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	10/28/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 Complaint NJ #:178839 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to develop and implement an abuse policy that addressed sexual abuse to ensure a resident was protected from staff-to-resident sexual abuse. This deficient practice was identified for one (1) of one (1) residents (Resident #59) reviewed for abuse, and was evidenced by the following: On 10/22/24 at 1:00 PM, two surveyors interviewed the Director of Nursing (DON) who stated that a Certified Nursing Assistant (CNA#1) reported that on 10/15/24, the CNA#1 observed a Licensed Practical Nurse (LPN #1) standing over Resident #59 in a compromising position. A review of the investigation revealed the Social Worker (SW) interviewed Resident#59, who stated, I gave him oral sex. Resident #59 stated that the sexual contact occurred in [Resident #59's] room and that Resident #59 told LPN #1, I'm scared because there are people around, and [LPN #1] shut the door. The resident began performing oral sex on LPN #1 until the resident heard the door open, and the resident said that they stopped and asked, what was that? The SW asked the resident if they continued after the door was closed and the resident responded that they continued for about two minutes until he ejaculated in my mouth. The facility failed to ensure all residents were protected from sexual abuse by not fully investigating, assessing, and reporting the witnessed actions of LPN #1. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 10/15/24, after LPN #1 had a sexual encounter with Resident #59. The facility DON, Assistant Director of Nursing (ADON), and [NAME] President of Clinical Services (VPCS) were notified of the IJ on 10/22/24 at 6:20 PM. The facility submitted an acceptable Removal Plan (RP) on 10/23/24 at 1:10 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 10/23/24. The evidence was as follows: (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy Abuse and Neglect Policy and Procedure dated November 2022, revealed Purpose: To ensure prevention, protection, prompt reporting and interventions in response to alleged, suspected or witnessed abuse .of any facility resident .Policy: The Facility will not condone the abuse/neglect of any resident by anyone, including, but not limited to, staff members, other residents .Crime: .examples of crimes that would be reported include but are not limited to .sexual abuse .Abuse is the willfull infliction of injury, unreasonable confinement, intimidation, or punishment with resulting a physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition cause physical harm, pain or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Investigative and Reporting Procedure: 2. If abuse/neglect is suspected or confirmed, the resident shall be assessed to determine the need for counseling. The Administrator or his/her designee will form an investigatory team that will thoroughly investigate the allegation and document the investigation .(a) Incident report will be completed. (b) Interviews will be conducted .All such statements will be in writing and placed in the investigatory file related to the alleged incident. (d) Medical records of the resident including, but not limited, to documentation related to the physical assessment of the resident, as well as any assessment relating to the resident's psychological condition, will be reviewed .will be documented and placed into investigatory file. Federal Requirement: Reporting Reasonable Suspicion of a Crime in Long-term Facility: (i) report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of crime against any individual who is a resident of, or receiving care from the facility and (ii) report immediately but not later than 2 hours after forming the suspicion. A review of the facility policy Risk Management Incident/Accident review date March 2024, revealed: Policy: The facility staff will document all accidents and incidents in Risk Management. Purpose: The purpose of these procedure as to provide guidelines for assessing a resident after an incident/accident and to assist staff in identifying causes of the incident. Procedure: .The attending physician will be notified by the charge nurse of all occurrences of Incidents and Accidents when applicable. Chart the incident in the progress notes sections. Include, as applicable: Factors that may have attributed to the incident/accident .A detailed prescription of findings, observations, and interventions. The time of physician notification .Any resident observations or comments. On 10/22/24 at 12:08 PM, during an interview with the surveyor, CNA #1 stated, I saw something inappropriate that happened last Tuesday (10/15/24) at the beginning of my shift between a resident (later identified as Resident #59) and a staff member (later identified as LPN #1). I told the DON. She added, the staff member is no longer here. The surveyor reviewed the electronic medical record (EMR) for Resident #59. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; metabolic encephalopathy (a chemical imbalance in the blood which can cause difficulty thinking clearly), anxiety disorder, unspecified, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life) and major depressive disorder, single episode, unspecified (a mental illness that can cause severe symptoms that affect a person's mood, thoughts, and daily activities.) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the quarterly Minimum Data Set, an assessment tool dated 8/21/2024, revealed the resident had a Brief Interview for Mental Status of 15 out of 15, indicating the resident was cognitively intact. A review of Resident #59's individual comprehensive care plan revealed: Goal .has difficulty processing complex thinking skills and is occasional forgetful of [Resident #59] prior request and actions. Revision on: 9/12/2022. Further review revealed: Goal . is receiving Psychotropic (high-risk) medication(s) by pharmacological classification r/t (related to) MDD [major depressive disorder]. Revision on 3/13/2024. Interventions: Document changes in mood/behavior noting precipitating factors .Keep MD (medical doctor) informed of concerns, date initiated 3/13/2024 .Observe/Monitor responses to tx/care (treatment), progress toward goal, for improvements, complications, or adverse consequences. Report concerns to MD [medical doctor] for prompt intervention, date initiated 3/13/2024. A review of the Psychiatric Evaluation dated 9/16/2024, revealed: denies any symptoms of depression or anxiety .Assessment/Plan: A Dose Reduction (GDR) is: contraindicated .due to noted efficacy and improvement in quality of life with current treatment, contraindicated, patient has major psychiatric illness, current regimen is required to maintain functional status at this time. A review of the Individual Psychotherapy progress noted dated 10/15/24 from 1:50 PM to 2:11 PM revealed: Observable Evidence Of Patient's Response To Treatment Intervention: .Follow Up will include addressing the following issues in treatment: Continue to monitor depressive symptoms and assist resident in increasing social interactions. A review of the facility provided Nursing, Daily Attendance Report revealed LPN #1 worked the day shift (7 AM to 3 PM) on 10/15/24. A review of the facility provided Assignment for [Name Redacted] Unit sheets revealed that LPN #1 was the assigned nurse for Resident # 59 for the day shift on 10/15/24. A review of the staff list provided by the facility revealed: LPN#1, DOH (date of hire)12/9/21, terminated 10/15/24, resigned effective immediately. A review of the facility provided employee file for LPN #1 revealed: -LPN #1 had an active Nursing, Lic. (licensed) Prac. (Practical) Nurse, expiration date: 5/31/2025. - Employee Performance Evaluation for LPN#1 for the evaluation period 12/9/22-12/9/23 dated and signed by LPN# 1 on 12/11/23 revealed 3. Satisfactory .Improvement plan: a check next to teamwork. -Background Screening Report dated 12/2/2021, Results: No reportable Records Found. - Background Screening Report dated 10/15/24, Results: No reportable Records Found. -Abuse Policy-Freedom from Abuse signed by LPN #1 on 6/18/24. -Essentials of Resident Rights completed 4/10/2024. -Ethics and Corporate Compliance completed on 9/1/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #59's EMR for 10/15/24, did not reveal documentation of the above mentioned incident, a nursing or physician assessment, or physician orders. On 10/22/24 at 12:14 PM, the surveyors interviewed the Unit Manager (UM), who stated that if any abuse was seen or heard, she would tell the DON, then the DON would call the police, the state or depending on what it was. The surveyor asked if there was any abuse recently. The UM stated, Yes, a male nurse (LPN#1) was accused of having oral sex with a patient (Resident #59), his penis was in the resident's mouth. She stated the DON came to the unit to collect the nurse's belongings, he was not allowed back on the unit. The UM stated LPN#1 was no longer here. The UM stated CNA#1 observed it (the incident) and reported it to the DON. On 10/22/24 at 1:00 PM, during an interview with two surveyors, the DON stated the full investigation was still open, she printed a copy of the investigation for the surveyors. The DON stated, needs work on it. According to the investigation, the DON stated she was in her office when CNA #1 told her what happened on 10/15/24. The DON went to the unit, but LPN#1 was not on the unit. The DON stated he (LPN#1) left the unit, he was not in the building, he left the facility. The DON called the Social Worker (SW) and the Assistant Director of Nursing (ADON) to the unit. The SW went to speak with the resident. After approximately 20 minutes, LPN#1 came back to the unit and the DON met him at the nurse's station. The DON asked LPN #1 for his keys and took him to the conference room to wait. The SW and the DON spoke to other residents. The Licensed Nursing Home Administrator (LNHA) and the DON went to the conference room to speak to LPN#1. The LNHA led the interview. The DON explained LPN #1 did not say much, he denied that it happened. The DON stated LPN#1 resigned immediately. The DON stated we did not report it to the state (New Jersey Department of Health (NJDOH)) or the police because it (the sexual encounter) was consensual, and the resident wanted everything to remain confidential. The DON stated the LNHA had left messages twice to the Board of Nursing to report the incident. A review of the undated investigation revealed the Statement Summary: Documented as written Writer (the DON identified as the SW) asked the resident about the relationship with LPN #1, inquiring if there has been any sexual contact. Resident #59 responded just today, adding that they otherwise have just joked. The writer asked what sexual contact happened today and the resident responded, I gave him oral sex. Writer asked about how this interaction occurred, and the resident responded, We're always joking about it .he came in my room when I was in the bathroom. He said, here you go, making a gesture with their hand, cupping their hand in an upward motion. The writer asked if that was a sexual gesture, and Resident #59 confirmed it was. The resident stated that the sexual contact occurred in (their) room and that the resident told LPN#1, I'm scared because there are people around, and he shut the door. The resident began performing oral sex on him until the resident heard the door open, and the resident said that they stopped and asked, what was that? The resident said the person closed the door. The writer asked if the resident continued after the door was closed and the resident responded that they continued for about two minutes until he ejaculated in my mouth. The resident stated that sexual contact had never occurred before, adding that they were a consenting adult and I don't want to get him in trouble. The resident added LPN#1 said, it wouldn't take long adding and it wasn't. The resident stated, I've never seen anything that fast. Resident #59 said, I figured it wasn't kosher for him to do that or for me to do that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Further review of the investigation revealed: Writer asked more about their relationship, and Resident #59 stated, We joke about oral sex a lot. Writer asked how long these kinds of jokes have been going on and the resident stated, Almost as long as he's been here. Resident #59 gave an example of a joke, stating they usually take their own medications, but that LPN#1 would give them the inhaler and say suck. Resident #59 said, I flirt with everyone and I am