ensure that they followed up with the resident's responsible party to ensure that larger shoes were provided. The DON further stated that we absolutely should have followed up, and that did not happen. The DON further stated that the care plan also should have been updated in October, not after surveyor inquiry. 2. On 1/5/26 at 12:35 PM, the surveyor observed Resident #164 lying in bed. When interviewed, Resident #164 expressed concerns with their lack of toenail care. The surveyor observed that the resident's toenails were long. On 1/6/26 at 11:55 AM, the surveyor interviewed Certified Nursing Assistant (CNA) # 5 who stated that Resident #164 required total care from staff and the resident was only able to wash their face. CNA #5 stated that either the aides or the residents cut the resident's fingernails, but Podiatry cut the resident's toenails. CNA #5 further stated that Podiatry had visited the facility last Tuesday. When the surveyor asked CNA #5 if the resident were referred to Podiatry for toenail care at that time? CNA #5 stated, You would have to ask a manager about that. On 1/6/26 at 12:05 PM, the surveyor reviewed Resident #164's hybrid paper medical record and there was no documented evidence of a Podiatry Consult within the paper chart. On 1/6/26 at 12:13 PM, the surveyor reviewed the electronic medical record (EMR) of Resident #164 which revealed the following: A review of the admission record, an admission summary, revealed the resident was admitted to the facility with diagnosis which included but were not limited to: Type 2 diabetes mellitus without complications (persistently high levels of sugar (glucose) in the blood), muscle weakness (generalized), difficulty in walking, not elsewhere classified, morbid (severe) obesity due to excess calories, and Unspecified B-Cell Lymphoma (blood cancer in the lymph nodes). A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated 11/16/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was fully intact. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 12/10/24, that the resident required assistance with self-care and mobility r/t (related to) deconditioning. Interventions included: Putting on/taking off footwear: Substantial assist x 2 (two) staff (both provide hands-on CNA care) Two helpers complete more than half of the activity. Both helpers use their own strength during the activity to lift or hold the resident's body, arms, or legs. While the resident requires 2 (two) helpers, the resident participated and completed less than half of the activity using own physical strength. Further review of the ICCP revealed an intervention dated 9/29/25, for Chair/Bed-to-chair transfer: Two-person mechanical lift. Inspect mechanical lift sling prior to use. A review of the Order Summary Report (OSR), dated as of 1/9/26, included the following physician orders (PO): A PO, dated 9/13/25, for Podiatry Consult as needed. A review of a facility provided Consultant Note: Podiatry, dated 9/29/25 at 10:18 AM, revealed the resident was seen at bedside on consult for podiatric evaluation and at risk foot care. Further review of the Consult revealed nails and digital ends painful upon palpation (touch), 1, 2, 4 b/l (bilateral, both sides) with nails digging into skin and discolored, thick, dystrophic (thickened and discolored) and very long x 10. Aseptic debridement (removal of damaged tissue) of nails x 10 .F/U (follow-up) in 2-3 months. On 1/7/26 at 12:39 PM, the surveyor observed the resident lying in bed awake. The resident stated that their toenails were very sharp and needed to be cut. The resident stated that the Podiatrist used to come and see me. On 1/8/26 at 9:57 AM, the surveyor observed the resident lying in bed awake. The resident reported still not having had their toenails cut. On 1/8/26 at 9:58 AM, the surveyor interviewed Registered Nurse (RN) #1 who stated that for a podiatry consult to be initiated nursing had to give the request to the scheduler who then set up the appointment on behalf of the resident. On 1/8/26 at 11:21 AM, the surveyor asked the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 to look at the resident's toenails with resident permission in the presence of the surveyor. When LPN/UM #1 looked at the resident's toenails she stated that their toenails needed to be cut to prevent a wound. LPN/UM #1 further stated that the resident's toenails should not have been that long. On (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/8/26 at 12:07 PM, the surveyor interviewed the Director of Nursing (DON) who stated that it was her expectation for the aides to tell the unit manager when the resident needed to have their toenails cut. The DON further stated that the resident could get an infection or an ingrown toenail if their toenails were not maintained.A review of the facility's Activities of Daily Living (ADL) Care and Support policy, revised 11/6/2025, included: .Nail care should be provided as needed for the resident.A review of the facility's Skin and Pressure Injury Prevention policy, revision date 6/27/24, included: The facility will assess residents for risk in the development of pressure injuries and implement preventative measures in accordance with current standards of practice; Staff inspect the skin when performing or assisting with personal care or ADLS (activities of daily living).Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan shall be developed to address the modifiable risks for pressure injuries and skin protection interventions.A review of the facility's Care Plans Comprehensive policy, revision date 10/19, included: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.A review of the facility's Health Care Provider (HCP) Consultations policy, revision date 7/30/25, included:.Consultants.may provide recommendations that must be reviewed and approved by the attending HCP.A review of the facility's Foot Care-Nail Clipping policy, revision date 3/23, included: The facility shall provide necessary treatment and foot care to residents in accordance with state standards of practice to maintain mobility and good foot health and to minimize the complications from conditions such as diabetes, peripheral vascular disease, or immobility.NJAC 8:39-27.1 (e), 27.2 (g)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) ensure necessary services and assistance, specifically incontinent care, was provided to a dependent resident (Resident #199) for 1 of 5 residents reviewed for bladder incontinence and b.) ensure that a resident's urinary catheter bag was covered with a privacy bag to maintain the resident's dignity. This deficient practice was identified for 1 of 1 resident, (Resident # 14) reviewed for urinary catheter. This deficient practice was evidenced by the following: a.) On 1/9/2026 at 9:44 AM, the surveyor completed a facility wide incontinence rounds. The surveyor requested Certified Nursing Assistant (CNA) #4 and another staff member to announce and request permission to see Resident #199's brief. CNA #4 indicated that the resident was on hospice and was cognitively impaired. CNA #4 proceeded to knock on the door and guided Resident #199 as they revealed what appeared to be a urine saturated brief, that had seeped up the back of their incontinence brief. The surveyor asked what the dressings were on the resident's buttocks. CNA #4 stated that Resident #199 had a wound. The surveyor reiterated that Resident #199 had a wound and was sitting in a saturated incontinence brief. The surveyor observed that the urine was brown in color. When asked to described the incontinence brief, CNA #4 confirmed that the brief was saturated in urine. The surveyor inquired when was the last time CNA #4 had checked Resident #199' brief to which she responded that the resident was on hospice and that the hospice aide had been providing care to the resident that morning. The surveyor then asked CNA #4 when the hospice aide had left for the day, but CNA #4 was unable to provide a time. The surveyor then proceeded to ask if hospice patient's were included in incontinence rounds. CNA #4 confirmed and further elaborated that incontinence rounds should be conducted every 2 (two) hours. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Unspecified Dementia. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/30/2025, included the resident was moderately impaired with daily decision making. Further review of the MDS under Section H- Bladder and Bowel revealed the resident was always incontinent of bowel and bladder. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 11/12/2018, that the resident had bowel and bladder incontinence [related to] cognitive impairment. Interventions included: check resident every 2-4 hours and assist with toileting as needed. A review of the CNA Task for Bowel Toileting Care every 2-4 hours and as tolerated during waking hours and PRN revealed that the resident only received care at 6:22 AM, on 1/9/25. On 1/9/25 at 10:14 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #5 who stated, the hospice aide had left the floor around 9:30 AM. It was unknown if she gave report to Resident #199's assigned nurse. When asked if it was important that residents with wounds receive regular incontinent care LPN #5 responded, absolutely. LPN #5 further stated that incontinence rounds are to be completed every 2 (two) hours. On 1/9/2025 at 9:58 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #3 who stated, that hospice residents were not to be excluded from the incontinence rounds and they should also be checked every two hours. LPN/UM #3 attempted to locate the hospice (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aide in the building, but they were unable to be found. On 1/9/2025 at 12:46 PM, the surveyor interviewed the Hospice Home Health Aide (HHA), who provided care to Resident #199. The HHA stated that she ended her care with the resident at approximately 7:30 AM and gave report to the nurse. The HHA stated that when she left the resident, they were not soiled and were freshly changed. The HHA further stated that when she had come in to care for the resident the past two days, the resident was found to be saturated to the point that the urine had went through the incontinence brief, through the sheets, the clothing, and onto the bed with bright yellow urine noted. On 1/9/2025 at 2:19 PM, the in the Regional Clinical Director (RCD), in the presence of the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the survey team, acknowledged that hospice residents were still a part of the CNA assignment and they should be rounded on every two hours. A review of the facility's Activities of Daily Living (ADL) Care and Support policy, revised 11/6/2025, included: 1. ADL care and support will be provided for residents who are unable to carry out ADLS independently, with the consent of the resident and in accordance with the resident's assessed needs, personal preferences, and individualized plan of care, that includes, but not limited to supervision and assistance with: [.] elimination (toileting): transfers and incontinent care; [.] 8. Toileting/perineal care/incontinence care will be provided with care and as needed. A review of the facility's Certified Nurses Aide documents included under Specific Responsibilities Continued: Takes care of incontinent residents, (clean and dry) and provides skin care; Ensures that residents who are unable to call for help are checked frequently. NJAC 8:39-19.4 (a) b.) On 1/5/2026 at 11:34 AM, the surveyor observed Resident #14 lying in bed with their catheter bag hanging from the bed frame. The catheter bag was not in a privacy bag and was visible from the hallway. On 1/6/2026 at 9:46 AM, the surveyor observed Resident #14 lying in bed with the catheter bag hanging from the bed frame. The catheter bag was still not in a privacy bag and was visible from the hallway. On 1/6/2026 at 12:29 PM, the surveyor reviewed the medical record for Resident #14. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but was not limited to: neuromuscular dysfunction of the bladder (occurs when nerves from the brain, spinal cord, or peripheral nerves were damaged, disrupting signals to the bladder, causing issues like incontinence), muscle weakness, and difficulty walking. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/30/2025, included that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed the resident had an indwelling urinary catheter (a thin flexible tube that drains urine from the bladder). (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 8/27/2025, that the resident had an indwelling catheter. Interventions included: maintain privacy bag and catheter care. A review of the Order Summary Report (OSR), dated as of 1/5/2026, included a physician's order dated 12/29/2025, for an indwelling catheter. On 1/8/2026 at 1036 AM, the surveyor made a follow-up visit with the resident. The resident was in bed watching television. When interviewed the resident stated that they would like a privacy bag. They further stated that when they left their room to go to therapy, the staff placed the catheter bag next to them, and the urine was visible to others. At that time, the catheter bag was still uncovered and could be seen from the hallway. On 1/8/2026 at 10:49 AM, the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM) #1, went to the resident's room. LPN/UM #1 confirmed the finding. At that time, LPN/UM #1 stated that there should be a privacy bag covering the urine catheter bag to maintain the resident's dignity. She further stated that the Certified Nurse Assistant (CNA) should have obtained a privacy bag from the nurse. On 1/8/2026 at 11:09 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #2 who stated that privacy bags were available at the facility, and the catheter bags should always be covered. On 1/8/2026 at 1:46 PM, the surveyor interviewed the Director of Nursing (DON) who also stated that Resident #14 should have had a privacy bag in place for dignity. A review of the facility's Quality of Life/Dignity policy revised 5/28/2024 included, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Staff shall promote, maintain and protect resident privacy, . NJAC 8:39- 27.1(a)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) obtain weekly weights according to a physician's order, and b.) obtain re-weights according to the facility's policy for 1 of 3 residents (Resident #7) reviewed for nutrition. This deficient practice was evidenced by the following: On 1/5/2026 at 11:26 AM, the surveyor observed Resident #7 in their room seated in a wheelchair beside their bed, dressed and groomed. Resident #7 stated they were vegetarian and wanted better food, like fresh fruits and vegetables. Resident #7 also stated they had lost a lot of weight since admission to the facility. A review of the admission Record, an admission summary, revealed that Resident #7 had diagnoses which included, but were not limited to, Parkinson's disease, anxiety, type 2 diabetes (a chronic condition in which the body does not make enough insulin or does not use insulin properly leading to high blood sugar (glucose) and hypertension (elevated blood pressure). A Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/29/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident had severe cognitive impairment. Further review of the MDS included the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months and was not on a physician-prescribed weight loss regimen. A Review of the Individualized Comprehensive Care Plan (ICCP) included a focus area, initiated on 5/12/25, that the resident had a nutritional problem or potential nutritional problem and was at risk for malnutrition related to a history of weight fluctuations related to edema (swelling), Parkinson's disease, cellulitis, hypertension, Type 2 diabetes, dysphagia (difficulty swallowing). Requesting sugar in place of sugar substitute. Had significant weight loss. Further review of the ICCP included an intervention to Follow weights as ordered, revised 5/12/25. A Review of the Order Listing Report, with an order date range from 10/7/25 until 12/31/25, included a physician's order for weekly weights for four weeks every dayshift every Monday and Wednesday for monitoring for four weeks. ordered 11/24/25. A Review of the Dietary progress notes, Comprehensive Nutritional Assessment, dated 11/6/25 revealed the resident's weight had ranged from 211 pounds to 187 pounds over the past six months, and no significant weight loss was noted. A further review of the progress notes revealed an Interdisciplinary team meeting High Risk Meeting note dated 11/20/25, for significant weight loss which revealed the resident's hospital readmission weight was 164 pounds, down 18.5% from last month. The team initiated twice daily nutritional supplement, referral to speech therapy and orders to monitor weights weekly. A review of the November 2025 and December 2025 Treatment Administration Record (TAR) revealed an order for weekly weights for four weeks, every day shift on Monday and Wednesday for monitoring for four weeks with a start date of 11/24/25 at 7:00 AM. According to the TAR, the nurse indicated the resident's weight had been taken on 11/24/25 and 11/26/25. A review of the December 2025 Treatment record revealed the