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	03/16/2026

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 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, record review, and review of facility documents, it was determined that the facility failed to provide preventive care, consistent with professional standards of practice, to residents who may be at risk for development of pressure injuries and ensure that air mattresses were accurately set according to the resident's weight.This deficient practice was identified for 4 of 4 residents (Residents #6, #7, #106, and #151) reviewed for risk of pressure ulcers and was evidenced by the following:1.On 3/6/26 at 10:50 AM, the surveyor observed Resident #6 in bed with the air mattress setting set to 330 pounds.On 3/10/26 at 11:48 AM, the surveyor observed Resident #6 in bed with the air mattress setting set to 180-230 pounds.A review of the admission Record (AR) (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to; hemiplegia (the total or partial paralysis of one entire side of the body) and hemiparesis (a neurological condition characterized by muscular weakness on one side of the body) right dominant side; muscle weakness; and cognitive communication deficit (an impairment in communication such as speaking or listening caused by issues like poor memory or poor attention).A review of the Order Summary Report (OSR) revealed a physician's order (PO) for air mattress on bed for pressure prevention, every shift check setting and function on air mattress, dated 3/7/26.A review of the vital signs in the electronic medical records (EMR) revealed a weight of 210.8 pounds, dated 3/4/26.A review of the annual Minimum Data Set (MDS), an assessment tool dated 1/20/26, revealed a Brief Interview for Mental Status (BIMS) of 7 out of 15, which indicated Resident #6's cognition was severely impaired.A review of the Individual Comprehensive Care Plan (ICCP) completed 1/6/26 revealed focus areas for:Extensive assist x2 with [name redacted] (a mechanical device used to safely transfer individuals with limited mobility) for transfers;Impaired functional status related to decreased mobility and impaired balance due to left Cerebrovascular Accident (CVA) with right sided weakness and dysphagia;Decreased Range of motion (ROM) due to contracture(s); Hemiplegia and hemiparesis; potential for further decline in ROM, potential for pain/discomfort related to contracture(s); andRisk for skin breakdown related to impaired ROM. and incontinence. An intervention for the focus area of risk for skin breakdown included air mattress to bed initiated 3/7/26, and pressure reduction mattress initiated 10/24/25. Wound history .mechanical injury sacrum resolved.On 3/11/26 at 10:32 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) who confirmed Resident #6 had an air mattress because of risk for pressure ulcers.2.On 3/10/26 at 11:45 AM, the surveyor observed Resident #7 in bed with the air mattress setting set at 180-230 pounds.A review of the AR revealed diagnoses that included but were not limited to; bed confinement status; chronic pain syndrome; and dementia.A review of the OSR revealed a PO for weekly skin assessment dated [DATE]; and a PO for air mattress on bed for pressure relieving, every shift for pressure prevention check setting and function on air mattress, dated 3/7/26.A review of the quarterly MDS dated [DATE], revealed a BIMS of 1 out of 15, indicating severe cognitive impairment. Further review revealed the resident had upper and lower extremities impairment on both sides and an indicator for pressure injury.A review of the ICCP dated 2/19/26 revealed a focus areas for:Extensive to dependent assist with Activities of Daily Living (ADLs).Risk for skin breakdown related to (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence of bowel and bladder and decreased mobility of bilateral lower extremities and preference to stay in bed, frequently squirms around in bed to get into his favorite position requiring staff to reposition him for safety.Right lateral foot arterial wound. Interventions for this focus area included air mattress to bed dated 1/1/24.Potential for pain related to limited range of motion to upper and lower extremity. Interventions for this focus are included to utilize pressure relieving mattress for comfort dated 1/27/26.A review of the vital signs in the EMR revealed a weight of 147.2 pounds, dated 3/10/26.A review of a wound assessment report, dated 2/11/26 revealed a new right lateral foot arterial ulcer. The assessment also revealed current pressure relieving devices as air mattress overlay.A review of a skin and wound note dated 3/4/26 revealed .right lateral foot arterial ulcer .history of chronic wound. Continue with turning and repositioning schedule per protocol for pressure prevention .Wound is stable.On 3/11/26 at 10:27 AM, the surveyor interviewed LPN#1, who confirmed Resident #7 had an air mattress. LPN#1 stated They get out of bed every Tuesday and Thursday due to refusal and as they requested. There are orders for the air mattress to check the setting and function, we make sure it is set to the appropriate weight. That is the setting that determines the amount of air in the mattress to relieve pressure.3.On 3/6/26 at 10:20 AM, the surveyor observed Resident #106 in bed with the air mattress settings set to 325 pounds.On 3/10/26 at 11:34 AM, the surveyor observed Resident #106 in bed with the air mattress settings set to 80 pounds.A review of the AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified symptoms involving cognitive function and awareness; and nontraumatic intracerebral hemorrhage (a severe stroke caused by spontaneous bleeding into brain tissue).A review of the OSR revealed a PO for air mattress on the bed for pressure prevention, every shift check setting and function on air mattress, dated 10/20/25. A further review revealed a PO for weekly skin assessment every Tuesday evening shift for monitoring.A review of the quarterly MDS dated [DATE], revealed the BIMS score was unable to be conducted, indicating severe cognition impairment. Further review revealed the resident was at risk for pressure injury.A review of the ICCP dated 1/5/26, revealed a focus area for risk for skin breakdown related to impaired mobility, incontinent. Interventions included air mattress to bed, dated 3/20/23.A review of the vital signs in the EMR revealed a weight of 147.2 pounds dated 3/9/26.A review of the facility provided Unit Wound Rounds form dated 1/12/26 revealed Resident #106 to have a facility acquired upper left buttock wound on 1/5/26, resolved, with a notation for air mattress.4.On 3/6/26 at 10:25 AM, the surveyor observed Resident #151, in bed with the air mattress setting set to 540 pounds.A review of the AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to; muscle weakness; muscle wasting; and chronic pain syndrome.A review of the OSR revealed a PO for air mattress on bed for pressure prevention, discontinued on 11/4/25. There was no active PO for air mattress was listed on the OSR.A review of the quarterly MDS dated [DATE] revealed a BIMS of 8 out of 15, indicating moderately impaired cognition.A review of the ICCP dated 3/1/26 revealed focus areas for: A preference to stay in bed with a gown on and complete a bed bath on shower days;Risk for skin breakdown related to decreased mobility.Interventions for this focus area included air mattress to bed, dated 6/7/22.A review of the vital signs in the EMR revealed a weight of 201.0 pounds dated 3/6/26.A review of a progress note dated 3/5/26 revealed .skin intact. On 3/11/26 at 10:36 AM, the surveyor interviewed the Unit Manager (UM), who confirmed Resident #151 did not have an order for an air mattress. The UM went to Resident #151's room in the presences of the surveyor to confirm the setting on the air mattress was at 540 pounds and stated it says 540. She further stated I think that has to be adjusted. It should be by his weight. The UM also stated the nurses should be signing out an order for placement and function of the air mattress.On 3/13/26 at 9:53 AM, the surveyor interviewed the Director of Nursing (DON). The surveyor made the DON aware of the above concerns for Residents #6, #7, # 106, and #151. The DON stated I'm not sure what happened. If there is a need for an air mattress, it is ordered. We have a template for an air mattress for skin breakdown and wounds. The DON further stated Paying attention to the correct pressure is what's (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missed. Looks like we need to provide education, the nurses check off on the Treatment Administration Record (TAR) to check function. The DON described the purpose of an air mattress as preventative care to improve skin integrity, to prevent wounds, and to improve the quality of life for the residents. The mattress uses alternating pressure to improve blood flow. The DON also stated, it should be set to the patient's weight regardless of the pressure.On 3/13/26 at 2:02 PM, the surveyor presented the findings to the facility administration, in the presence of the survey team.On 3/16/26 at 10:27 AM, the Licensed Nursing Home Administrator (LNHA) stated Resident #151 prefers to have a firm mattress. It is not in his care plan, but it will be. No further information was provided.A review of the In-Service Attendance Sheets dated 1/21/26, 1/22/26, and 1/23/26 for Summary: Air Mattress Weight Calibration Why Does It Matter revealed education provided to nursing and certified nursing assistant (CNA) staff. Education focus areas included:The mattress uses air pressure to float the resident and redistribute weight;If the mattress is set too low the resident will bottom out, increasing pressure on the bony area;If set too high, the surface becomes too firm and loses pressure relief benefits;Identify the resident's weight and adjust the setting to line up to resident's weight;On the monitor, there is a yellow dot/indication of resident's weight.A review of the facility Wound Management policy last reviewed by the facility July 2025 revealedPolicy .to prevent pressure ulcer development in our residents and to plan, implement, and evaluate the effectiveness of wound management.Procedure .A pressure reducing mattress will be placed on every bed. Upgraded wound management mattresses will be placed on resident beds as individually assessed. Definitions.Pressure ulcer risk factor-Examples of risk factors include immobility and decreased functional ability.resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence.Pressure reducing device-Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water, or gel, or other cushions placed on a chair, wheelchair, or bed. Includes pressure reducing, and pressure redistributing devices.A review of the C.N.A. Standards of Care policy last reviewed by the facility September 2025 revealed Procedure .All residents are to be properly positioned with appropriate padding protecting bony prominence. NJAC 8:39-27.1 (a)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure residents were transported from one area of the unit to another in a dignified manner. This deficient practice was identified for 1 of 1 residents (Resident #45) reviewed for dignity and was evidenced by the following. On 3/10/26 at 11:45 AM, during the initial tour of the [NAME] unit, the surveyor observed the Certified Nursing Assistant (CNA) transport Resident #45 in a recliner chair facing backwards from the hallway near room [ROOM NUMBER] to the lounge area across from the nursing station. The surveyor reviewed the electronic medical record (EMR) for Resident #45. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; bipolar disorder (a mental health condition that causes extreme mood swings), chronic pain syndrome (pain that lasts over 3 months), localized edema (swelling in a specific body area), neuralgia (nerve pain) and neuritis (inflammation of the nerve). A review of the most recent quarterly Minimum Data Set ,assessment tool dated 2/27/26, revealed the resident had a Brief Interview for Mental Status score of 15 out of 15, indicating cognitively intact cognition. Further review revealed the resident required a wheelchair for transfers. A review of the individualized comprehensive care plan (ICCP) revealed a focus area with a revision date of 9/11/24, included risk for falls, knee pain, arthritis, ambulatory dysfunction and antidepressant use. The ICCP interventions included assist with transfers as needed, assist to participate in activities of choice, and escort/transport to activities as needed. On 3/10/26 at 11:50 AM, the surveyor interviewed the CNA, who stated residents should be transported forward facing. She further stated that pulling a resident backwards was not the proper way when transporting a resident. The CNA acknowledged she should have turned the resident around. On 3/10/26 at 12:08 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated the proper way to transfer a resident was to push them forward. She further stated they should not be pulled backwards as this was a dignity issue for the resident. On 3/12/26 at 1:07 PM, the surveyor interviewed the Director of Nursing (DON) who stated that staff were expected to transport a resident forward facing due to dignity issues. She further stated that it was for the resident's safety. She acknowledged that the CNA should not have pulled the resident backwards down the hall. On 3/16/26 at 10:27 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, Regional Nurse Consultant, and the survey team, were made aware of the above concern for Resident #45. He further acknowledged that the resident should not be pulled down the hallway backwards. A review of the facility policy Resident Rights implemented on April 2025 revealed.physical and personal environment.to be treated with courtesy, consideration, and respect for your dignity and individuality. Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment .Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. NJAC 8:39-4.1(a)12,16

