STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Grove Healthcare and Rehabilitation, LLC	2300 Hamilton Ave Hamilton, NJ 08619

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617 Based on interviews, medical records (MR) review, and review of pertinent facility documentation's, it was determined that the facility failed to update and revise a resident care plan (CP), add interventions as deemed necessary, for 1 of 3 (Resident #3) residents reviewed for CP revision. The deficient practice was evidenced by the following: A review of Resident #3's Admission Record (AR) indicated the Resident was admitted with the following diagnoses which included but not limited to: Acute Embolism and Thrombosis, Atherosclerotic Heart Disease, Hypertension, Metabolic Encephalopathy, Dementia, Anxiety Disorder, Osteoarthritis, Mood Disorder, and Depression. A review of Resident #3's Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of each resident's functional capabilities, in its quarterly assessment dated [DATE], revealed that Resident #3's Brief Interview for Mental Status (BIMS) score is 00 indicating that Resident's Cognitive Skills was severely impaired. Resident #3's MDS further revealed in Section GG Functional Abilities and Goals that the Resident was dependent on staff for completion of his/her Activities of Daily Living (ADL)s. A review of Resident #3's document labeled ADMISSION OBSERVATION-V12 (AO) dated with effective date of 07/15/2024 documented and e-signed by Licensed Practical Nurse (LPN) #1 on 07/15/2024, revealed that Resident #3 had Admission: 07/15/2024; Facility [name]. The AO further indicated under .R. SKIN/BODY OBSERVATION: .2. Site: 32) Left buttock, Description: 2x2, Pressure Ulcer; 47) Right ankle, Description: Blood Blister 2x2 cm; Other, Left Outer Foot, DTI [deep tissue injury]; 5th digit toe, DTI [deep tissue injury]; Other, Rt [right] Foot (Posterior [the back] Great Toe), DTI [deep tissue injury]'. A review of Resident #3's weekly wound notes as documented by the wound doctor [name of physician] under Nursing Home Visit (NHV) Encounter, electronically signed by [name of physician] indicated the following: 1) NHV dated 06/03/2024 under Wound Assessment: Wound #1 LOCATION: right heel; TYPE: PI [pressure injury] unstageable [depth of wound is obscured] with stable eschar [dark or black tissue] and dry; DATE OF ONSET: 5-2024, electronically signed by wound physician [name] on 06/03/2024 at 09:07 am [morning]. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) NHV dated 06/10/2024 under Wound Assessment: Wound #1 LOCATION: right heel; TYPE: PI stage 3 [full thickness tissue loss], was unstageable; DATE OF ONSET: 5-2024, electronically signed by wound physician [name] on 06/10/2024 at 10:12 am [morning]. 3)NHV dated 06/17/2024 under Wound Assessment: Wound #1 LOCATION: right heel; TYPE: PI stage 3 [full thickness tissue loss]; DATE OF ONSET: 5-2024, electronically signed by wound physician [name] on 06/17/2024 at 10:32 am [morning]. 4)NHV dated 06/24/2024 under Wound Assessment: Wound #1 LOCATION: right heel; TYPE: PI stage 3 [full thickness tissue loss]; DATE OF ONSET: 5-2024, electronically signed by wound physician [name] on 06/24/2024 at 10:43 am [morning]. 5)NHV dated 07/01/2024 under Wound Assessment: Wound #1 LOCATION: right heel; TYPE: PI stage 3 [full thickness tissue loss]; DATE OF ONSET: 5-2024, seen by wound physician [name] on 07/01/2024; and 6)NHV dated 07/22/2024 under Wound Assessment and electronically signed by wound physician [name] on 07/22/2024 at 11:21 am [morning] as follows: -Wound #1 LOCATION: right heel; TYPE: PI stage 3 [full thickness tissue loss]; DATE OF ONSET: 5-2024. -Wound #2 LOCATION: right lateral [side] foot proximal [near]; TYPE: DTPI [deep tissue pressure injury]; DATE OF ONSET: 7-2024. -Wound #3 LOCATION: right medial [middle or toward center] foot; TYPE: DTPI [deep tissue pressure injury]; DATE OF ONSET: 7-2024. -Wound #4 LOCATION: right medial [middle or toward center] malleolus [ankle]; TYPE: PI stage 3; DATE OF ONSET: 5-2024. -Wound #5 LOCATION: left lateral [side] foot; TYPE: DTPI [deep tissue pressure injury]; DATE OF ONSET: 7-2024. -Wound #6 LOCATION: sacrum [lowest area of back]; TYPE: PI stage 3 [full thickness tissue loss]; DATE OF ONSET: 7-2024. A review of Resident #3's CP, initiated on 08/03/2022 and last revised on 07/15/2024, indicated that Resident #3's CP has a Focus [health problem] of at Risk for skin breakdown r/t [related to] bowel incontinence, weakness, and poor mobility. Furthermore, the Resident's CP didn't show documented evidence that the pressure injuries on those dates indicated that new interventions were developed for the specific pressure injuries for Resident #3. During the interview with the surveyor on 10/08/2024 at 12:46 am [morning], the Registered Nurse (RN) #1 Unit Manager stated with new wounds we document in the nurses' notes initially, put it in the 24 hour report, we call the family, notify the physician for and confirm orders and we give referral to the Assistant Director of Nursing (ADON) and the ADON notifies and gives referral to the wound doctor [name of physician] of residents to see.When asked who revised and update the CP, RN #1 Unit Manager stated, I do. