New Jersey Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		15A101	B. WING		04/01/2024	
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
SPRING O	SPRING OAK OF TOMS RIVER 2145 WHITESVILLE ROAD TOMS RIVER, NJ 08755					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
A 000	Initial Comments		A 000			
	Initial Comments: TYPE OF SURVEY: COMPLAINT #: NJ00	•				
	CENSUS: 80					
	SAMPLE SIZE: 3					
	all of the standards in Administrative Code & Licensure of Assisted Comprehensive Perso Assisted Living Progra submit a plan of corre completion date for ea that the plan is implem	3:36, Standards for Living Residences, conal Care Homes and cams. The facility must ection, including a cach deficiency and ensure mented. Failure to correct cult in enforcement action in isions of New Jersey Fitle 8, Chapter 43E,				
A 310	1. Ensuring the d	or designee shall be ot limited to, the following:	A 310			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

C

C

15A101

CTREET ADDRESS CITY STATE 7D CORE

		15A1U1	2:9		04/01/2024			
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE				
SPRING OAK OF TOMS RIVER			2145 WHITESVILLE ROAD					
			RIVER, NJ 08755					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETE E DATE			
A 310	Continued From page	e 1	A 310					
	by: Complaint: NJ001457 Based on interview a policies and procedur the facility failed to er policy for Security of according to state reg for 1 out of 3 resident	ris not met as evidenced r92 and review of the facility's res it was determined that asure that a comprehensive the facility was developed gulations and implemented as reviewed, Resident #1.						
	who moved in the fact diagnoses which included a support of the further review of the Nurses Notes dated	record (MR) of Resident #1 ility on W ex order 26.4b1 with						
	pendants transmit to and to the front desk. the Receptionist at th 8:00 p.m., when the f front desk phone call	eyor interviewed the D) who stated that the call pagers that the aides carry The ED further stated that e front desk is there until ront door is locked and the sare forwarded to a cell ed Medication Aide or						

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			756.256		c	
		15A101	B. WING		04/01/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
SPRING C	OAK OF TOMS RIVER		ITESVILLE ROAI VER, NJ 08755)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
A 310	Continued From page	2	A 310			
	Licensed Practical Nu	ırse carries.				
	asked if the facility had details the process the	eyor interviewed the ED and s a security policy that e facility takes to secure the y of the residents, the ED				
A 779	8:36-7.5(c) Resident A	Assessments and Care	A 779			
	called at the onset of condition of any resid assessment of the res	sident's nursing care needs for needed nursing care				
	This REQUIREMENT by: Complaint: NJ001457	is not met as evidenced				
	determined that the fadocumented evidence (RN) was notified who	nd record review, it was acility failed to provide that the Registered Nurse en 1 of 3 residents accordance.				
		record (MR) of Resident #1 ility on NJ ex order ^{26,4b1} with				

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		C	
		15A101	B. WING		04/01/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SPRING C	OAK OF TOMS RIVER		ESVILLE ROA	D		
			ER, NJ 08755			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
A 779	Continued From page	3	A 779			
	NJ ex order 26.4b					
	review of the resident	A further 's MR revealed a physician's				
		for NJ ex order 26.4b1				
	NJ ex order 26.4b	01				
		eview of the Medication				
		for Resident #1, revealed , NJ ex order 26.4b1				
	during the NJ ex or	and again der 26.4b1				
	At 4:05 p.m., the surv					
		urse who confirmed that the N) was not notified that the				
	resident NJ ex orde					
	The facility failed to n	otifiy the RN when Resident				
	#1 NJ ex order 26					
A 963	8:36-11.5(f) Pharmac	eutical Services	A 963			
		pe accurately administered				
	and documented by prindividuals, in accordance	properly authorized ance with prescribed orders.				
		•				
		is not met as evidenced				
	by: Complaint: NJ001457	'92				
	Based on observation	n, interview, and record				
	review it was determi	ned the facility failed to				
	ensure NJ Ex Order 26.4	(b)(1) was accurately erved by qualified personnel				
	Godinonica ana 005	or tod by quaimed personner				

PRINTED: 02/10/2025 FORM APPROVED New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ С B. WING 15A101 04/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2145 WHITESVILLE ROAD SPRING OAK OF TOMS RIVER TOMS RIVER, NJ 08755 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 963 A 963 Continued From page 4 in accordance with prescriber orders for 1 of 3 residents reviewed for NJ Ex Order 26.4(b)(1) Resident #1. This deficient practice was evidenced by the following: On 4/01/2024 at 12:04 p.m., the surveyor reviewed the medical record (MR) of Resident #1 who moved in the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1 further review of the resident's MR revealed a physician's order dated NJ ex order 26.4b1 A review of the Medication Adminisration Record for Resident #1 revealed on NJ ex order 26.4b1 was documented NJ ex order 26.4b1 and again during the NJ ex order 26.4b1 At 12:55 p.m., the surveyor interviewed the Licesned Practical Nurse (LPN) who confirmed that on Medication Aide, the Certified Medication Aide on NJ ex order 26.4b1 shift reported to her that Resident #1 NJ ex order 26.4b1 . The LPN further confirmed that she documented that

STATE FORM 6899 QP2T11 If continuation sheet 5 of 5

resident NJ ex order 26.4b1

during the NJ ex order 26.4b1

NJ ex order 26.4b1

with the resident or entered the residents room

The facility failed to ensure that Resident #1's

however, she never spoke