STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Hills Post Acute Hamilton	3 Hamilton Health Place Hamilton, NJ 08690

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45622 Complain #: NJ171631 Based on interview and record review on 05/13/2024 and 05/14/2024, it was determined that the facility failed to accurately encode a resident's wound in the Minimum Data Set (MDS) assessment for 1 of 5 residents (Resident #2) reviewed for MDS accuracy. This deficient practice was evidenced by the following: Reference: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 October 2023, under Section M: Skin Conditions . M0210 Unhealed Pressure Ulcers/Injuries .Coding Instructions Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days. Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers. Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Coding Tips If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury. Under DEFINITIONS STAGE 1 PRESSURE INJURY An observable, pressure related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters .persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues. NON-BLANCHABLE Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device. The surveyor reviewed the closed medical record for Resident #2: According to the Admission Record, Resident #2 was admitted to the facility with medical diagnoses that included but were not limited to End Stage Renal Disease (gradual loss of kidney function), Major Depressive Disorder, Difficulty in Walking and Anemia (deficiency of red blood cells in the blood). (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/07/2023 indicated that Resident #2 had a BIMS (brief interview for mental status) score of 13 indicating the resident was cognitively intact. The MDS further indicated under Section M (used to assess skin condition during a 7-day look-back period), M0150 is this resident at risk of developing pressure ulcers/injuries Indicated No. M0210, Unhealed Pressure Ulcers/Injuries indicated that the Resident did not have a pressure ulcer. Review of Resident #2's Admission Evaluation assessment dated [DATE], under diagram revealed the resident was admitted with a Sacral wound with slough. Review of facility documentation showed on 12/5/2023 Resident #2 was seen by the Wound Care for Sacral Ulcer. During the interview with the Surveyor on 05/13/2024 at 2:18 P.M., the Unit Manager/Licensed Practical Nurse (UM/LPN) confirmed Resident #2 was admitted to the facility with sacral ulcer. During the interview with the Surveyor on 05/14/2024 at 10:36 A.M, the MDS Coordinator (MDSC) confirmed that previous MDS staff (who no longer work in the facility) miscoded the 12/07/2023 assessment, Section M. She further stated the MDS should have reflected that Resident #2 had a sacral ulcer. The Surveyor attempted to reach the previous MDS coordinator but was unsuccessful. The job description for Care Navigator/MDS Coordinator Job Description, undated, indicated Duties and Responsibilities Conducts patient assessments to determine the patient's prior level of function to establish patient centered goals, treatment plans that focus on recovery and discharge planning. Review of the facility policy titled Comprehensive Assessment, dated 04/2023, indicated Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. NJAC 8:39-11.2(e)(1)

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NAME OF PROVIDER OR SUPPLIER: Spring Hills Post Acute Hamilton		STREET ADDRESS, CITY, STATE, ZIP CODE: 3 Hamilton Health Place, Hamilton, NJ 08690	

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45622 Complaint #: NJ 171631 Based on interview, medical record review, and review of other pertinent facility documentation on 5/13/2024 and 5/14/2024, it was determined that the facility failed to develop a Baseline Care Plan (BCP) for a newly admitted resident with a Sacral wound. This deficient practice was identified for Resident #2, 1 of 5 residents reviewed for BCP. This deficient practice was evidenced by the following: The surveyor reviewed the closed medical record for Resident #2: According to the Admission Record, Resident #2 was admitted to the facility with medical diagnoses that included but were not limited to End Stage Renal Disease (gradual loss of kidney function), Major Depressive Disorder, Difficulty in Walking and Anemia (deficiency of red blood cells in the blood). Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/07/2023 indicated that Resident #2 had a BIMS (brief interview for mental status) score of 13 indicating the resident was cognitively intact. Review of Resident #2's Admission Evaluation Assessment revealed the resident was admitted with a Sacral wound with slough. Review of facility documentation revealed there was no BCP initiated for Resident #2 upon admission to address Resident #2's Sacral wound. During an interview with the Surveyor on 5/13/2024 at 1:3 P.M, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that Resident #2 should have had a BCP in place for their sacral wound. The LPN/UM continued that all newly admitted residents should have a BCP upon admission. During an interview with the Surveyor on 5/13/2024 at 2:18 P.M., the Director of Nursing (DON) stated the BCP is a roadmap to the resident so that all parties (departments) know the care of the resident. The DON continued to say, if a resident is admitted with a pressure ulcer, the admitting nurse will put in a wound consult, document the wound, obtain treatment for the wound and initiate a BCP with all appropriate interventions. When presented with Resident #2's CP, the DON acknowledged there was no BCP initiated upon admission. During the survey, the Surveyor attempted to reach the admitting nurse for Resident #2 but was unsuccessful. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Care Plans-Baseline with a revised date of 04/2023, indicated under Policy Statement that, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The facility policy continued under Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. physician orders; c. Dietary orders; d. Therapy orders. NJAC 8:39-11.2(d).