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with the surveyor on 10/09/2024 at 2:54 pm [afternoon], the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA), stated upon admission of new residents and after assessment, the nurse supervisor or admitting nurse would generate the care plan. The DON further stated if there are any changes to the residents or new orders to the residents' care, the care plan will be updated and revised by the Unit Manager (UM) first and then by the ADON or the nurse IP [infection Preventionist] and the DON oversee. The DON stated the CP is very important because of any changes in the residents. The DON agreed that Resident #3's CP was not updated nor revised, and interventions not added with referenced to the Resident wound pressures. A review of the facility's policy on Admission and Baseline Care Plan Policy & Procedure, revised March 2024, under Procedure: 1) On the date of initial admission to the facility, the admitting nurse will complete an initial admission nursing observation. Upon completion of this observation and based on the findings, an initial admitting plan of care will be developed. This initial plan of care also serves as the baseline care plan (BCP) for the resident; . ii) In addition, this initial baseline care plan (BCP) will address any additional areas of concern or resident preferences, as well as the minimum healthcare information, including but not limited to initial goals based on physician orders and resident goals and preferences, and- .(c) The resident's immediate health and safety needs; .iii) This plan of care will include measurable objectives and interventions to address resident specific care needs and will be updated as needed until the comprehensive care plan is developed .2) The completed BCP will be reviewed with the resident and/or their representative . ii) Upon completion of the comprehensive assessment and care plan, any changes to the resident's goals, or physical, mental, or psychosocial functioning .The staff member that presents this updated information will document in the record .3) The BCP will be used as the foundation for care planning with additions/revisions being incorporated into the comprehensive care plan. Once the comprehensive care plan has been developed and implemented, any additional changes will be made to the comprehensive care plan based on the needs of the resident. N.J.A.C:8:39-11.2(i)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48618 COMPLAINT #: NJ00173980 Based on observation, interview, review of medical records and other pertinent facility documentation on 10/08/24 and 10/09/24 it was determined that the facility failed to follow acceptable standards of nursing practice by not documenting a registered nurse's (RN) assessment of a reported injury of unknown origin. This deficient practice was identified for 1 of 10 residents reviewed (Resident #10) and was evidenced by the following: On 10/09/24, at 10:12 A.M., the surveyor observed the resident lying in bed asleep. On 10/9/24, at 10:26 A.M., the surveyor interviewed the resident's assigned RN #1 for the day, who stated that the resident was receiving hospice services. She further stated that the resident was declining and although the resident would occasionally call out a family member's name, the resident was no longer verbal. According to the facility Admission Record, Resident #10 was admitted with diagnoses that included, but were not limited to dementia, Parkinson's Disease (a degenerative brain disease that affects muscle control), and Type II diabetes. According to the quarterly Minimum Data Set (MDS), dated [DATE], an assessment tool used to facilitate the management of care revealed that Resident #10 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated that the resident's cognition was severely impaired. A review of Resident #10's Care Plan revealed that the resident had a focus related to receiving hospice care services which was initiated on 11/27/23. A review of Resident #10's Progress Notes revealed the following: -On 05/21/24, at 7:01 P.M., a Licensed Practical Nurse (LPN) documented, The writer was called into the room by the resident's [family member] and he/she showed the writer a mark, 'U shaped' with blister on resident's right inner forearm, resident is unable to explain how the mark got there. The shift supervisor was notified, and he came over to assess the mark. NP [Nurse Practitioner] is contacted via phone, unable to reach, message left, awaiting call back. Further review of the electronic medical record did not reveal any further documentation of the mark. On 10/09/24, at 12:30 P.M., the surveyor interviewed the Assistant Director of Nursing (ADON), who stated that concern of a bruise/injury should be reported to staff. She further added that staff should then inform the shift supervisor. The ADON stated that with any report of a bruise of unknown origin, the abuse protocol should be initiated. She further stated that the protocol included a nursing assessment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24, at 1:47 P.M., the surveyor interviewed the Nurse Practitioner (NP) the Director of Nursing (DON) and the ADON. During this interview the NP stated that she observed the resident on 05/28/24 and she did not observe any skin issues at that time. The NP further stated that she did not observe the resident on 05/21/24, the day that the mark was observed by the LPN. During the same interview, the ADON further stated that if a bruise/injury was identified, that an investigation should have been conducted. On 10/09/24, at 2:53 P.M., the surveyor interviewed the Administrator who stated that a RN should have documented further as to what was observed. On 10/09/24, at 3:16 P.M., the surveyor interviewed RN #2 who recalled the incident on 5/21/24. He stated that he was the Shift Supervisor at the time of the incident. He explained that he was on another unit when he received a call from the LPN who told him that Resident #10 had a mark on the skin. He further stated that he responded to the room where family members were present. He stated that he observed that the resident had a linear skin pigmentation, he did not observe a bruise, a blister, nor a raised area. He further added that he explained to the family that he did not see anything. The RN #2 stated, I should have documented. I got distracted. He further stated that if he had seen an injury he would have formally investigated and reported the incident. NJAC 8:39- 27.1(a)