New Jersey Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		55a006	B. WING		C 12/29/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE	
			IEAU AVENUE	,	
SPRING H	ILLS MATAWAN	MATAWA	AN, NJ 07747		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
A 000	Initial Comments		A 000		
	Initial Comments: TYPE OF SURVEY: COMPLAINT #: NJ 0	·			
	CENSUS: 56				
	SAMPLE SIZE: 4				
	The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.				
A 749	Plans (a) The resident genereviewed and, if necesemi-annually, and maked upon the residuals.	ore frequently as needed ent's response to the care inges in the resident's	A 749		
	This REQUIREMENT by:	is not met as evidenced			

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 1 2.1.1			A. BUILDING: _			
		55a006	B. WING		C 12/29/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SPRING H	IILLS MATAWAN		AU AVENUE			
	OLIMANA DV. OT		N, NJ 07747	DROWDEDIO DI ANI OF CORRECTIO	N.	
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
A 749	Continued From page	e 1	A 749			
	Complaint #NJ00141	972				
	review, it was determ ensure that the Gene were reviewed and up condition to ensure apwere developed and imanner to address the and behaviors for 1 or Resident #2. This defevidenced by the follow. On 12/29/20 at 10:37 the Move In Record or revealed that the residence was and the second of the s	AM, the surveyor reviewed of Resident #2 which dent was admitted to the				
	Check Note written by	ed a Monthly Wellness y Licensed Practical Nurse ,which revealed that with EX Order 26 § 4b1				
	The surveyor reviewe LPN #2 on that Resident #2	ed a Behavior Note written by at 10:05 PM, which detailed Order 26 § 4b1				
	Note written by LPN #	ed a Monthly Wellness check #4 on West order 28-45, which nt #2 was noted to have Corder 26 § 4b1				
	The resident had incr EX Order 26 § 4b had a telehealth sess					

New Jers	ey Department of Hea	<u>itn</u>				
STATEMENT	OF DEFICIENCIES	(X1) PROV DER/SUPPLIER/CLIA	(X2) MULT PLE	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			· · · · · · · · · · · · · · · · · · ·		_	
		NO SECURICA DE CARACIANO	B WWW		С	
		55a006	B. WING		12/2	9/2020
NAME OF D	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZID CODE		
INAMIL OF F	ROVIDER OR SUFFLIER			IL, ZIF GODE		
SPRING H	IILLS MATAWAN		AU AVENUE			
C.E.A.B.HILLOHIA.		MATAWAN	, NJ 07747			
(X4) ID		ATEMENT OF DEFIC ENCIES	D	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	N. A. C.	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENT FY NG INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	MAIE	DATE
				DET (CIETOT)		
A 749	Continued From page	2	A 749			
		NAME OF THE PARTY				
	and a new o					
	was	obtained.				
		ed an Acuity Documentation				
	Note written by LPN #					
	which revealed that L	PN #1 observed Resident				
	#2 who NJ Ex Order	26.4b1 and was Ex. Order 26.4(b)(1)				
	7/2	Ex.Order 26.4(b)(1)				
	and and re	efused to NJ Ex Order 26.4b1 LPN				
	#1 documented that t	he Director of Resident				
	Care (DRC) and nurs	ing aide assisted the				
		PN #1 documented that the				
		d and she awaited orders.				
	- A-2					
	The surveyor reviewe	ed the NJ Ex Order 26.4b1				
	Medication Administra	ation Record (MAR) which				
	revealed that on	ation Record (MAR) which Resident #2 was				
	ordered EX Order					
	ordered LA Order 2	20 9 401				
	4	Further review of the MAR				
	91.5 (2000) 91.053	dent was medicated with				
		during the month of				
	NJ Ex Order 26.4b1	st dose was administered on				
	- Province at the board and the board.					
	The surveyor reviewe	ed an Acuity Documentation				
		#3 on at 11:21 PM,				
		Resident #2 had an episode				
		became EX Order 26 § 4b1				
	to staff mem	bers, and EX Order 26 § 4b1 in				
	/room on the NJ E					
	resident was EX Order 28 § 4	with the assistance of five				
	staff members.					
	The surveyor reviewe	ed a Transfer to Hospital				
	Summary Note writte	n by LPN #5 on the control at				
		ealed that Resident #2				
	presented with a char					
	documented that the					
		1 NJ Ex Order 26.4b1				
			1			L