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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 45622

Complaint #: NJ171631

Based on interview, observation, record review, and facility policy reviewed on 5/13/2024 and 5/14/2024, it was determined that the facility failed to provide 1 of 5 residents (Resident #2) reviewed for Activities of Daily Living (ADLs) with showers twice a week as scheduled. The Certified Nursing Aide (CNA) also failed to follow their job description.

This deficient practice was identified for Resident #2, and was evidenced by the following:

The surveyor reviewed the closed medical record for Resident #2:

According to the Admission Record, Resident #2 was admitted to the facility with medical diagnoses that included but were not limited to End Stage Renal Disease (gradual loss of kidney function), Major Depressive Disorder, Difficulty in Walking and Anemia (deficiency of red blood cells in the blood).

Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/07/2023 indicated that Resident #2 had a BIMS (brief interview for mental status) score of 13 indicating the resident was cognitively intact. The MDS also indicated the resident needed partial/moderate assistance with ADL.

Review of Resident #2's comprehensive Care Plan (CP), identified that Resident #2 has a self -care performance deficit. A CP Intervention. indicated, Bathing/Showering: Assist-one.

Review of the facility Documentation Survey Report v2 (DSR) dated for December 2023, and January 12th 2024, revealed Resident #2's shower days were on Wednesdays and Saturdays during the 7:00 A.M to 3:00 P.M. shift.

Review of Resident #2's December 2023, DSR, indicated no shower was provided on 12/02/2023 (Saturday), 12/09/2023 (Saturday), December 16,2023 (Saturday), December 20,2023 (Wednesday) and December 30, 2023 (Saturday).

Review of Resident #2's January 2024 DSR, indicated no shower was provided on 1/10/2024 (Saturday).

Review of Resident #2's Progress Notes (PNs) dated for December 2023 through January 2024, revealed no documentation for refusal of shower on the aforementioned dates.

During a telephone interview on 5/14/2024 at 12:26 P.M., with the Certified Nuring Assistant (CNA) assigned to Resident #2, she stated, the CNAs were responsible to provide showers to all residents twice weekly on their scheduled shower days. The CNA stated that if the ADL sheet was left blank, then more than likely I did not do the showers. She further stated, sometimes the resident (Resident #2) would refuse their shower. When asked if refusal should be documented, she said Yes, if a resident refuses shower, we (CNAs) should document refusals in the Point of Care (POC) and also inform the nurse.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/2024 at 11:43 A.M., the Licensed Practical Nurse/Unit Manager (LPN/UM), revealed the CNAs were responsible to provide shower to the residents twice weekly on their scheduled shower days, and document in the POC. She confirmed blank spaces on the POC will indicate the task was not completed. The LPN/UM said the expectation is for all task to be completed and documented daily. During an interview on 5/13/2024 at 2:18 P.M., the Director of Nursing (DON) stated her expectation is for all task and documentation to be completed daily by the CNAs. She further stated blank spaces on the POC will indicate the task was not done. When asked by the Surveyor about the blank spaces on Resident #2's DSR, the DON said, technically there should be no blanks on the POC. During the exit conference on 5/14/2023 at 2:26 P.M., the DON in the presence of the Administrator and Nursing Consultant confirmed Resident #2 shower days were Wednesday and Saturdays on the 7:00 A.M. to 3:00 P.M., shift and acknowledged the blank spaces. Post survey, an email was sent by the Administrator on 5/15/2024 containing a written statement dated 5/14/2024 from the CNA previously interviewed by the Surveyor during the survey. The statement revealed: I recall having Resident #2 as an aide during their stay at Spring Hills [NAME]. Resident #2 did refuse showers often during his/her stay here and would (I) give her bed baths at his/her request. I recognize that I should've documented all the care that I performed in POC. However, there was at no time I did not provide care as scheduled and as needed at the resident's request. Review of the facility's policy titled; Bathing and Showering, dated 04/2023, under Policy indicated: The facility will offer showers and tub baths to residents in accordance with their preferences. Under Policy Interpretation and Implementation, indicated: 1. The facility will offer showers and tub baths to residents twice per week. 4. Provision and refusals of shower and or tub baths will be documented in the medical record by the certified nursing assistant and /or licensed nurse. Review of the facility undated job description for Certified Nursing Assistant under Purpose revealed: The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors. Under Duties and Responsibilities Assist residents with bath functions (i.e., bed bath, tub, or shower, etc) as directed. NJAC 8:39-27.2(i)