nurse had indicated the resident's weight had been taken on 12/1/25, 12/3/25, 12/8/25, 12/10/25, 12/15/25, and 12/17/25. A review of Resident's Electronic Health Record (EHR), under the weights and vitals tab in the EHR, revealed the following weight documentation: On 10/7/25 the resident weighed 200 pounds (mechanical lift) On 11/11/25 the resident weighed 164.2 pounds (chair) On 11/20/25 the resident weighed 163 pounds (wheelchair) On 11/24/25 the resident weighed 157.6 pounds (wheelchair) On 11/26/25 the resident weighed 157.2 pounds (mechanical lift) On 12/5/25 the resident weighed 159 pounds (mechanical lift) On 12/22/25 the resident weighed 156.2 pounds (mechanical lift) On 1/8/26 the resident weighed 155.6 pounds (mechanical lift) There were no corresponding weights for the dates of the physician's order for 12/1/25, 12/3/25, 12/8/25, 12/10/25, 12/15/25 or 12/17/25. A further review revealed that on 10/7/25, the resident weighed 200 pounds. On the subsequent date of 11/11/25, the resident weighed only 164.2 pounds. That was a 17.9% difference in one month. There was no documented evidence that a re-weight was done to verify the significant weight loss that the resident may have experienced. On (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/8/26 at 11:05 AM, the surveyor interviewed the resident's Licensed Practical Nurse #6 (LPN #6) who stated the resident was on weekly weights. At that time, the surveyor reviewed the resident's November and December TARs with LPN #6. She verified that nurses initialed the TAR, which indicated that the resident's weights were taken weekly per the physician's order. The surveyor then reviewed the weights and vitals tab located in the EHR with LPN #6. She explained that the dates that the weights were supposed to be completed on the TAR, did not correspond with dates the weights that were completed on the weights and vs tab located in the EHR. The only weights that matched the weights documented on the TAR and the weights and vs tab were dated 11/24/25 and 11/26/25. On 1/8/26 at 11:17 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager #4 (LPN/UM #4) for the second floor A/B wing who stated that resident's weights were taken by the certified nurse aides (CNA) who would then report the weights to the LPN/UM or the dietician. She stated that she or the dietician would enter them into the EHR. LPN/UM #4 added that the resident should be weighed using the same method each time and if there was more than a two percent difference from the last time, the resident should be re-weighed. At that time the surveyor reviewed the resident's EHR weights and the TARs. LPN/UM #4 confirmed the dates on the TAR should correspond to the dates of the weights documented in the EHR. She also confirmed there should have been a re-weight done in November after the significant weight difference was recorded. On 1/9/26 at 12:59 PM, the surveyor interviewed the Registered Dietician (RD) via telephone who stated the CNAs were responsible for weighing the residents and the nurses were responsible for recording the weights in the EHR. The surveyor reviewed Resident #7's weights with the RD who confirmed that after the recorded weight loss from October to December these weights were considered a significant weight loss, and the resident should have been re-weighed. The surveyor then reviewed the dates in the TAR that indicated that the resident should be weighted and the dates in the weight section of the EHR that indicated the resident was actually weighted. The RD confirmed that there were missing dates and that the dates did not correspond with each other. On 1/9/26 at 2:07 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team who confirmed there was a discrepancy in recording and monitoring the resident's weights according to the physician's orders for weekly weights. The DON also acknowledged there should have been a re-weight in November after the significant weight loss recorded from October to November. On 1/12/26 at 11:22 AM the surveyor interviewed the Regional Clinical Director (RCD) who acknowledged the EHR weight days did not correspond to the dates the nurse indicated the resident's weights had been recorded in the TAR, and after a significant weight loss was recorded the resident should be re-weighed within 48 hours to ensure the weight was accurate. A review of the facility's Weight Management policy, dated revised 3/1/2024, included, The facility shall manage resident's weights in accordance with current evidence-based standards of practice, state/federal regulations and resident desires and preferences. The resident's weights shall be obtained. as clinically indicated for the residents and documented in the clinical record. Resident's may require a re-weight for a weight change of five pounds in a month or three pounds in a week, the re-weigh should be completed within forty-eight hours after the identified discrepancy and documented in the clinical record. NJAC 8:39-27.2 (a)(e)		