PRINTED: 09/18/2023 FORM APPROVED New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) PROV DER/SUPPLIER/CLIA (X2) MULT PLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ С B. WING 55a006 12/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 FRENEAU AVENUE SPRING HILLS MATAWAN** MATAWAN, NJ 07747 SUMMARY STATEMENT OF DEFIC ENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFIC ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENT FY NG INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 749 A 749 Continued From page 3 frame and tried to NJ Ex Order 26.4b1 was medicated with and called. The surveyor reviewed a Return from Hospital/Rehabilitation Summary written by LPN #6 on NJ EX Order 26.4b1 at 3:39 AM, which revealed that Resident #2 returned from the hospital with recommendations for EX Order 26 § 4b1 . LPN #6 documented that the DRC was notified. The surveyor reviewed Resident #2's General Service Plan (GSP) which indicated that the document was initialed on Succeeding and was last reviewed on NJEXOGER 26.451. Further review of the document revealed an entry dated excorder 26 which detailed that the resident had self-care related to EX Order 26 § 4b1 and required the assistance of one care team member for NJ Ex Order 26.4b1 . The document was not updated , to include the resident's change in condition related to behavioral management with related appropriate staff interventions and goals.

At 10:48 AM, the surveyor interviewed the DRC who stated that Resident #2 had experienced a cooler 26 to over the past two months related to with a change in behavior over the past west of the stated that the resident's regular

. She stated that the resident had begun

. She stated that this had been going on

was ordered

consult

behavior included EX Order 26 § 4b1

all over the place and

further stated that

for Resident #2's behaviors, a

over time and did not just happen. The DRC stated that she saw it herself last week. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
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At 1:13 PM, in a later stated that regarding stated that regarding stated that the facility resident GSP's at on were too many to cal Resident #2's GSP were sident's behavioral documented in the P stated that care may in the GSP but a lot have a different goal. The surveyor reviewed "Individualized Service Date: Rev. January of following: Each Resident shall Service Plan which were sident specific care Service Plan shall be resident's level of fur Procedure: A Resident Service Fladmission, then ever in condition or service The Resident Individinclude the coordinate Resident Evaluation Physical. The plan standividuality, personal	resident was treated for a at the control of the resident was treated for a at the control of the resident was treated for a Resident #2's GSP, she will planned to update all the time in January as there in the residual control of the residual planned to updated the residual planned to updated the residual planned to reflect the status but the facility staff regress Notes. She further not have been documented and been done and the GSP and the facility policy, the Plan (ISP)" (Approval 5, 2020) which revealed the receive an Individualized will include a coordination of a redistribution of the receive and service needs. The redesigned to maximize the rectional abilities. Plan shall be developed upon by 180 days or upon a change resident and shall include and Level of Care, History & all support the principles of all dignity, freedom of choice ment and shall include	A 749			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDIEAN	N GOTTLEGHOT	IDENTIFICATION NONBERG	A. BUILDING: _			LD
		55a006	B. WING		C 12/29/	/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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A1187	Continued From page	÷ 5	A1187			
A1187	8:36-17.3(a)(1) Housekeeping-Sanita	ation-Safety-Maintenance	A1187			
	in paragraphs 1 throu Application of this req individual living enviro consideration residen style of living: 1. The facility and surfaces such as table	d its contents, including all les, floors, walls, ers, shall be clean to sight				
	This REQUIREMENT by: Complaint #NJ001419	is not met as evidenced				
	other pertinent facility determined that the fa- carpets, showers and apartments were kept 6 resident apartments	n, interview and review of v documents, it was acility failed to ensure that I all surfaces of resident t clean and homelike for 1 of s, the apartment of Resident ctice was evidenced by the				
	facility's Memory Care a resident who was so hallway. The surveyor Caregiver who identiff #2. The Caregiver sta	chair outside of his/her				