a jokester. On 10/22/24 at 2:21 PM, the surveyor interviewed the Director of Social Services (DSS), who stated if there was an allegation of abuse, the staff would be suspended and the allegation of abuse would be reported (to the NJDOH) within two hours, a full investigation would be completed, and the police would be called. She then stated, the DON and LNHA are responsible to report the event. She confirmed she was aware of the sexual incident that occurred on 10/15/24, between LPN#1 and Resident #59. She also confirmed that the sexual incident was not reported to the NJDOH or to law enforcement. The DSS stated she met with Resident#59 who acknowledged what had happened and that it happened only one time and it was consensual. She stated Resident #59 was flirty but had no knowledge of the resident having a history of inappropriateness. She stated statements were taken. She added, the LNHA and DON met with LPN#1 to obtain a statement but, I don't think he gave one; he resigned. The DSS further stated that she met with the LNHA, the DON, and the ADON to see if any follow up was required. She stated, we were all unsure because the resident was adamant about it being consensual. She added the resident was worried about being in trouble. The DSS stated the LNHA reviewed the regulations, and it was concluded that the incident did not meet the standards for reporting. She added, it was a collective discussion. On 10/22/24 at 3:21 PM, the surveyors met with Resident #59 and asked if they could interview the resident in private. The resident agreed. The SW offered her office for the private interview. The surveyor informed the resident that at any time during the interview the resident does not have to answer the questions and could stop the interview. The resident acknowledged understanding. The surveyor asked what had happened on 10/15/24, between the nurse and the resident. Resident #59 stated, I am a jokester. He told me to hold it, he then unzipped his pants, I regret it happened. The resident stated, it happened about 9:30 in the morning. He was passing medications. I have COPD (chronic obstructive pulmonary disorder-lung disease that block airflow and make it difficult to breath) and use an inhaler. He stated ready to suck for me. The resident told the nurse, There are too many people, he said nobody is here and he shut the door. The resident stated. He pulled his fly down. He came in my mouth, and I swallowed it. The resident added, I am afraid the facility will kick me out. On 10/22/24 at 5:15 PM, the LNHA approached the survey team in the conference room and apologized, but stated he had to go it's my holiday. The Team Coordinator stated that you may want to stay. He stated, I know the [NAME] but I have to go. He stated the DON would still be available. On 10/22/24 at 5:56 PM, during an interview with the survey team, the ADON, the VPCS, and the DON stated sexual abuse was inappropriate touching from one person to the other, undesired touching. When asked if sexual abuse was a crime, the DON stated, yes. When asked if a crime occurs would you call police, the DON stated, yes. When asked what should be done for any incident, the DON stated an investigation was started, obtain statements from employees, an incident report was started, the MD and family were notified. When asked why were you reporting the incident to the Board of Nursing, she stated, I think it is unethical based on professional standards. When asked what did he do that was unprofessional, she stated, he had interactions with a resident under his care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	At that time the VPCS, stated, The LNHA makes the decision to report or not. The DON stated it was not reported because it was consensual. An acceptable removal plan was received on 10/23/24 at 1:16 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: 1) LPN#1 was immediately removed from the facility; 2) Resident #59 was assessed; 3) the resident's physician was notified; 4) the incident was reported to the New Jersey Department of Health (NJDOH); 5) the abuse and neglect policy was updated; 6) the police were called; and 7) all staff were educated on the facility abuse policies and procedures. The survey team verified the implementation of the removal plan during the continuation of the on-site survey on 10/23/24. On 10/25/24 at 1:42 PM, in the presence of the survey team, the Medical Director was interviewed via the phone. He agreed to being placed on speaker phone. The surveyor asked if he was the primary care physician for Resident #59, he stated yes. When asked if he was aware of the incident that occurred on 10/15/24, regarding Resident #59. He stated, he was made aware this past week, sometime this past weekend. He was unable to recall exactly what day he was notified. When asked when you were made aware of the incident what recommendations did you make, he stated, a psychology consult, therapy sessions and testing. On 10/28/24 at 11:48 AM, the survey team met with DON, the ADON, the LNHA and the Regional LNHA. The LNHA stated he was the abuse officer. He stated an allegation of abuse example was someone who said they were punched in the face. He stated it would be investigated and if it was something that needs to be reported, then it would be reported within two hours. He stated the above incident was not reported because we did not feel abuse took place. He stated, I read through the regulations and felt that there was no abuse that had occurred since it was consensual. He confirmed he had been inserviced on reporting and investigating for F 600. He then stated after rereading F 600 it (the above mentioned incident) should have been reported. NJAC 8:39-4.1 (a) NJAC 8:39-33.2 (c) (12)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48964 Complaint # NJ 178839 Refer to F 600 Based on interviews and review of the medical record and other facility documentation, it was determined that the facility staff failed to report an allegation of sexual abuse by a staff member to a resident to the New Jersey Department of Health (NJDOH) as required. This deficient practice was identified for 1 of 1 resident (Resident #59) and was evidenced by the following: On 10/22/24, the surveyor reviewed Resident #59's medical record which included a quarterly Minimum Data Set (MDS), an assessment tool dated 