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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. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure: a.) respiratory equipment was stored in an appropriate way to prevent the spread of infection, and b) a physician's order (PO) was obtained for necessary treatment for 2 of 3 residents (Resident #110 and #184) reviewed for respiratory care. This deficient practice was evidenced by the following: On 1/5/2026 at 10:26 AM, the surveyor observed Resident #184 in the bed with a C-PAP (Continuous Positive Airway Pressure) machine (a common treatment for sleep apnea that uses pressurized air delivered through a mask to keep your airway open during sleep, improving breathing, and overall health by preventing pauses in breathing which consisted of a motor, a hose, and a mask (nasal or full-face) that delivers a steady stream of air) on the nightstand next to them. The C-PAP mask was uncovered and touched the surface of the nightstand. At that time, Resident #184 stated that they last used their C-PAP one day last week, and they typically used it a couple of times per week. On 1/6/2026 at 9:53 AM, the surveyor made a follow-up visit to the resident's room. The C-PAP was still uncovered. The resident stated that they did not use it on the night of 1/5/2026. A review of the admission Record, an admission summary, revealed the resident had a diagnosis which included, but was not limited to, anemia (a condition marked by deficiency of red blood cells or of hemoglobin in the blood). The admission summary did not include obstructive sleep apnea. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/28/2025, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 10/22/205, that the resident was at risk for alteration in respiratory status related to shortness of breath. Interventions included but were not limited to: elevate the resident's head of bed to help alleviate shortness of breath. The interventions did not identify C-PAP use. A review of the Order Summary Report (OSR), dated as of 1/6/2026, did not include a physician's order for a C-PAP. A review of the Consultant Pulmonologist Progress Note (CPPN) dated 12/31/2025 at 2:58 PM, revealed that the resident had obstructive sleep apnea and was on a C-PAP and should continue using the C-PAP at night. On 1/8/2026 at 12:22 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #4 who stated that the C-PAP mask should be cleaned daily once the resident was finished using it. She further stated that after the mask was cleaned and dried, it should be placed in a plastic bag with the resident's name written on the bag. On 1/8/2026 at 12:41 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #4 who stated that the C-PAP mask should be placed in a plastic bag when it was not in use. She further stated that there should have been a physician's orders for the C-PAP use, setting, and maintenance. On 1/8/2026 at 1:46 PM, the surveyor interviewed the Director of Nursing (DON) who stated that physician orders for the C-PAP should have been obtained upon admission to the facility. She further stated that the C-PAP mask should have been bagged when not in use. 2. On 1/5/2026 at 11:11 AM, the surveyor observed resident #110 in their room, sitting on the bed. A nebulizer machine (a machine that turns liquid medicine into a fine, inhalable mist, allowing it to be breathed directly into the lungs through a mouthpiece or mask to treat respiratory conditions like asthma, wheezing, and shortness of breath) on the nightstand with the face mask on the machine and opened to the air. The resident stated that they last received medication via the nebulizer a couple of days ago. On 1/6/2026 at 9:38 AM, the surveyor conducted a follow-up visit to the resident's room. Resident #110 was observed in their room, sitting on the bed. The nebulizer mask was still uncovered and opened to air. On 1/6/2026 at 11:10 AM, the surveyor reviewed Resident #110's medical record. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but was not limited to: chronic obstructive pulmonary disease (COPD) a progressive lung condition causing airflow blockage leading to shortness of breath, cough with mucus, wheezing, and chest tightness, anemia (a condition marked by (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deficiency of red blood cells or of hemoglobin in the blood).A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/26/2025, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 2/5/2024 that the resident had an alteration in respiratory system related to COPD. Interventions included but were not limited to; administer treatments (nebulizer) and medication per doctor's orders, incentive spirometry (use to help take slow, deep breaths to expand your lungs, prevent lung infections, clear mucous, and improve breathing) as ordered.A review of the Order Summary Report (OSR), dated as of 1/5/2026, revealed the following POs:A PO, dated 8/25/2024, to change and date the nebulizer kit and storage bag once per week.A PO, dated 8/19/2024, to rinse and disinfect the nebulizer equipment after each use and to wash the pieces with warm soapy water.Further review of the OSR did not reveal orders for the DuoNeb or a PO for the incentive spirometer.A review of the CPPN (Consultant Pulmonologist Progress Note), dated 12/10/25, revealed that the resident should continue with DuoNebs (a medication administered via a nebulizer for controlling symptoms such as wheezing, shortness of breath, and asthma).A further review of the CPPN, dated 12/10/25, revealed that the resident should continue with incentive spirometry.On 1/6/2026 at 11:53 AM, the surveyor interviewed LPN #4 who stated that Resident #110 was getting breathing treatments via the nebulizer. She then went to the medication cart and pulled out a three-milliliter vial of ipratropium bromide albuterol sulfate and stated that the resident was getting that medication via the nebulizer. LPN #4 then pulled up the resident's medical record and stated that the resident did not have a current order for the DuoNeb or any medications that needed to be administered via the nebulizer, and she did not know what happened to the physician's order. She then stated that she did not recall the last time that she personally administered that medication to the resident.At that time, LPN #4 further stated that the care plan guides the care needed for the resident and it should have been implemented. She added that the nebulizer mask should have been covered for infection control