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	OF DEFICIENCIES	(X1) PROV DER/SUPPLIER/CLIA	(X2) MULT PLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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		55a006			12/2	9/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
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	OUR MAR DV OT		<u> </u>	DD0//DEDI0 D/ 44/ 05 00DD507/04		
(X4) ID PREFIX		ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL	D PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		
A 1107	O	. 0	A1187			
A1187	Continued From page	9 0	AIIO			
	and EX Order 26 § 4b1 and re	eferred the surveyor to the				
	resident's assigned n	urse, LPN (Licensed				
	Practical Nurse) #1.	·				
	•					
	At 10:06 AM, the surv	eyor interviewed LPN #1				
	who stated that Resid	lent #2's room was changed				
	after the resident Ex.C	Order 26.4(b)(1). She stated				
	that she was unsure v	when the resident's room				
		nged and the facility planned				
	to change the residen	nt's carpet.				
		when the surveyor entered				
	the apartment that Re					
		hat the surface of the carpet				
		oiled in multiple areas with a that varied in size on the				
		pathroom floor tiles. LPN #1				
	stated that the NJ Ex					
		N-95 mask (respirator that				
		of airborne particles) covered				
		nd face shield was unable to				
	, ,	dor. LPN #1 stated that the				
		room was kept closed to				
		n attempting to enter it				
	because it was	er 26.4b1				
	The surveyor observe	ed that Resident #2's bed				
	•	ere were no sheets or				
		There were multiple articles				
		r, plastic bag that contained				
	~	bed. The surface of the				
	mattress contained multiple NJ Ex Order 26.4b1					
	areas that varied in bo					
		ed a beige chair in Resident				
		piled in multiple areas with a				
		. The surveyor observed a				
	NJ Ex Order 26.4					
	stand that was placed	d beside the chair.				

New Jers	sey Department of Hea	itn				
STATEMENT	FOF DEFICIENCIES	(X1) PROV DER/SUPPLIER/CLIA	(X2) MULT PLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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			B. WING		С	
		55a006	b. WING		12/29/	2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
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SPRING H	IILLS MATAWAN					
	T		I, NJ 07747			
(X4) ID		ATEMENT OF DEFIC ENCIES	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
		•		DEFICIENCY)		
A1187	Continued From page	e 7	A1187			
	The surveyor noted the	hat the tiled floor in Resident				
		everal small areas of a Wexage				
	#20 Butili Com Had Co	. There was a wheelchair				
	narked in the residen	t's walk-in shower. A white				
	•	ed on the floor beneath the				
	_	n rag was soiled with a wexa				
	wheelenan. The wasi	riag was solled with a				
	•					
	At 10:09 AM, the surv	vevor interviewed the				
		ated that she last cleaned				
	•	hree days ago. She stated				
		rpet had been like that since				
		r stated that she reported				
		arpet to her supervisor, the				
		or (HD), and he stated that				
		e stated that the stated that				
		t that she needed to double				
		ident's room. She stated				
		not moved from the room to				
	her knowledge.					
	The Herman et e					
		ated that she was required to				
	_	esident rooms every other				
		ed daily room checks to				
		al cleaning was required in				
		s. She stated that she she				
		nt #2's room yesterday due				
		ugh the room was a mess				
		She stated that she saw				
		er seven days ago and				
		ervisor. She further stated				
	that the resident had	done this once before.				
	At 10:18 AM, in a late					
		who stated that she noted				
		's floor one week ago and				
		t out to the hospital. She				
	further stated that the	e resident's room was				
	changed and the resi	dent had no further				
	NEX Order 20-451 in the new room.					

STATEMENT OF DEFICIENCIES (X1) PROV DER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NUMBER.	A. BUILDING: _		COMITE	LILD
		55a006	B. WING		12/2	; 9/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SPRING H	IILLS MATAWAN		AU AVENUE N, NJ 07747			
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
A1187	Continued From page	e 8	A1187			
	because the resident move everything. Sh resident's preference located in the hall out assigned room. The surveyor attempt who was SX Order 20 when spoker ahead. At 10:25 AM, the surve Resident #2 was reported the room failed to resident's name was entrance of the room that the room failed to resident's personal be the bed was covered were no additional linual At 10:28 AM, the survey Assistant (AA), who is behaviors included required a lot of activities of daily living. The AA stated that Relike that for about a wobserved the resident not to that extent. She past the facility used carpet. The AA stated	moved to the new room did not want the facility to e stated that it was the to sit in the chair that was side of his/her originally ed to interview Resident #2, 6 § 4b1, and resident #2, 7 or entered the room that ortedly moved to. The not displayed outside of the The surveyor observed to contain any of the elongings. The mattress of by a fitted sheet and there ens or pillows on the bed. The veyor interviewed the Activity stated that Resident #2's and the resident The sident #2's and the resident The sident #2's and the resident with g. The sident #2's room had been seek. She stated that she the carpet before, but the further stated that in the an extractor to clean the				
		eyor reviewed the Move In 2 which revealed that the				