8/21/24, which indicated a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating intact cognition and diagnoses which included but were not limited to diabetes (high blood sugar), respiratory disease, anxiety disorder, and depression. On 10/22/24, a review of an investigation provided by the facility revealed that on 10/15/24, a staff member observed the resident in a compromising position with another staff member (Licensed Practical Nurse (LPN) #1). A review of the investigation revealed the Social Worker (SW) interviewed Resident #59 who when asked what sexual contact happened today stated, I gave him (LPN#1) oral sex. Further review revealed that Resident #59 stated that the sexual contact occurred in the room and that the resident told LPN #1, I'm scared because there are people around, and he (LPN#1) shut the door. Resident #59 began performing oral sex on him until the door was heard to open, when Resident #59 said the activity was stopped and asked, what was that? The person closed the door. The SW asked if the oral sex continued after the door was closed and Resident #59 responded that it continued for about two minutes until he (LPN#1) ejaculated in the mouth. Resident #59 stated that sexual contact had never occurred before, and further stated, I don't want to get him in trouble, and I figured it wasn't kosher for him to do that or for me to do that. On 10/22/24 at 1:00PM, the surveyors interviewed the Director of Nursing (DON) who stated the investigation was still open and was not completed yet. She further stated that according to the resident, the incident was consensual but that it was not appropriate. She also stated that neither the police, nor the NJDOH were notified because the encounter was consensual, and the resident requested privacy regarding the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 10/22/24 at 3:21 PM, the surveyors met with Resident #59 and asked if they could interview the resident in private. The resident agreed. The SW offered her office for the private interview. The surveyor informed the resident that at any time during the interview the resident does not have to answer the questions and could stop the interview. The resident acknowledged understanding. The surveyor asked what had happened on 10/15/24 between the nurse and the resident. Resident #59 stated, I am jokester. He told me to hold it, he then unzipped his pants, I regret it happen. The resident stated, it happened about 9:30 in the morning. He was passing meds. I have COPD (chronic obstructive pulmonary disorder-lung disease that block airflow and make it difficult to breath) and use an inhaler. He stated ready to suck for me. The resident told the nurse, There are too many people, he said nobody is here and he shut the door. The resident stated. He pulled his fly down. He came in my mouth, and I swallowed it. The resident added, I am afraid the facility will kick me out. When asked if the facility offered to call the police, Resident #59 stated they did not and that the resident did not want the police called as it was partly his/her fault. On 10/22/24 at 5:56PM, the surveyor interviewed the DON and the [NAME] President of Clinical Services in the presence of the surey team, who stated that crimes were reported to the police and that what happened to Resident #59 was consensual, therefore it was not a crime. On 10/28/24 at 11:48AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the surey team, who stated that abuse should be reported (to the NJDOH) within 2 hours of the allegation. He further stated he reread Federal Tag (the system through which federal nursing home regulations are identified in the survey process) #600 and the incident should have been reported. A review of the facility policy Abuse and Neglect Policy and Procedure dated November 2022, revealed Policy: The Facility will not condone the abuse/neglect of any resident by anyone, including, but not limited to, staff members, other residents .Crime: .examples of crimes that would be reported include but are not limited to .sexual abuse .Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting a physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition cause physical harm, pain or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm Federal Requirement: Reporting Reasonable Suspicion of a Crime in Long-term Facility: d. (i) report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of crime against any individual who is a resident of, or receiving care from the facility and (ii) report immediately but not later than 2 hours after forming the suspicion. NJAC 8:39-9.4(f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. 48964 Complaint # NJ 178839 Refer to F 600 Based on interviews, review of the medical record and other facility documentation, it was determined that the facility failed to thoroughly investigate an alleged incident of sexual abuse between a staff member and a resident. This deficient practice was identified for 1 of 1 resident (Resident #59) reviewed for abuse and was evidenced by the following: On 10/22/23, the surveyor reviewed Resident #59's medical record which included a quarterly Minimum Data Set (MDS), an assessment tool dated 08/21/24, which indicated a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating intact cognition and diagnoses which included but were not limited to diabetes (high blood sugar), respiratory disease, anxiety disorder, and depression. On 10/22/24, a review of an investigation provided by the facility revealed that on 10/15/24, a staff member observed the resident in a compromising position with another staff member (Licensed Practical Nurse (LPN) #1). A review of the investigation revealed the Social Worker (SW) interviewed Resident #59 who when asked what sexual contact happened today stated, I gave him (LPN#1) oral sex. Further review revealed that Resident #59 stated that the sexual contact occurred in the room and that the resident told LPN #1 I'm scared because there are people around, and he (LPN#1) shut the door. Resident #59 began performing oral sex on him until the door was heard to open, Resident #59 said the activity was stopped and they asked, what was that? The person closed the door. The SW asked if the oral sex continued after the door was closed and Resident #59 responded that it continued for about two minutes