purposes.On 1/6/2026 at 12:18 PM, the surveyor, accompanied by Licensed Practical Nurse/Unit Manager (LPN/UM) #2, went to the resident's room. She confirmed that the nebulizer mask was on the nightstand, uncovered and open to air.At that time, LPN/UM #2 stated that all medications administered required a physician's order. She also stated that the care plan should be current and followed.On 1/6/2026 at 1:23 PM, the surveyor interviewed the Attending Physician (AP) who stated that typically he followed the consultant recommendations unless the resident does not want the medication. He further stated that he spoke with the resident after surveyor inquiry, and they would like to continue with the nebulizer treatments. He added that any medications administered should have a doctor's order. He also noted that sometimes the orders just drop off. He added that if the resident needed an order for medication, he should have been notified.On 1/7/2026 at 12:12 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the nebulizer masks should be in a bag and it should not have been lying on the counter for infection control reasons. She further stated that the nurse should have reviewed the consultant pulmonologist recommendations and notified the physician to obtain orders if the physician was in agreement. She also added that the communication should be documented in the medical record. She further noted that if the consultant made a recommendation for something and it was not addressed, that would be considered a missed order. The DON also stated that all medications required a physician's order.A review of the facility's Health Care Provider (HCP) Consultations, policy, reviewed 7/2025, included, The attending HCP will review the appropriateness of the consultant's recommendations relative to the resident current condition, risk factors, existing medication regimen, etc.The attending HCP is responsible for all orders and should remain involved with any aspect of care for which a consultant is involved; .As appropriate, the attending HCP will approve orders based on consultant recommendations.A review of the facility's Medication Orders policy, last revised 9/2020, included, Medications shall be administered only upon the written/or (continued on next page)		

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Form Approved OMB
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered order of a person duly licensed and authorized to prescribe such medications in this state .A review of the facility's Nebulizer (small volume) Medication policy, last revised 8/27/2025, included, .store dried equipment in a labeled plastic bag.Once treatment series for resident is completed, remove the nebulizer equipment from the resident's room, clean and disinfect following manufacturer's instructions for useNJAC 8:39-27.1(a), 19.4(a)		

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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. Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 forms) were completed with sufficient detail to enable accurate reconciliation for 5 of 5 forms reviewed. This deficient practice was evidenced by the following: On 1/9/25 at 2:09 PM, the surveyor reviewed the facility provided DEA 222 forms which revealed on five of the five provided forms Part 5, had not been completed upon receipt of the medications from the provider pharmacy as instructed on the reverse of the ordering form. The forms were as follows: Order form #240870463 dated 3/11/25 #240870454 dated 5/27/25 #250798148 dated 7/31/25 #250798149 dated 9/5/25 #250798150 dated 10/15/25 - Part 5 was not completed with the number of items received and the date they were received On 1/12/2026 10:00 AM, the surveyor interviewed the Director of Nursing (DON) who stated the process for completing the DEA 222 form entailed that the DON filled in Part 1 and Part 2 of the form, then the Medical Director would review the form and sign it. The DON would then make a copy to keep in the file for reconciliation, and the original form was then sent to the provider pharmacy. She continued to explain the following steps:-Once the pharmacy delivered the medication, two nurses must sign and verify the contents of the package were correct based on the packing sheet and the DEA 222 form. -Task 5 should then be completed with the number of packages received and the date the medications were received. -The nurses would then load the medications into the automated medication dispensing machine. -The DON or the assistant DON (ADON) would ensure the form had been correctly filled out. The surveyor and the DON reviewed the DEA 222 form and confirmed task 5 had not been completed as instructed. The DON acknowledged according to the instructions on the reverse of the DEA 222 form Task 5 should be completed upon receipt of the medications. A review of the Instructions for DEA Form 222, under Part 5. Controlled Substance Receipt, 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item . A review of the Medication Storage policy, dated revised 12/17/25, did not address the process for completing the DEA 222 form. NJAC 8:39-29.7(c)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to: follow appropriate infection control practices by having necessary personal protection equipment (PPE) readily available for a resident who required enhanced barrier precautions (EBP). This deficient practice was identified for 1 of 10 residents (Resident #55) reviewed for infection control and was evidenced by the following: This deficient practice was evidenced by the following: 1. On 1/9/26 at 11:18 AM, the surveyor knocked on Resident #55's closed door, at that time the surveyor observed a sign posted outside of Resident #55's door that revealed Enhanced Barrier