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to follow up on a physician's recommendation for a gradual dose reduction (GDR) of an antipsychotic medication for 1 of 5 residents (Resident #5) reviewed for unnecessary medications.This deficient practice was evidenced by the following:On 3/6/2026 at 11:32 AM, the surveyor observed Resident #5 sitting in a reclining area in the hallway near the nursing station. The resident had a splint on their left hand/wrist. The surveyor reviewed the electronic medical record (EMR) for Resident #5.A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; major depressive disorder, single episode, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities), Post-Traumatic Stress Disorder (PTSD) (a treatable mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or traumatic events) and Paranoid schizophrenia (a chronic mental disorder defined by intense, irrational delusions and auditory hallucinations, such as believing they are being plotted against or monitored). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 1/16/2026 revealed the resident had a Brief Interview for Mental Status (BIMS) of 00 out of 15, indicating the resident's cognition was unable to be assessed. Further review revealed the resident was receiving antipsychotic medications.A review of the individualized comprehensive care plan (ICCP) revealed a focus area of Risk for falls r/t hx (related to history). psychotropic drug use and difficulty with environment, revision on 4/19/2022, with an intervention of Monitor [identifier redacted] for adverse effects r/t psychotropic med use. A review of the Psychiatric Progress Note (PPN) dated 1/5/2026, revealed ASSESSMENT/PLAN:.2. GDR: Discontinue current Seroquel order. Start Seroquel 25 mg (quetiapine fumarate-antipsychotic medication primarily used to treat schizophrenia) PO (by mouth) q HS (at bedtime) x 7 days then discontinue. A Dose Reduction (GDR) is: recommended, as per above.Medication Consent: Recommendations discussed with facility staff, who will await approval from PCP (Primary Care Physician) and then obtain consent from appropriate decision-maker.A review of the physician order summary revealed a physician's order (PO) quetiapine fumarate Tablet 50 MG, Give 1 tablet by mouth at bedtime (HS) for SCHIZOPHRENIA B/P PER POLICY. Order date 10/8/2025; discontinue date 02/02/2026.A review of the January and February 2026 Medication Administration Record (MAR) revealed the above order was signed as administered as ordered at 9 PM from 1/6/26 to 2/2/26. A review of the progress notes did not reveal documentation the GDR was addressed by the PCP or the resident representative. Further review of the PPNs dated 2/3/2026 revealed the same recommendation as the 1/5/2026 PPN. A review of the Consultant Pharmacist's Monthly report dated 1/13/2026 revealed a note the psych consult dated 1/5/26 recommended GDR: Discontinue current Seroquel order. Start Seroquel 25 mg PO q (every) HS X 7 days then discontinue. Please follow-up with the recommendation and/or documentation. Action Taken: Seroquel d/c (discontinued) 2/3/2026. On 3/13/2026 at 11:18 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who stated the psychiatrist usually sent an email by the next day of their recommendations. She stated as soon as she saw the recommendation she would call the attending physician (AP) to let them know what the psychiatrist was recommending. The RN/UM stated if the AP approved it, she would call the resident representative for consent, and documentation would be done with the consent. She stated it would usually be addressed within the day. The RN/UM further stated the pharmacy consultant sends their report with recommendations to the Assistant Director of Nursing (ADON) who then gave it to the unit managers. She stated the recommendations would then be addressed right away or as soon as possible and that she would expect to see a progress note that it was addressed. At that time, the surveyor and the RN/UM reviewed the PPN note for a GDR on 1/5/26, the progress notes from 1/5/2026, and the MARs. The (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN/UM acknowledged there was no documentation addressing the requested GDR. On 3/13/2026 at 12:57 PM, the surveyor interviewed the Director of Nursing (DON), who acknowledged that a psychiatric recommendation for a GDR and the pharmacy consultant recommendation should be addressed as soon as they were made. She stated she would expect to see documentation that the AP and the resident representative were notified whether they agreed or disagreed with the recommendation in progress note. The surveyor reviewed the psych recommendation from 1/5/2026, the DON stated, it should have been addressed. On 3/13/2026 at 2:02 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA), the DON, the Regional Nurse Consultant, and the [NAME] President of Clinical Services were made aware of the above concerns. No additional information was provided. A review of the policy Psychotropic Medication Policy updated 5/2025 revealed Policy: It is the policy of this facility to ensure Residents only receive psychotropic medication when other nonpharmacological interventions are clinically contraindicated and with gradual dose reduction and behavioral interventions attempted, unless contraindicated .Gradual Dose Reduction: Residents who use psychotropic drugs receive gradual dose reductions, unless clinically contraindicated, in an effort to find an optimal dose of medications, to determine whether continued use of the medication is benefiting the resident or could have dangerous side effects, or to discontinue these drugs.The GDR will be documented in the electronic health record reflecting the date it was attempted, the outcome of the dose reduction attempt and a plan for future evaluation of GDR attempts. N.J.A.C. 8:39-27.1(a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, 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 criminal background check prior to the first day of work for 1 out of 96 employees (Employee #4). This deficient practice was identified for newly hired employee files reviewed since last survey from 10/28/24 and was evidenced as follows:During the facility survey dates of 3/10/26-3/16/26, the survey team reviewed the newly hired employee files since the last survey which revealed the following:For Employee #4, a Certified Nursing Assistant (CNA), with a date of hire (DOH) of 2/28/25 and first day of work as 2/28/25, there was no evidence of a background check prior to the start of employment.On 3/13/26 at 2:02 PM, the survey team presented this finding to the administration team including the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), the Regional Nurse Consultant, and the [NAME] President of Clinical Services. The LNHA could not provide any additional information regarding this finding.A review of the facility Resident Abuse/Neglect Policy and Procedure reviewed by the facility on February 2, 2026, revealed:Purpose: to ensure prevention (of).abuse, neglect, mistreatment, misappropriation of property, or exploitation of any facility resident.Policy: Screening.All prospective employees, will be carefully screened using the following processes to identify potential risk of abuse/neglect of any resident: 2.background check. Employee criminal and other background checks are run on Applicant Safe.ALL staff (licensed and non-licensed) are screened upon hire and on a monthly basis for exclusions.These records will be maintained in the Human Resources Office.A review of the facility Hiring and Recruitment policy, last reviewed by the facility 8/2025, revealed:Policy .The facility will ensure that all employees meet credentialing, background check, and training requirements before performing resident care duties.Purpose .All staff meet New Jersey .background check requirements.Policy Guidelines .All employees must undergo criminal history background checks as required by New Jersey law. Employees may not begin work until required screening procedures are completed and approved. Prior to employment, the facility may conduct: Criminal background checks .The facility shall maintain a personnel file for each employee containing: Background check documentation. Personnel files will be maintained in accordance with state and federal requirements.Responsibility-The Administrator and Human Resources Department are responsible for ensuring that hiring procedures comply with regulatory requirements and that all documentation is maintained appropriately.NJAC 8:39-9.3(b)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to complete a discharge Minimum Data Set (MDS), an assessment tool, as required for 1 of 1 system