until he (LPN#1) ejaculated in their mouth. Resident #59 stated that sexual contact had never occurred before, and further stated, I don't want to get him in trouble, and I figured it wasn't kosher for him to do that or for me to do that. On 10/22/24 at 1:00PM, the surveyors interviewed the Director of Nursing (DON), who stated the investigation was still open and was not completed yet. She further stated that according to the resident, the incident was consensual but that it was not appropriate. The surveyors were provided a printed summary of the incident. No incident report was provided as the DON stated that she ensured the resident was safe and did not think of an incident report. The summary provided included interviews with six alert and oriented residents that were on LPN #1's assignment. Interviews did not include Resident #59's alert and oriented roommate. No documentation was noted regarding an assessment of Resident #59 after the incident - summary indicated the DON noted no injury during interview. No documentation provided indicated that non alert and oriented residents were assessed for any inappropriate sexual contact. There was no documentation to indicate that Resident #59's primary physician was notified. No written statements were included in the summary from the witness or anyone else. (continued on next page)

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	315423	A. Building B. Wing	10/28/2024

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/22/24 at 3:21PM, the surveyor interviewed Resident #59, who was agreeable to speak to two surveyors. The resident stated that she and LPN #1 both joked around with sexual undertones. On the morning of 10/15/24, LPN #1 during morning medication pass, brought the resident his/her inhaler and asked if he/she was ready to suck for him. The resident was sitting in the room when LPN #1 came closer and pulled down his zipper and told Resident #59 to put his/her hand in his pants. Resident #59 told him there were too many people around, including an alert, oriented roommate. LPN #1 stated that nobody was around, and he shut the door. Resident #59 stated that he/she put their hand in his pants and that LPN #1 ejaculated into their mouth, which the resident swallowed. Resident #59 stated that he/she was not forced or coerced. Resident #59 further stated that it was an indiscretion and a mistake and that it was quick, very short. On 10/22/24 at 3:21 PM, the surveyors met with Resident #59 and asked if they could interview the resident in private. The resident agreed. The SW offered her office for the private interview. The surveyor informed the resident that at any time during the interview the resident does not have to answer the questions and could stop the interview. The resident acknowledged understanding. The surveyor asked what had happened on 10/15/24 between the nurse and the resident. Resident #59 stated, I am jokester. He told me to hold it, he then unzipped his pants, I regret it happen. The resident stated, it happened about 9:30 in the morning. He was passing meds. I have COPD (chronic obstructive pulmonary disorder-lung disease that block airflow and make it difficult to breath) and use an inhaler. He stated ready to suck for me. The resident told the nurse, There are too many people, he said nobody is here and he shut the door. The resident stated. He pulled his fly down. He came in my mouth, and I swallowed it. The resident added, I am afraid the facility will kick me out. On 10/25/24 at 11:31 AM, the surveyor interviewed the Medical Director who stated he was the attending physician for Resident #59, and he was made aware of the incident this past weekend. Upon notification, he stated that he recommended a psychiatric consultation, sexually transmitted infections testing, and psychotherapy. On 10/25/24 at 01:48 PM, the surveyors met with the DON and the Assistant DON (ADON). The DON stated that the attending physician should have been notified about the time when the incident happened. She also stated that the notification of the attending physician should be documented and that if something was not documented, it was not done. A review of the facility policy Abuse and Neglect Policy and Procedure dated November 2022, revealed Policy: The Facility will not condone the abuse/neglect of any resident by anyone, including, but not limited to, staff members, other residents .Crime: .examples of crimes that would be reported include but are not limited to .sexual abuse .Investigative and Reporting Procedure: 2. If abuse/neglect is suspected or confirmed, the resident shall be assessed to determine the need for counseling. 3. The Administrator or his/her designee will form an investigatory team that will thoroughly investigate the allegation and document the investigation .(a) Incident report will be completed. (b) Interviews will be conducted .All such statements will be in writing and placed in the investigatory file related to the alleged incident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy Risk Management Incident/Accident review date March 2024 revealed: Policy: The facility staff will document all accidents and incidents in Risk Management. Purpose: The purpose of these procedure as to provide guidelines for assessing a resident after an incident/accident and to assist staff in identifying causes of the incident. Procedure: .The attending physician will be notified by the charge nurse of all occurrences of Incidents and Accidents when applicable. Chart the incident in the progress notes sections. Include, as applicable: Factors that may have attributed to the incident/accident .A detailed prescription of findings, observations, and interventions. The time of physician notification .Any resident observations or comments. NJAC 8:39-9.4(f)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41858 Based on observations, interviews, record review and review of other facility documentation, it was determined that the facility failed to ensure heel booties were consistently applied to prevent skin breakdown. This deficient practice was identified for Resident #72, 1 of 2 residents reviewed for position and mobility. This deficient practice was evidenced by the following: On 10/18/24 at12:18 PM, during initial tour, the surveyor observed Resident #72 sitting in a reclining chair in the