Precautions, once inside the room, the surveyor observed the resident seated in a wheelchair, hair disheveled and the resident smelled of smoke. When the surveyor asked the resident if the staff wore a gown and gloves while caring for them, Resident #55 stated, I don't know. The surveyor did not observe any PPE (personal protective equipment-Clothing or equipment worn to protect one from injury or infection) readily available for staff use. On 1/9/26 at 11:20 AM, the surveyor interviewed Certified Nurse Aide (CNA) #6 who stated she cared for Resident #55 who mostly stayed to themselves and was noncompliant with care, often refusing a shower and could be verbally abusive to staff. When asked if she needed to wear PPE when caring for Resident #55, she stated, no. When asked about the red sign beside the door, CNA #6 stated the sign was for the resident in the room next door. On 1/9/26 at 11:33 AM, the surveyor interviewed Resident #55's Licensed Practical Nurse #7 (LPN) #7 who stated the resident did not really socialize but they did go out to smoke. LPN #7 stated the resident had behaviors, but usually because of people bothering them about not smelling great from refusing to shower. LPN #7 stated the resident was on EBP related to their communicable disease and if staff were assisting them with care, staff must wear a gown and gloves. LPN #7 stated when the resident went out to smoke the staff would change Resident #55's sheets and both a gown and gloves were worn. When asked how staff knew the resident was on EBP, LPN #7 stated because there should be red signage and PPE on the door. LPN #7 checked Resident #55's room and door and confirmed there was no PPE readily available for use on Resident #55's door. On 1/9/26 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager #4 (LPN/UM) #4 who stated the red sign outside Resident #55's room was posted because the resident was on EBP. She explained that enhanced barrier precautions meant that staff must wear a gown, gloves, mask and a face shield when performing direct resident care. She confirmed that there should be a kit outside the door or a yellow caddy on the door that would have all the essentials like gloves, masks and gowns. LPN/UM #4 checked the resident's door and confirmed there was no PPE readily available for use. On 1/9/26 at 1:39 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team who stated Resident #55 did not require EBP based on their communicable disease. The physician had ordered the resident be placed on EBP based on a prior Infection Preventionist's preference. When asked if there should be PPE readily available if the resident had current orders to be on EBP, and the DON stated yes. On 1/12/26 at 11:22 AM, the surveyor interviewed the Regional Clinical Director (RCD) who confirmed that if Resident #55 had active physician orders for EBP, then there should there have been PPE readily available for staff use when caring for the resident. A review of the facility provided Enhanced Barrier Precautions policy revised 3/12/25, included .EBP is primarily intended to apply to care that occurs within a resident's room where high-contact resident care activities are commonly bundled together.EBP requires wearing disposable gloves and an isolation gown prior to high contact activity. Face protection may also be needed/worn if performing activities with a risk of splash or spray. Hand hygiene should be performed before and after each resident contact and after removing PPE. High contact resident care activities include: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care/use and wound care. NJAC 8:39 - 19.4(a); 27.1 (a)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility documents, it was determined that the facility failed to a.) document the administration of the influenza vaccine after signed consent was obtained for one (Resident #41) of five sampled residents; b) ensure the provision of the influenza and pneumococcal vaccines were properly offered to a resident with impaired cognition for one (Resident #6) of five residents reviewed for influenza and pneumococcal immunizations. This deficient practice was evidenced by the following: On 1/6/2025 at 12:42 PM, the surveyor observed Resident #6 walking in the hallway and yelling. A review of the admission Record, an admission summary, revealed Resident #6 had diagnoses which included, but were not limited to: Schizophrenia, Major Depressive Disorder, and Anxiety Disorder. A review of Resident #6's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/8/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident's cognition was severely impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 2/27/2023, that the resident [had] impaired cognition related to disease process (schizophrenia). Interventions included: ask yes/no questions in order to determine the resident needs; provide simple directions to resident. A review of the Psychiatric progress notes dated 5/2/2025 included documentation on 3/17/2025 and 1/29/2025 of Resident #6 as being confused and only oriented to name. A review of the facilities' Influenza Immunization Consent Form for Resident #6 identified that the Influenza Vaccine was declined and above the signature of recipient unable to sign was identified. The facility was not able to produce any documentation that Resident #6 received or declined the Pneumococcal Vaccine. On 1/9/2026 at 12:39 PM, the surveyor interviewed the facility Infection Preventionist (IP) who stated that providing residents with immunizations was the responsibility of the IP. She stated that she offered flu/pneumonia vaccines and obtained consents and declinations. When asked what would happen if a resident had a low BIMS score, the IP told the surveyor they should not sign the form