selected residents with a MDS record over 114 days reviewed (Resident #208), and was evidenced by the following:On 3/11/26 at 11:16 AM, the surveyor reviewed the system selected MDS record over 114 days which revealed Resident #208 was overdue for a MDS assessment. A review of Resident #208's electronic medical record (eMR) revealed that the resident was discharged from the facility on 11/3/25. A review of the residents' MDS assessments revealed the last MDS completed was a quarterly assessment dated [DATE]. There was no assessment completed for the resident's discharge. On 3/11/26 at 1:00 PM, the surveyor interviewed the MDS Coordinator, who confirmed Resident #208 was discharged from the facility on 11/3/25, and there was no completed MDS assessment for the discharge. The MDS Coordinator further stated that a discharge MDS assessment should have been completed. The MDS Coordinator stated that the resident's assessment was missed. On 3/12/26 at 9:31 AM, the Licensed Nursing Home Administrator (LNHA) stated that the facility does not have a policy related to MDS assessments, but the facility follows the Resident Assessment Instrument Users' manual. On 3/16/26 at 10:27 AM, the LNHA, in the presence of the Director of Nursing (DON), Regional Nurse Consultant, and the survey team, acknowledged that there was no discharge MDS assessment completed when the resident was discharged . He further stated that it should have been done and was corrected immediately. NJAC 8:39 - 11.1

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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. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan for a resident with an order for enteral tube feeding. This deficient practice was identified for 1 of 1 resident reviewed for tube feeding (Resident #1), and was evidenced by the following:On 3/6/26 at 11:26 AM, during the initial tour of the facility, the surveyor observed Resident #1 sleeping in their bed. The surveyor observed the enteral tube feeding running at 70 ml/hr (milliliters per hour). The surveyor reviewed the medical record for Resident #1. A review of the admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; dysphagia (difficulty swallowing), gastrostomy (feeding tube inserted directly into the stomach through the abdominal wall to provide nutrition, fluids, and medications), and gastro-esophageal reflux disease without esophagitis (stomach acid flows back up into the esophagus and causes heartburn). A review of the most recent comprehensive Minimum Data Set, an assessment tool dated 12/30/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating severely impaired cognition. A further review of section K swallowing/nutritional status revealed that Resident #1 had a feeding tube on admission. A review of the individualized comprehensive care plan (ICCP) included a focus area with a revision date of 9/19/25, for risk for aspiration related to dysphagia due to a cerebrovascular accident (stroke). The ICCP interventions included; to assist as needed during meals to take small sips of fluids and small mouthfuls of food, assist with feeding only when alert, provide thickened liquids as ordered, and monitor for signs of difficulty tolerating diet consistency. A further review included a focus area with an initiated date of 12/24/25, receiving enteral feedings to meet nutrition and hydration needs. Interventions included administer feeding as ordered, monitoring for intolerance, check residual as ordered, administer flushes as ordered, and maintain NPO (nothing by mouth) status. A review of the Order Summary Report included the following physician orders (PO): A PO, dated 1/9/26, NPO diet, NPO texture, and NPO consistency for diet. A PO, dated 1/26/26, enteral feeding one time a day and take down when the total volume of 1400 ml is completed. On 3/11/26 at 1:21 PM, the surveyor interviewed the Licensed Practical Nurse/ Unit Manager (LPN/UM), who stated care plans were updated or revised every 3 months, annually and as needed when there was a change in the resident's plan of care. The LPN/UM confirmed that Resident #1 was strictly NPO. She acknowledged that the residents care plan should have been updated when the residents diet changed from PO (by mouth) to NPO to ensure proper patient care. She further stated that she missed it and was going to fix it immediately. On 3/12/26 at 1:01 PM, the surveyor interviewed the Director of Nursing (DON), who stated that care plans were updated when there was any change in the resident's care. The DON confirmed that the resident's care plan should have been updated when their diet order changed and tube feedings were started. The DON further stated that it was the responsibility of the unit manager, DON and nursing team to update the care plans. The DON stated that care plans were important because they reflect how to manage the resident's care. On 3/16/26 at 10:27 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, Regional Nurse Consultant, and the survey team, acknowledged that a care plan should be updated when there were any changes in the residents' care. A review of the facility's Care Plans, Comprehensive Person-Centered policy, reviewed March 2025, 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.includes the resident's stated goals upon admission and desired outcomes.reflects currently recognized standards of practice for problem areas and conditions.assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.the interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition. NJAC 8:39-27.1(a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure nursing staff appropriately follow a physician orders (PO) and acceptable standards of clinical practice in accordance with the New Jersey Board of Nursing Statutes. The deficient practice was identified for 1 of 2 residents (Resident #142) reviewed for smoking. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 3/06/2026 at 11:32 AM, during the initial tour of the secured Klockner unit, the surveyor observed Resident #142, dressed, sitting in a wheelchair in the common area by the nurse's station. A review of the facility provided smoking list revealed Resident #142 was a smoker. The surveyor reviewed the electronic medical record (EMR) for Resident #142. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; anxiety disorder, unspecified, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life) and schizoaffective disorder, bipolar type (a chronic mental health condition combining schizophrenia symptoms-hallucinations, delusions, disorganized speech-with severe mood swings, specifically mania and sometimes depression). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 2/25/2026, revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. A review of the individual comprehensive care plan (ICCP) revealed a focus of requires supervision with smoking- resident chooses to smoke inspite of the possible ill effects of smoking. Date Initiated: 01/07/2025. A review of the smoking evaluation dated 9/23/2025, revealed section AA. Entry Question 1. Does resident smoke? A. yes was selected. A review of the physician orders revealed a PO: CIGARETTES AND LIGHTER KEPT BY STAFFS, 5 CIGARETTED TO BE GIVEN ON 7-3 AND 3-11. every day and evening shift. Start date: 2/28/2023. A review of the February 2026 Medication Administration Record (MAR) revealed Licensed Practical Nurse (LPN) #1 had signed the above order as completed as ordered on 6 day shifts. A review of the March 2026 MAR revealed LPN #1 had signed the above mentioned PO as completed as ordered on 6 day shifts, including day shift on 3/12/2026. On 3/12/2026 at 11:33 AM, the surveyor interviewed LPN #1, who stated she was Resident #142's assigned nurse. She stated Resident #142 took their medications every day. She added the resident liked to stay in their wheelchair. The surveyor asked LPN #1 if Resident #142 smoked and the LPN #1 stated she never saw [identifier redacted] smoke. The surveyor asked what her signature abbreviations meant, she stated if she signed it (the MAR), it meant she did it. At that time, LPN #1 reviewed the MARs with the surveyor, she acknowledged and verified her signature abbreviations. She was unable to answer why she had signed the order as being completed on multiple days. On 3/12/2026 at 11:36 AM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM #1), who stated Resident #142 was periodically a smoker. She stated the resident did not smoke every day. RN/UM #1 stated if the MARs were signed as being done, it meant it should have been done. The surveyor made RN/UM #1 aware LPN #1 was unable to speak to being aware the resident smoked or why she was signing the MARS as administering the cigarettes. On 3/12/2026 at 11:58 AM, the surveyor interviewed the Director of Nursing (DON), who stated if nurses signed the MARs they were giving cigarettes 5 per day and 5 per night, they should be giving them. They should not be signing they were, if they were not giving them. The surveyor made her aware of the above mentioned findings. On 3/13/2026 at 2:02 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA), the DON, the Regional Nurse Consultant, and the [NAME] (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	President of Clinical Services were made aware of the above concerns. No additional information was provided. A review of the facility's policy Documentation Policy reviewed 9/2025 revealed Policy: Documentation is a professional tracking to enhance continuity of care. The key goals of sound clinical documentation are to describe information in a way that everyone can understand what is happening to the resident and to enhance continuity of care so that the staff on all shifts and among all disciplines will know what must be carried out to monitor outcomes of care. NJAC 8:39-27.1 (a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure that incontinence care was provided to a dependent resident in a timely manner. This deficient practice was identified for 1 of 10 residents (Resident #147) observed during incontinence care rounds and b.) provide a resident with nail care during activities of daily living (ADL) care. This deficient practice was identified for 1 of 7 residents reviewed for ADL care (Resident #195),This deficient practice was evidenced by the following:1. On 3/11/26 at 7:54 AM, during incontinence rounds with Registered Nurse/Unit Manager (RN/UM) #1, the surveyor observed Resident #147's incontinence brief completely saturated with urine, and yellow urine-like stains on multiple areas on the top sheet. At that time, the surveyor asked RN/UM #1, if she had any concern with the observation. She stated that it was a concern because the resident was soaking wet. RN/UM #1 stated that the resident's incontinence brief should not have been completely soaked, because the other shift (11:00 PM-7:00 AM) just left and the resident should not have been left in this condition. RN/UM #1 further stated that leaving the resident in a soaked incontinence brief put the resident at risk for skin breakdown. The surveyor asked RN/UM #1 when Resident #147's last incontinence care was completed. RN/UM#1 reviewed the Electronic Medical Record (EMR) system in the presence of the surveyor and confirmed the last documented incontinence care was on 3/10/26 at 10:59 PM during the 3:00 PM-11:00 PM shift. RN/UM #1 confirmed that there was no documentation for the resident on 3/11/26 during the 11:00PM-7:00 AM shift for incontinence care. On 3/11/26 at 8:26 AM, the assigned Licensed Practical Nurse (LPN #1) stated that she received report from the 11:00 PM-7:00 AM nurse that the resident was changed and dry. LPN #1 stated, I did not check the resident. On 3/11/26 at 8:31 AM, the assigned Certified Nursing Assistant (CNA #1) stated that she was assigned to Resident #147 and arrived late on the unit. On 3/11/26 at 8:35 AM, during a follow up observation with CNA #1 and LPN #1 revealed Resident #147's top sheet had yellow colored urine like stains and the surveyor noted a very strong urine odor. Resident #147 was soiled with urine and feces, and urine and feces stains were observed on the bed padding and fitted sheet. On 3/11/26 at 8:45 AM, during a follow up interview with the surveyor, LPN #1 confirmed that the resident was completely soiled with urine and feces, the bed padding was soaked through, and the resident's fitted sheet had urine and feces on it. LPN #1 stated that the resident should not have been soaked through with urine and feces because it could cause skin breakdown. LPN #1 stated that the resident was there for care and needed help from staff. LPN #1 further stated that the previous shift should have taken care of the resident and done the care, including changing the resident's linen. On 3/11/26 at 11:35 AM, the surveyor tried to reach the assigned CNA (CNA #2) on the 11:00 PM-7:00 AM shift via telephone and got no response. On 3/11/26 at 11:37 AM, the surveyor interviewed the assigned nurse on 11:00 PM-7:00 AM shift, LPN #2, via telephone. When the surveyor asked LPN #2 if the resident should have been saturated with urine and feces, she stated, No, the resident should not have been left saturated with urine and feces, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that shows that the previous shift did not do their job. LPN #2 further stated that if the resident was not changed in a timely manner, resident could have skin breakdown. LPN #2 stated CNA #2 did not answer the call light multiple times and she had to remind the CNA that the residents needed to be changed. The surveyor reviewed the electronic medical record (EMR) for Resident #147. A review of the Resident's admission Record (AR) (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; Type 2 Diabetes, Muscle weakness, difficulty walking, Elevated white blood cell count, Hyperlipidemia (high levels of fat in the blood), Depression, Anxiety Disorder, and Hypertension (high blood pressure). A review of the resident's Annual Minimum Data Set, (MDS), an assessment tool used to facilitate the management of care, dated 2/18/26, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated the resident was severely cognitively impaired. A further review of the resident's MDS, revealed that the resident was Dependent (Helper does ALL of the effort) on assistance for toileting. A review of the Individual Comprehensive Care Plan (ICCP) revealed a Focus: Risk for skin breakdown r/t (related to) . left trochanter (hip) 3 surgical incisions proximal to distal, Initiated on 2/11/26, Revised on 3/8/26, .Interventions: Offer/assist with toileting during care, before/after meals and activities, and at HS (night); Provide prompt incontinence care. Initiated on 2/11/26. On 3/13/26 at 10:38 AM, the surveyor interviewed the Director of Nursing (DON) who stated the expectation was for all 3 shifts was to do rounding on residents, to change the residents if soiled at least two times each shift, and as needed. The DON stated, No resident should be saturated and soiled like that at all. The Nurse should have reported concerns to the supervisor. The CNA should have provided care to the resident to prevent skin breakdown and if the CNA had difficulty, she should have called the nurse for assistance. When the surveyor asked the DON what the expectation for documentation for Resident #147, she stated that the expectation was for incontinence care to be completed it when care was provided. 