main activity area. The resident was wearing white socks with their heels resting on the footrest. A review of the electronic medical record (EMR) for Resident #72 revealed the following: A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities) and Alzheimer's Disease, unspecified a brain disorder that slowly destroys memory and thinking skills.) A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 8/7/24, revealed the resident had a Brief Interview for Mental Status (BIMS) of 99, indicating the resident was severely cognitively impaired. Further review revealed the resident did not have a pressure ulcer. A review of the individual comprehensive care plan (ICCP) revealed: Intervention/Tasks: Booties to feet bilateral while in and oob (out of bed) for skin protection, Date Initiated: 08/06/2024. A Review of the physician orders (PO) revealed: HEEL BOOTIES TO BILATERAL HEELS AT ALL TIMES. CHECK PLACEMENT Q SHIFT every shift for skin integrity Active 8/6/2024 15:00. A review of Treatment Administration Record (TAR) revealed: HEEL BOOTIES TO BILATERAL HEELS AT ALL TIMES. CHECK PLACEMENT Q SHIFT had a check, check=administered, for the day shift by the Licensed Practical Nurse/Unit Manager (LPN/UM) for 10/24/24. On 10/24/24 at 1:34 PM, the surveyor interviewed the LPN/UM, who was Resident #72's assigned nurse. She stated the resident wears booties at night in bed. The LPN/UM reviewed the PO in the presence of the surveyor and confirmed that the heel booties should be worn at all times. She stated the purpose of booties was for skin integrity. She stated the resident did not have any skin breakdown. The LPN/UM observed the resident, in the presence of the surveyor, in a recliner chair and confirmed that the resident was currently wearing black socks and that the booties were not on the residents. She confirmed she had signed the order on the TARs as being completed. She acknowledged it's my fault. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 2:36 PM, in the presence of the survey team, Assistant Director of Nursing and the [NAME] President of Clinical Services, the surveyor interviewed the Director of Nursing (DON), who stated the nurses and certified nursing assistants make sure heel booties are applied. She stated, if a resident is in a recliner the booties should be on. The surveyor made the DON aware of the above observation. The Licensed Nursing Home Administrator was not available for interview. A review of the facility's policy Policy for Splint Application reviewed 08/2024, revealed: Policy: It is a policy of this facility to apply splints, braces, hand rolls and etc. as per physician's orders. NJAC 8:39-27.1 (a)

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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. 48964 Based on observation, interview, and review of pertinent documents it was determined that the facility failed to ensure that the resident's care plan and smoking evaluation were followed to ensure the resident's ability to safely smoke cigarettes in accordance with their facility policy. The deficient practice occurred for 1 of 2 residents reviewed for smoking (Resident #74) and was evidenced by the following: On 10/18/24 at 12:45 PM, the surveyor observed Resident #74 in a wheelchair in the dining room waiting on lunch. On 10/23/24 at 1:34 PM, the surveyor observed Resident #74 outside smoking with supervision provided by the Director of Activity (DOA). The surveyor observed that the DOA lit the resident's cigarette. The surveyor did not observe a smoking apron in use for Resident # 74. Two other residents had smoking aprons applied before their cigarettes were lit. The DOA stated that Resident #74 does not use a smoking apron, he/she does pretty well. She further stated that the activity department supervised the smoking in the facility. On 10/23/24, the surveyor reviewed the electronic medical record (EMR) which revealed an Annual Minimum Data Set, an assessment tool dated 5/24/24, which indicated that Resident #79 had a Brief Interview of Mental Status score of 13 out of 15, indicating an intact cognitive function, and diagnoses that included but not limited to; cancer and anemia (low blood count), and tobacco use was marked as yes. The surveyor reviewed a smoking evaluation dated 6/18/24, which indicated that Resident #79 had no history of burns, did not use oxygen, had no history of non-compliance with smoking, required adaptive safety equipment identified as a smoking apron and required assistance with lighting cigarettes. The evaluation indicated that Resident #79 was able to smoke with supervision. A review of Resident #79's individualized comprehensive care plan (ICCP) included a focus area dated 5/29/19, which reflected that this resident chose to smoke. Interventions included provision of a smoking apron, assist with application & removal of apron as needed, and to monitor use of apron. On 10/25/24 at 9:25 AM, the surveyor interviewed the Registered Nurse Unit Manager, who stated that the smoking assessments were completed quarterly. She reviewed Resident #79's ICCP and stated that he/she used an apron during smoking. She also stated that a smoking apron should have been used each time the resident smoked since it was included in the ICCP. She further stated that she should have reassessed the resident and discontinued his/her smoking apron as the resident did not need it. When asked by the surveyor how the supervising staff would know which residents needed to use a smoking apron, she stated that was communicated verbally between the staff. On 10/25/24 at 1:48 PM, the surveyor met with the DON, who stated that Resident #79 did not need a smoking apron and that the staff should have reassessed the resident and updated the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility provided Smoking Policy and Procedure revised on 4/25/23 included: C. Residents who smoke and have been deemed as needing supervision will have an individualized plan of care that addresses their smoking. The care plan will be kept current and updated as needed in accordance with any variance of the individual's capabilities and needs. NJAC 8:39-27.1(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34033 Based on observation, interview, and record review, it was determined that the facility failed to provide services in a manner consistent