and reached out to the guardians for consent. On 1/9/2025 at 2:19 PM, the surveyor, in the presence of the Regional Clinical Director (RCD), the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the survey team, acknowledged that they were not able to produce any evidence that Resident #6 received or declined the Pneumococcal Vaccine. In addition, when asked if a resident with a BIMS of 0, an implemented care plan of impaired cognition, and psychiatrist documentation of being confused and only oriented to name had the ability to refuse vaccines, the facility responded that Resident #6 was their own guardian. The surveyor again questioned if that was possible given the facility documentation. The RCD stated that this consent should have proceeded to the IDT (interdisciplinary team) and the Physician as to whether or not it should have been administered. b.)A review of the admission Record (admission summary) reflected that Resident #41 was admitted (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the facility with diagnoses that included but were not limited to: unspecified dementia, bipolar disorder, and osteoarthritis. A review of the comprehensive Minimum Data Set (MDS), an assessment that facilitates a resident's care, dated 11/23/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS also indicated that the resident was independent with all aspects of activities of daily living (ADL's). On 1/9/2026 at 11:32 AM, the surveyor reviewed the Electronic Medical Record (EMR) to verify the vaccination status for Resident #41. The EMR revealed that Resident #41 did not have the flu vaccination for flu season 2025. The facility provided the surveyor with an influenza consent form dated 12/1/25, which indicated Resident #41 had signed consent to receive the influenza vaccine. The consent also reflected documentation of the site and location the flu vaccination was administered, the manufacture date, lot number and expiration date of the flu vaccine vial that was administered to the resident. The consent was not completed and there was no documented evidence that the facility asked the resident pertinent health questions prior to administration of the vaccination. The surveyor reviewed the resident's EMR and there was no documented evidence that a physician's order was obtained prior to the administration of the vaccination, nor was there documentation in the progress notes or Medication Administration Record (MAR) that verified that the resident received the vaccination. In addition, there was no documentation in the EMR that the resident was monitored for side effects post administration of the vaccination. On 1/9/2026 at 11:51 AM, the surveyor interviewed Resident #41 who verified that the flu vaccination was administered to him/her during the 2025 flu season. The surveyor reviewed the comprehensive MDS dated [DATE], which indicated that Resident #41 had the flu vaccination for the 2024 flu season, not the 2025 flu season. On 1/9/2026 at 12:39 PM, the surveyor interviewed the facility Infection Preventionist (IP) who stated that providing residents with immunizations was the responsibility of the IP. She stated that she offered flu vaccines and obtained consents and declinations. She stated that it was the responsibility of the IP to obtain a physician's order, check the residents' vital signs (VS) prior to and for 72 hours after the administration to monitor for side effects. She stated that it should be documented in the MAR. On 1/12/2026 at 11:00 AM, the surveyor interviewed the facility Director of Nursing (DON) who stated that the resident first declined the flu vaccination but then agreed to have the vaccination. According to the DON, the former IP administered the flu vaccination to Resident #41, however, failed to document in the medical record that the vaccination was given. She also confirmed the former LPN/IP did not get a physician's order for the vaccination and did not document the vaccination administration in the MAR. A review of the facility's Pneumococcal Vaccination policy, dated/revised: 10/22/2025, included: 1. Prior to or within (5) working days after admission, residents will be assessed for eligibility to receive pneumococcal vaccine and when indicated will be offered and provided the vaccine within thirty (30) (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Hammonton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 N White Horse Pike Hammonton, NJ 08037	
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days of admission to the facility unless medically contraindicated, the resident refuses, or the resident is not eligible to receive [.] A review of the facility's Influenza Vaccine policy, dated/revised: 8/22/2024, included under the title Residents: 2a. Resident without decision making capacity and who have no resident representative will be immunized with the influenza vaccine annually as ordered by their healthcare provider unless medically contraindicated [.] A review of the facility's, Influenza Vaccine policy, dated 9/26/2024 (C-IC-5), indicated that the facility shall provide the resident vaccine Information Sheet (VIS) and documentation of the education would be maintained in the resident's clinical record. The policy also indicated that the facility licensed nurses would contact the healthcare providers for influenza vaccination orders for their residents. The policy indicated that the influenza immunizations would be administered by licensed nurses in accordance with standards of states Nurse Practice Act. For residents who receive the vaccination the following information would be included in the resident's medical record: education was provided regarding the benefits and potential side effects of the vaccine. NJAC 8:39-19.4(h), (i), (j)		