2.On 3/6/26 at 11:40 AM, during the initial tour of the Klockner unit, the surveyor observed Resident #195 in the main area, across from the nurse's station. The surveyor noted the residents' nails to be long on both hands, with a black substance under the right thumb and index finger. The surveyor reviewed the electronic medical record (EMR) for Resident #195. A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions), Alzheimer's Disease (unspecified a brain disorder that slowly destroys memory and thinking skills) and hemiplegia (total paralysis)and hemiparesis (weakness) following cerebral infarction (a stroke) affecting left non-dominant side. A review of the annual MDS dated [DATE], revealed the resident had a BIMS of 9 out of 15, indicating the resident was moderately cognitively impaired. Further review revealed the resident was dependent on ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the ICCP revealed a focus of potential for adverse effects r/t (related to) psychotropic med use r/t dx (diagnosis) dementia with psychosis and depression. [identifier redacted] has episodes of combative behaviors during ADL care. Revision on: 2/1/23 with Intervention of allow [identifier redacted] time to calm down. Revisit to provide needed care when combative during ADLS. A review of the order summary report revealed a physician's order (PO) to ensure that nails are clean, trim, and filed as needed. every day shift every Tue for Provision of good nail care, dated 11/29/22. A review of the March 2026 Treatment Administration Record (TAR) revealed the above PO was signed as being completed as ordered by Licensed Practical Nurse (LPN) #3 for the day shift on 3/12/2026. On 3/11/2026 at 7:46 AM, during incontinence rounds with RN/UM #2, the surveyor requested RN/UM #2 to look at the resident's nails, noting both hands had long fingernails, and the right hand thumb and index fingernail had a black substance under them. The surveyor made RN/UM#2 aware of the observation during the initial tour on 3/6/2026. RN/UM #2 acknowledged the nails should not be that long and that nails should be cut and cleaned everyday as needed. At that time, Certified Nursing Assistant (CNA) #3 entered the room with the resident's breakfast tray. CNA#3 confirmed he was the residents assigned CNA and that he was the assigned CNA resident yesterday. CNA#3 stated AM care included bathing, washing hair and doing the residents nails. The surveyor asked if he did the residents nails yesterday, he stated No, the resident was resistant to care. The surveyor asked what he should he have done, he stated, I should have reported it, but it slipped my mind. On 3/12/26 at 11:33 AM, the surveyor interviewed LPN #3, who stated she was Resident #195's assigned nurse. She stated the if she saw the resident needed their nails done, she would let the CNA know immediately. She stated if a resident refused it, it would be documented. In the presence of the surveyor, LPN #3 reviewed the TARS and acknowledged she had signed nail care was done on 3/10/2026 for the day shift. She stated if she signed it (the TAR), she did it. The surveyor made her aware of the observation with RN/UM#2 on 3/11/26 of Resident #195's nails. LPN #3 could not explain why she had signed the nail care was completed. On 3/12/26 at 11:36 AM, RN/UM #1 reviewed the EMR in the presence of the surveyor. She acknowledged if LPN #3 had signed the TARS on 3/10/26, then yes, she should have done nail care. RN/UM #2 reviewed the progress notes and verified that LPN #3 did not document that Resident#195 refused nail care. On 3/12/26 at 11:52 AM, the surveyor interviewed the Director of Nursing (DON), who stated nail care was a standard of care and was part of daily care. The surveyor made the DON aware of the above observations on 3/6/26 and 3/11/26. The Director of Nursing reviewed the TARS in presence of surveyor and stated if it was signed, it meant it was done and if it wasn't there should be a progress note as to why it was not. On 3/13/2026 at 2:02 PM, during a meeting with the survey team, the licensed Nursing Home Administrator, the DON, the regional Nurse Consultant, and the [NAME] President of Clinical Services were made aware of the above concerns. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided. A review of the facility's policy Activities of Daily Living (ADLS), Supporting reviewed 3/2025 revealed Policy: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . c. elimination (toileting).4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate. A review of the facility's policy Documentation Policy reviewed 9/2025 revealed Policy: Documentation is a professional tracking to enhance continuity of care. The key goals of sound clinical documentation are to describe information in a way that everyone can understand what is happening to the resident and to enhance continuity of care so that the staff on all shifts and among all disciplines will know what must be carried out to monitor outcomes of care .Where It Will Be Documented revealed, All documentation will be documented in the Electronic Health Record (HER) which in this facility is [name redacted]. A review of the facility's C. N. A Standards of Care reviewed 9/2025, revealed Procedure:.21. All resident's' nails to be maintained clean, trimmed and checked weekly with showers .29. As a guide check every incontinent resident every two hours while awake and check/change at night & change as needed; 30). Residents should be rounded on and checked within 1-2 hours of shift for need of incontinence care. NJAC 8:39-27.2 (g)(h)

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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, interviews, record review, and review of facility documents, it was determined that the facility failed to ensure tracheostomy (a surgical opening directly into the trachea (windpipe) used to assist breathing) care was completed using sterile technique per facility policy and clinical guidelines. This deficient practice was identified for 1 of 4 residents (Resident #46) reviewed for respiratory care and was evidenced by the following:On 3/11/26 between 10:20 AM and 10:37 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform tracheostomy care for Resident #46. During that time, the LPN was first observed performing hand hygiene, then placing a nonsterile drape over a bedside table. She was then observed opening and placing a tracheostomy care kit on the drape. She then opened a packet of 4x4 sterile gauze and a disposable inner cannula and placed them onto the drape. The LPN then used two single use sterile saline containers and emptied their contents into the open packet of sterile gauze. The LPN then reached into the packet (with bare hands) and pulled out the sterile gauze, then placed the saline soaked gauze into the tracheostomy care kit's basin. A packaged pair of sterile gloves were noted inside the tracheostomy care kit, the LPN's hands remained ungloved throughout the preceding preparations. The LPN then went to the treatment cart and retrieved a box of nonsterile exam gloves and a packet of sterile gauze and placed them onto the draped bedside table. The LPN performed hand hygiene, donned a pair of gloves from the nonsterile box, then wiped the resident's tracheostomy site with the gauze from the tracheostomy kit's basin. The LPN removed the resident's tracheostomy inner cannula and disposed of the cannula. She removed her gloves and threw them away. She then performed hand hygiene. The LPN donned a pair of nonsterile gloves from the box, opened a new sterile gauze packet and removed the gauze to dry the resident's tracheostomy site, then she removed the gloves and performed hand hygiene. The LPN put on a set of clean gloves from the box, placed the new inner cannula and placed a sterile slit-gauze at the resident's tracheostomy site. The packaged sterile gloves were noted to be inside of the tracheostomy care kit and remained unused.The surveyor reviewed the medical record for Resident #46. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; autistic disorder, aphagia (inability to swallow), unspecified asthma, and chronic obstructive pulmonary disease (lung condition characterized by airflow obstruction) with acute exacerbation.A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 1/9/26, revealed the resident had a Brief Interview for Mental Status score of 99, which indicated that the resident's cognition was severely impaired and was rarely/never understood. A further review revealed the resident was dependent on staff for activities of daily living and required tracheostomy care.A review of the individual comprehensive care plan (ICCP) included a focus area, dated 1/27/22, that the resident was at risk for complications related to having a tracheostomy. Interventions included monitoring skin integrity and performing tracheostomy care every shift.A review of the Order Summary Report (OSR), included the following physician orders (PO):A PO, dated 2/12/26, for tracheostomy, every shift.A PO, dated 2/13/26, for oxygen, 2 liters per minute via Trach collar, every shift.A PO, dated 2/12/26, for tracheostomy care, every shift.A PO, dated 2/12/26, for suctioning, as needed for increased secretions.On 3/13/26 at 11:17 AM, the surveyor interviewed the LPN who stated that nursing carried out respiratory care every shift as ordered by the physician and that staff were in-serviced on the procedure. When asked if tracheostomy care required aseptic (sterile) technique the LPN replied yes, it did. She further stated that the sterile gloves in the kit should be used when performing tracheostomy care. The LPN stated they did not remember if they had used the sterile gloves from the kit during care. The surveyor then asked the LPN why maintaining sterility and using aseptic technique was important for a ventilated patient during tracheostomy care. The LPN replied that they were important measures used to prevent the spread of infections.On 3/13/26 at 10:57 AM, the surveyor interviewed the Unit Manager (UM), who stated that nursing was responsible for carrying out (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respiratory orders and were recently in-serviced by the facility. When asked what gloves should be used during tracheostomy care, the UM stated staff should use the ones provided in the tracheostomy care kit, the sterile gloves. When asked if any nonsterile items should be placed onto the sterile field during care the UM stated no, that aseptic technique should be used to minimize the risk of infection for a ventilated resident.On 3/13/26 at 1:15 PM, the surveyor interviewed the Director of Nursing (DON). When asked how the facility makes sure nurses were competent in tracheostomy care, the DON replied that the facility recently had tracheostomy care education taught by a respiratory therapist, competencies were done yearly and the procedure was taught during orientation. When asked if tracheostomy care would be considered a clean or sterile procedure and if any aseptic technique should be used, the DON replied that the procedure was sterile because of the airway and it had to be very particular for infection control, she stated that the sterile gloves inside of the tracheostomy care kit should be used and that nonsterile items should not be placed onto the sterile field.On 3/13/26 at 2:02 PM, the surveyor made the Licensed Nursing Home Administrator (LNHA) aware of the concerns that were identified with the resident's tracheostomy care.A review of the facility's undated Tracheostomy Care policy .Procedure for Changing Disposable Inner Cannula: 1. Wash hands and explain procedure to the patient. 2. Confirm the patient's identification using two identifiers. 3. Gather equipment: sterile disposable inner cannula, sterile suction catheter, sterile container, sterile gloves, sterile water, trach ties, drain sponge, sterile cotton applicators. 4. Put sterile gloves on.12. Using aseptic technique, cleanse the stoma site with the hydrogen peroxide, rinse with sterile water and dry it with a sterile 4x4 dressing.It is recommended infection control practice that trach care be performed on each shift.NJAC 8:39-27.1(a)

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	03/16/2026

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview, record review, and review of facility documents, it was determined that the facility failed to evaluate the performance of Certified Nursing Assistants (CNAs) on an annual basis.This deficient practice was identified for five (5) of five (5) CNAs whose randomly selected employee files were reviewed and was evidenced by the following:On 3/11/26 at 9:34 AM, the surveyor requested the education and performance reviews for five (5) randomly selected CNAs.The surveyor reviewed the education provided by the facility for the five (5) CNAs. No performance evaluations were provided.On 3/11/26 at 11:10 AM, the performance evaluations were requested from the Licensed Nursing Home Administrator (LNHA) who could not provide them.On 3/13/26 at 12:00 PM, the performance evaluations were requested from the Human Resources Director (HRD) who could not provide them.03/13/2026 at 12:16 PM, the HRD stated to the survey team There are no performance evaluations for the last year for CNAs because they are unionized. There are also no facility policies for performance evaluations.A review of the facility Hiring and Recruitment policy, last reviewed by the facility 8/2025, revealed:Policy Guidelines, Personnel Records-The facility shall maintain a personnel file for each employee containing.Performance evaluations.Personnel files will be maintained in accordance with state and federal requirements. NJAC 8:39-43.17 (b)

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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, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure medications were administered to a resident according to standards of practice. This deficient practice was identified for 1 of 36 (Resident #9) residents reviewed and was evidenced by the following:On 3/6/26 at 1:30 PM, the surveyor observed Resident #9 lying in their bed, awake, eating their lunch which was on their overbed table. The surveyor observed a medication cup with two (2) unidentified medication tablets in it, on the overbed table. At that time, the surveyor requested the Licensed Practical Nurse/Unit Manager (LPN/UM) come to the room. The LPN/UM acknowledged that in the medication cup there were two tablets: one pink and one white. At this time, the resident stated that they thought they took all their medications. The LPN/UM stated that the nurse should stay with the resident when administering their medications to ensure that they took all of them. She further stated that the nurses should never leave medications at the resident's bedside. On 3/6/26 at 1:45 PM, the surveyor interviewed the Registered Nurse (RN) who stated Resident #9 stated to her that they were going to swallow the medications. She acknowledged that medication should never be left at the resident's bedside unattended. The surveyor reviewed the electronic medical record (EMR) for Resident #9. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; primary open-angle glaucoma (eye disease that causes vision loss), bilateral ocular hypertension (pressure inside the eye is higher than normal), and end stage renal disease (kidney failure). A review of the most recent quarterly Minimum Data Set, an assessment tool dated 1/28/26, revealed the resident had a Brief Interview for Mental Status score of 15 out of 15, indicating cognitively intact cognition. Further review revealed the residents' vision was highly impaired. A review of the March 2026 Order Summary Report, included the following Physician's Order's (PO): Abilify tablet 10mg PO (administered by mouth) one time a day for delusional disorders (mental disorder in which a person has delusions) at 1400, dated 10/16/25 and nephro vitamins tablet 0.8mg PO one time a day for supplement at 1400, dated 5/3/25. A review of the March 2026 Medication Administration Report (MAR) revealed the RN signed the electronic medication administration record (eMAR) for all medications scheduled for 1400 (2:00pm) indicating they were administered as ordered by the physician. On 3/16/26 at 10:27 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON), Regional Nurse Consultant, and the survey team, was made aware of the above concern for Resident #9. He acknowledged that the resident's medication should never be left at their bedside and that the nurse should observe the resident taking the medication. He then stated the nurse thought the resident swallowed all the medications. A review of the facility policy Administration Procedures for All Medications reviewed 9-25 revealed.medications will be administered in a safe and effective manner. The guidelines in this policy apply to all medications. NJAC 8:39-29.2(d)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure a medication error rate below 5%. This deficient practice was identified for 2 of 5 residents (Resident #2 and #197) on 2 of 4 units. The surveyor observed 2 nurses administered 28 doses of medication and there were 2 errors resulting in a medication error rate of 7.14%. The deficient practice was evidenced by the following: 1.On 3/11/26 at 8:55 AM, during the morning medication administration pass, the surveyor observed the Licensed Practical Nurse (LPN #1) on the Klockner Unit, preparing the medications (meds) for Resident #2 using the electronic Medication Administration Record (eMAR) while pulling the medications. The surveyor observed an order for one tab of sennosides-docusate sodium 8.6 -50 mg for constipation. At that time, LPN #1 pulled Geri-Kot (Senokot) 8.6 mg one tab and stated, this is the only one we have at the facility and then administered the medication to Resident #2 (ERROR #1). The surveyor reviewed the electronic medical record (EMR) for Resident #2. A review of the admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; anemia (a shortage of healthy red blood cells or hemoglobin, which prevents the body from getting enough oxygen), pain in joint and constipation (a condition in which a person has uncomfortable or infrequent bowel movements). A review of the Order Summary Report (OSR) included the following physician's order(PO):sennosides-docusate sodium Tablet 8.6-50 mg- give one tablet by mouth one time a day for constipation. On 3/11/26 at 2:41 PM, during an interview with the surveyor, LPN #1 stated Senokot was a stool softener and sennosides-docusate was a combination of stool softener and a laxative. LPN #1 acknowledged she administered Senokot to Resident #2. On 3/11/26 at 2:47 PM, during an interview with the surveyor, the Registered Nurse/ Unit Manager (RN/UM) stated the nurse brought it (the above-mentioned concern) to her attention. On 3/13/26 at 9:35 AM, during an interview with the surveyor, the RN/UM stated LPN #1 should have performed three checks prior to med administration. The RN/UM stated the three checks were important because the nurses need to know the route, the dose and need to make sure the nurses were giving the right medication to the right patient. The RN/UM acknowledged that LPN #1 did not follow the five rights during med administration. The RN/UM stated if the order said 8.6-50 mg in the order and the bottle had only 8.6 mg, the LPN #1 should not have given the medication. 2.On 3/11/26 at 9:29 AM, the surveyor observed LPN #2 on the [NAME] Unit, preparing the meds for Resident #197 using the eMAR while pulling the medications. The surveyor observed an order for two tabs of sennosides-docusate sodium 8.6 -50 mg for constipation. At that time, LPN #2 pulled Geri-kot (Senokot) 8.6 mg two tablets and then administered them to Resident #197 (ERROR #2). The surveyor reviewed the EMR for Resident #197. A review of the AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to; muscle weakness and essential hypertension (high blood pressure). A review of the OSR included the following PO:senna plus 8.6-50 mg (Sennosides-Docusate Sodium) - give two tabs by mouth two times a day. On 3/11/26 at 2:22 PM, during an interview with the surveyor, LPN #2 confirmed that she had administered geri-kot (Senokot) to Resident #197 in the morning. LPN #2 further stated, senna plus and Senokot were both the same thing and both meds had 8.6 mg. On 3/11/26 at 2:31 PM, during an interview with the surveyor, LPN/UM stated the process during med administration was to perform three checks to make sure the meds are correct for the patient. The LPN/UM stated it was important to review POs prior to med administration to make sure that we were not giving wrong meds or wrong doses to the residents. The LPN/UM stated the difference between the senna plus and Senokot was that the Senokot did not have docusate in it. The surveyor made the LPN/UM aware of the above-mentioned concerns for Resident #197. The LPN/UM acknowledged that it was a med error. On 3/13/26 at 11:25 AM, during an interview with the surveyor, the Director of Nursing (DON) stated the expectation from the nurses during med pass was to identify (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents, review and ensure what was ordered and what was available to administer. The DON stated the nurses should verify the meds prior to administration. The DON stated Senna and Senokot were two different meds and further stated the nurses should have held the medication if it was not available. The surveyor made the DON aware of the above-mentioned concerns for Resident #2 and #197 from the med pass error observation. On 3/13/2026 at 2:02 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator, the DON, the Regional Nurse Consultant, and the [NAME] President of Clinical Services were made aware of the above concerns. No additional information was provided. A review of the policy Administration Procedures for All Medications reviewed 9/2025 revealed Policy: Medications will be administered in a safe and effective manner. The guidelines in this policy apply to all medications. Under section Procedures: III. 5 rights (at a minimum) At a minimum, review the 5 rights at each of the following steps of medication administration. 1. Prior to removing the medication package/container from the cart/drawer: a. Check the MAR/TAR for the order. 2. Prior to removing the medication from the container: a. Check the label against the order on the MAR. NJAC 8:39-11.2(b), 29.2(d)