with standards of practice to maintain a urinary catheter from 8/28/24 until surveyor inquiry. The deficient practice was identified for one (1) of three (3) residents, (Resident #55), reviewed for urinary catheter care. The deficient practice was evidenced by the following: On 10/22/24 at 10:42 AM, the surveyor observed Resident #55 in a wheelchair in their room. The resident stated that they had just returned from physical therapy and was exhausted. The surveyor had not observed a urinary catheter drainage bag (a device inserted to collect urine from the bladder into a drainage bag). On 10/22/24 at 10:49 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that she was familiar with Resident #55 and had the resident on her assignment. CNA #1 added that the resident had a urinary drainage bag when they were in bed and when the resident was out of bed, the urinary drainage bag was changed to a leg bag. The surveyor reviewed the electronic medical record for Resident #55. A review of the comprehensive admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated 9/4/24, reflected that the resident had a Brief Interview for Mental Status score of 11 out of 15, which indicated the resident had an intact cognition. In addition, the MDS reflected that the resident had an indwelling catheter. A review of the individualized comprenhesive care plan (ICCP) created on 8/28/24 with a revision date of 9/14/24, reflected a focus area Risk for UTI (urinary tract infection) r/t (related to) cath (catheter) use. A review of the Order Summary Report reflected diagnoses which included but were not limited to, hydronephrosis with renal and urethral calculous obstruction (a blockage in one or both of the tubes (ureters) that carry urine from the kidneys to the bladder causing a swelling of the kidneys) and chronic kidney disease. Further review of the Order Summary Report reflected the following physician's orders (PO) dated 8/28/24: -[name redacted] Catheter care every shift. -Follow up with [name redacted] for urinary retention in 1-2 weeks. Call [phone number redacted] to schedule. -Follow up with [name redacted] nephrology in 1 week. [address and phone number redacted]. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor was unable to identify any documented consult reports or scheduled appointments for a consult for the resident. On 10/24/24 at 9:31 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN), who verified that Resident #55 had a urinary catheter upon admission. The UM/LPN stated that she was unaware that the resident required any consults to be scheduled. At that time, the UM/LPN reviewed the POs for the resident. The UM/LPN verified that there were PO's for a urology consult and a nephrology consult that had been ordered on 8/28/24. The UM/LPN added that she was responsible for checking the POs and setting up the consults. The UM/LPN also stated that she had not been working for a while during September due to personal reasons and the appointments were not done. The UM/LPN added that she was unaware of the PO for appointments to be scheduled for the urologist and nephrologist and would have to schedule them now. On 10/24/24 at 2:25 PM, the survey team met with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and Regional [NAME] President of Clinical Services. The surveyor reviewed the above concern that the PO for the nephrology and urology consults were not completed for Resident #55. On 10/28/24 at 12:50 PM, the survey team met with the Licensed Nursing Home Administrator, DON and ADON. The ADON stated that Resident #55 was originally admitted to the sub-acute unit and the PO were obtained for the consults but was unsure if the nurse had scheduled the appointments. The ADON added that shortly after admission the resident was transferred to the [NAME] Unit on 9/4/24, and the nurse who accepted the in-house transfer had missed the PO and had not scheduled the appointments. The ADON stated Somehow the orders fell through the cracks. In addition, the ADON stated that there was no facility policy for the nurses when admitting a resident but that the process was that nurses were to follow an in-house check-off list as a guide to make sure every order was followed through. Also, the ADON stated that there was no facility policy for the transcription of a PO but that the nurses were to follow the standard of practice that a PO was to be completed. NJAC-8:39-11.2(b), 27.1(a)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 Based on observations, interviews, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents a.) conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission and b.) were seen by the physician or nurse practitioner every thirty days with a physician visit at least every sixty days. This deficient practice was observed for 2 of 9 residents (Resident #28 and #167) reviewed for physician visits. This deficient practice was evidenced by the following: 1. On 10/18/24 at 12:10 PM, during the initial tour, the surveyor observed Resident #28 wearing a gray sweatshirt. The resident was walking around the unit. The surveyor reviewed the electronic medical record (EMR) for Resident # 28. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; metabolic encephalopathy (a chemical imbalance in the blood which can cause difficulty thinking clearly) and unspecified dementia, unspecified severity, without behavioral disturbance (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions.) A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 8/19/24, revealed the resident had a Brief Interview for Mental Status (BIMS) of 2 out of 15, indicating the resident was severely cognitively impaired. A review of the EMR did not reveal a history and physical or physician progress notes from the resident's attending physician since the resident's admission in February of 2024. On 10/24/24 at 1:24 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM), who was Resident # 28's assigned nurse. The LPN/UM reviewed the EMR in the presence of the surveyor. The LPN/UM was unable to locate the attending physician notes or a history and physical. She stated she was unsure how often they (the attending physicians) should write a note. 2. On 10/18/24 at 12:05 PM, during initial tour, Resident #167 was observed sitting with other residents in the common area in front of nurse's station. The surveyor reviewed the electronic medical record (EMR) for Resident #167. