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	02/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint #: 2788031Based on interviews, record reviews, and review of other pertinent documentation, it was determined that the facility failed to ensure that a cognitively impaired resident received nectar thick liquids (slightly thicker consistency than water, coats a spoon) as ordered and failed to develop interventions to ensure that the resident did not receive liquids that were inconsistent with their ordered diet. This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed for diet accuracy and was evidenced by the following:Resident #2 was no longer in the facility; a closed record review was conducted. A review of the admission Record (AR) for Resident #2, revealed that the resident was admitted with diagnoses including but not limited to: metabolic encephalopathy (brain dysfunction caused by non-traumatic issues like organ failure (liver, kidney), chemical imbalances, or toxins); need for assistance with personal care; dysphagia (difficulty swallowing), oral phase; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool dated 12/19/2025, revealed that Resident #2 had a Brief Interview for Mental Status score of 99, which indicated that the resident was unable to complete the assessment interview. The MDS revealed that Resident #2 had short- and long-term memory problems and had severely impaired cognitive skills for daily decision making. A review of the physician orders (POs) for Resident #2 revealed an order for regular diet, pureed texture with nectar (mildly thick) consistency liquids. The order start date was 10/18/2025. A review of the care plan (CP) for Resident #2 was conducted. The CP revealed a focus, initiated on 04/21/2025, that the resident was at risk for aspiration related to their dementia and did not want to be assisted by staff during meals. Interventions included but were not limited to: monitor for signs and symptoms of aspiration including coughing, gurgling sounds, and difficulty breathing; and provide thickened liquids as ordered. The progress notes (PNs) for Resident #2 were reviewed. A PN dated 02/21/2026 at 11:40 AM, revealed that Resident #2's family member (FM) brought a smoothie into the facility from outside and asked Registered Nurse (RN) #1 if it was alright to give it to the resident. RN #1 informed the FM that Resident #2 was supposed to receive nectar thick liquids and the FM stated that the smoothie looked alright and that the resident was only going to have a taste. The PN further revealed that the cup of smoothie contained approximately 45 cubic centimeters (1.5oz) of smoothie and that RN #1 did not witness the smoothie being given to Resident #2. The PN did not reveal that RN #1 followed up with Resident #2's FM to determine of the smoothie was given to the resident, or with the resident's physician to inform them of the potential concern. On 02/27/2026 at 11:03 AM, the Licensed Nursing Home Administrator informed the surveyor that there were no incident/accident reports for Resident #2 regarding FMs bringing in inappropriate food items for the resident on 02/21/2026. An interview was conducted with RN #1 on 02/27/2026 at 12:13PM. RN #1 stated that on 02/21/2026 Resident #2's FM showed her a smoothie from McDonald's and asked about giving it to Resident #2. RN #1 stated that she informed (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the FM that the smoothie was not consistent with the PO for Resident #2. RN #1 further stated that she did not know if the smoothie was given to Resident #2 or how much was given. During a follow up interview on 02/27/2026 at 3:15 PM, RN #1 stated that she did not follow up with Resident #2's FM to find out if Resident #2 was given any of the smoothie. RN #1 further stated that she did not notify the resident's physician, RN #1 could not identify a reason why she did not notify the resident's physician. An interview was conducted with Unit Manager (UM) #1 on 02/27/2026 at 3:41 PM. The 02/21/2026 11:40 PN by RN #1 was reviewed. UM #1 stated that the FM should have been educated and the resident's physician should have been notified. UM #1 stated that there was no documentation that a physician was notified that the resident was given the wrong thickness of fluids. UM #1 further stated that the UM or Director of Nursing (DON) were responsible for updating the resident's CP with any new interventions. An interview was conducted with the DON on 02/27/2026 at 3:57 PM. The DON stated Resident #2 was ordered nectar thick fluids because the resident had dysphasia, and to prevent aspiration. The DON stated that the usual process when outside food was brought in, was for FMs to have the food checked by a nurse. The DON stated that the food was checked by a nurse for safety reasons, to ensure that it met with the resident's ordered diet, and to make sure that nothing happened. The DON stated that if a resident's family brought in outside food, it should be added to the resident's CP because the resident had dysphasia, and outside food may not have been appropriate. The DON stated that the CP was to guide care and to make sure care was appropriate and timely. During the same interview the DON stated that if the nurse knew for sure that Resident #2 received the wrong fluid thickness, the resident's physician should have been notified. The DON stated that in general, a family meeting to educate FMs could be held. The DON stated that this was not done after the 02/21/2026 incident. When asked what was done to prevent a similar incident from happening again, the DON responded that there was no measure put into place to prevent this from happening again. The facility policy, Risk Management Incident/Accident with an effective date of February 2015 and a review date of September 2025 was reviewed. Under, Policy the policy revealed that facility staff would document all accidents, incidents and unusual occurrences experienced by residents in the facility's electronic medical record. Under, Purpose, the policy revealed that the purpose of the procedure was to provide guidelines for assessing a resident after an accident or incident and to assist in identifying its cause. Under, Procedure, the facility policy revealed that all incidents and accidents must be reported to the Nursing Supervisor immediately to ensure timely assessment of the resident. This section of the facility policy revealed that the attending physician should be notified of all incidents and accidents. This section of the facility policy further revealed that the DON will investigate incidents or accidents and ensure completeness of the reports. NJAC 8:39-27.1(a)