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	11/19/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, facility document review, and facility policy review, the facility failed to ensure one of three residents (Resident (R) 2) sampled for medication errors, was free from significant medication errors of 11 sample residents. Specifically, R2 was administered another resident's medications. This continued practice fails to protect residents from receiving the wrong medications that could result in significant harm. Findings include:Review of the facility's policy titled, Medication Administration, dated 09/25, revealed It is the policy of the facility to administer medications according to accepted standards of practice.Medication and treatment errors and/or undesirable effects are to be immediately reported to the attending physician, and the resident will be monitored. A medication/treatment error report will be turned in to the nursing office as part of the quality assurance program.Prepare all meds for the resident as ordered for the time it is due. Take meds to the resident after identifying the resident correctly. This can be accomplished by asking the resident his/her name or checking their Identification (ID) band.Review of R2's undated admission Record located under the Profile tab of the electronic medical record (EMR) revealed R2 was admitted on [DATE] with diagnoses including traumatic subdural hemorrhage, dysphagia, and pleural effusion and was transferred to the hospital on [DATE] for coffee ground vomiting.Review of R2's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/12/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated R2 was severely cognitively impaired. R2 exhibited behaviors including behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, and disruptive sounds).Review of R2's Facility Reportable Event, dated 07/07/25, provided by the facility, revealed on 07/04/25 at approximately 4:40 PM, Agency Nurse [Licensed Practical Nurse (LPN) 1], administered Rivaroxaban 15mg [milligram] (Xarelto, is an anticoagulant medication used to prevent and treat blood clots), Nifedipine 30mg (calcium channel blocker used to treat high blood pressure and angina) (chest pain), Flomax 0.4mg (benign prostatic hyperplasia (BPH), also known as an enlarged prostate), and Insulin Lispro 2 units subcutaneously to [R2]. [LPN1] administered the medication intended for another resident to [R2] erroneously. [R2] developed nausea and vomiting on 07/05/25 requiring hospitalization for upper gastrointestinal (GI) bleed. [LPN1] provided the facility with a statement acknowledging that she did not inform the supervisor on duty or inform the primary care physician (PCP) that she administered the wrong medication to the wrong resident.Review of the Progress Notes located under the Progress Notes tab of the EMR and Medication Administration Records (MAR) located under the Orders tab of the EMR revealed the medication error was not documented. LPN1 was not available for an interview.During an interview on 09/30/25 at 7:45 AM, Certified Nurse Aide (CNA) 1 stated she had just come into work when R2's family asked if they could take him outside, the nurse spoke to the family and CNA1 went back to work. CNA1 stated that LPN1 did not ask her to identify the R2 and CNA1 did not witness the administration of the medication.During an interview on 09/30/25 at 9:30 AM, Medical Director (MD) was questioned if he was familiar with R2 and his past history. MD responded that he had taken care of R2 in the hospital. MD stated that R2 was a [AGE] year-old male, with a history of a recent subdural hemorrhage, metabolic encephalopathy, and anemia. MD was questioned if he was notified of the medication error on 07/04/25. MD responded that his team was made aware on 07/05/25 of R2 having nausea and vomiting coffee ground emesis, and he was sent to the hospital. He stated the hospital notified him of a possible medication error. MD was questioned in his opinion, did the medication error have caused the upper GI bleed and decline in the R2's condition. MD stated that it was merely speculation and that he did not believe the medication errors had caused GI bleed. The MD stated because R2 was not eating, there was a possibility of ulcers, and was on aspirin for coronary artery disease (CAD) and had a diagnosis of adult failure to thrive and poor appetite several months prior to incident. MD added that R2 was discharged to another facility on 07/10/25 from the hospital. He stated R2 was stable, he had an esophagogastroduodenoscopy (EGD), evaluated by GI [gastrointestinal], and was cleared as stable for discharge.During an interview on 09/30/25 at 2:35 PM, Registered Nurse (RN) 1 (also the Unit Manager for the Smart Unit) was questioned when she was made aware of the medication error. RN1 stated that the Director of Nursing (DON) made her aware on 07/07/25, not sure when DON was made aware. RN1 stated the initial actions were to contact the Agency where LPN1