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; metabolic encephalopathy and dementia in other diseases classified elsewhere. A review of the MDS dated [DATE], revealed the resident had a BIMS of 5 out of 15, indicating the resident was severely cognitively impaired. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the EMR revealed an attending physician progress note dated 1/5/2024. It did not reveal any additional physician progress notes or a history and physical. Further review of the EMR, revealed the resident was readmitted to the facility in July of 2024. On 10/24/24 at 1:24 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM), who was resident # 167's assigned nurse. She reviewed Resident #167's EMR in the presence of the surveyor. She confirmed the last attending progress note for Resident #167 was 1/5/2024. On 10/24/24 at 2:36 PM, in the presence of the survey team, Assistant Director of Nursing and the [NAME] President of Clinical Services, the surveyor interviewed the Director of Nursing (DON), who stated the attending physician should see the resident on admission and whenever we call with a concern. She stated the attending physician should see the long term residents monthly and document the visit under physician progress notes in the EMR. The surveyor presented the above concerns for attending physician progress notes for Resident #28 and #167. The administrative team were made aware that the LPN/UM was unable to locate attending physician progress notes for Resident #28 since the resident's admission and Resident #167's last attending progress note dated 1/5/24. The Licensed Nursing Home Administrator was not available for interview. On 10/25/24 at 9:21 AM, the surveyor interviewed the DON, who confirmed that the only attending physician note for Resident #28 was dated 08/30/24 Late Entry and a History and Physical dated 10/23/24 Late Entry. She confirmed the last attending progress note for Resident #167 was dated 1/5/24 and then one for 10/23/24 Late Entry. On 10/25/24 at 1:42 PM, the surveyor interviewed the medical director via phone, who stated the attending physicians should see their residents within 72 hours of admission. The Medical Director was made aware of Resident #28's attending physician had not written a progress note or history and physical since the resident was admitted in February 2024. He stated, that was unacceptable. He was made aware of Resident #167's attending physician's progress note dated 1/5/2024, and then on on10/23/24. A review of the facility's policy, Physician Visits reviewed December 2023, revealed: Policy Statement. The Attending Physician must make visits in accordance with applicable state and federal regulations. Policy Interpretation and Implementation: 1. The Attending Physician will visit in a timely fashion, consistent with applicable state and federal requirements and depending .2. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. NJAC 8:39-23.2(d)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40042 Based on interview and review of facility documentation, it was determined that the facility failed to ensure that a.) all Certified Nursing Assistants (CNAs) received 12 hours of mandatory in-service training as required for 5 of 5 CNAs and b.) abuse prevention training was completed for 2 of the 5 CNA files reviewed for in-service training. This deficient practice was evidenced by the following: On 10/24/24, the surveyor reviewed in-service education hours for five randomly selected CNA files which were provided by the Director of Nursing (DON). The surveyor reviewed the following for the 2023 to 2024 calendar year, corresponding with the CNA hire dates: CNA #1 was hired on 8/17/18, with a total of 6 hours (hrs.) of in-service training for the current 12-month period. CNA #2 was hired on 8/25/15, with a total of 5.5 hrs. of in-service training for the current 12-month period. CNA #3 was hired on 8/10/23, with a total of 6 hrs. of in-service training for the current 12-month period, which did not include abuse prevention training. CNA #4 was hired on 9/27/18, with a total of 6.5 hrs. of in-service training for the current 12-month period, which did not include abuse prevention training. CNA #5 was hired on 8/10/23, with a total of 8.25 hrs. of in-service training for the current 12-month period. The above in-service content was provided to the surveyor as a Transcript print out for each of the five CNAs reviewed. The transcript reflected online education module titles with respective quantified hours of training, and date completed. The surveyor reviewed additional information submitted by the DON, which did not reflect quantifiable time related to topics of education and therefore could not be included in total hours of education. On 10/24/24 at 1:03 PM, the surveyor interviewed the Director of Human Resources who stated that she provided the CNA files, and the in-services included all the orientation and education provided by the facility. On 10/24/24 at 2:25 PM, the surveyor interviewed the DON, in the presence of the survey team, as well as the Assistant DON (ADON) and the [NAME] President of Operations. The DON acknowledged that the additional information provided [Inservice Attendance Records, Educational Enhancement Seminar and User Learning tracking sheets] had no quantification of time to include in the calculation of the 12 hours of mandatory in-service training. (continued on next page)

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	10/28/2024

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

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/24 at 1:47 PM, the surveyor interviewed the DON, in the presence of the survey team and the ADON, who stated the previous educator who was responsible to ensure CNAs received their 12 hours of mandatory training had been out on a leave, then returned in July of this year and then left the role. She further stated, so we had sort of a gap. The DON stated that corporate scheduled monthly online education and that the Licensed Nursing Home Administrator (LNHA) and herself were responsible to ensure staff completed the education. At that same time, the DON stated that the facility did not have a policy related to CNA education. NJAC 8:39-43.17 (b)