New Jers	New Jersey Department of Health							
	OF DEFICIENCIES	(X1) PROV DER/SUPPLIER/CLIA	(X2) MULT PLE CONSTRUCTION		(X3) DATE SURVEY			
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NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE				
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		MATAWA	N, NJ 07747					
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				DEFICIENCY)				
A1187	Continued From page	9	A1187					
	. •							
	resident was admitted	d to the facility in ^{Ex.Order 26.4(b)(1)} of hat included: EX.Order 26 § 451						
	with diagnosis t	nat included.						
	The surveyor reviewe	ed Resident #2's Evaluation						
	and level of care date	ed ^{NJ Ex Order 26.4b1} , that was						
		r of Resident Care (DRC).						
	Review of the docum							
	resident was	d NJ Ex Order 26.4b1						
	The resident was des							
		ne time, demonstrated						
	and was notentially	EX Order 26 § 4b1 , X Order 26 § 4b1						
		urther review of the						
		nat the resident had a normal						
	and no history of	EX Order 26 § 4b1						
								
		ed Resident #2's medical						
		thin the Progress Notes (PN)						
		at 10:05 PM, titled was written by LPN #2, who						
		sident #2 EX Order 26 § 451 all over						
		m. LPN #2 described the						
		ved on the resident's carpet						
	as NJ Ex Order 26							
		plan was to tell the aides to						
	the resident who	o appeared to be NEXON						
	Further review of the	DN revealed an entry dated						
		PN revealed an entry dated I, titled Acuity						
		nich LPN #3 detailed that						
		episode of EX Order 26 § 4b1						
	and would not allow s							
		ırther review of the						
	document revealed th							
		NJ Ex Order 26.4b1 and						
	NJ Ex Orde							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN C)F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPL	ETED
		55a006	B. WING		12/2	; 9/2020
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
SPRING H	IILLS MATAWAN	40 FRENEA MATAWAN	AU AVENUE N.I 07747			
(V4) ID	SUMMARY ST.	ATEMENT OF DEFIC ENCIES	1	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
A1187	Continued From page	2 10	A1187			
	At 10:39 AM, the survi Housekeeping Director Thursday the Housek Resident #2's carpet stated that it happener room but never to that cleaning the rug was that he did not have a detailed when Reside and cleaned or how on the HD stated that Recleaned at least seven was all over the been an ongoing probable the the carpet and then Housed disinfected it during of time the carpet was befurther stated that state Resident #2's old room.	veyor interviewed the or (HD) who stated that last deeper reported that was soiled with				
	who stated that Resid over the past over the past She stated recently hospitalized					
	behaviors included N. She further starecently began to that didn't all just hap saw the condition of the complained about the	JEX Order 26.4b1 Ited that the resident all over the place but pen. She stated that she he resident's room last week room. She stated that she e condition of the room to the D) for at least a month. She				

		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
701012701	or dorate of the transfer of t	ibertii io, iiioit itombert	A. BUILDING: _				
		55a006	B. WING		C 12/29/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS CITY STA	TE ZIP CODE			
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	T	MATAWAN,	NJ 07747				
(X4) ID PREFIX TAG	EFIX (EACH DEFIC ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC				BE COMPLETE		
A1187	Continued From page	e 11	A1187				
	further stated that she clean it.	e was told that the HD would					
	who stated that Reside the room on cleaned. The ED states she saw the condition that at that point it was unable to provide documentation that per room condition and cleaned that there should documentation, but the the DRC stated that last evening on that she went into Re observed that staff she	ed that on stated that the facility est the surveyor with ertained to Resident's #2's leaning schedule. She ald have been here was not. she was called by nursing at 6 PM. She stated sident #2's room and lowered Resident #2 in not the new room that the					

				ST	ATE FORM: RE	VISIT REPORT				
	R / SUPPLIER / CI CATION NUMBER	·	MULTIPLE CONS A. Building B. Wing	STRUCTION					DATE O	F REVISIT
NAME OF FACILITY SPRING HILLS MATAWAN						STREET ADDRESS, CIT 40 FRENEAU AVENUE MATAWAN, NJ 07747	TY, STATE, ZIP C	ODE Y2	3/20/20	Y3
corrective	e action was acc tion prefix code p	omplished	I. Each deficien	cy should be	e fully identified us	y reported that have bee ing either the regulation les shown to the left of e	or LSC provision	on number and	the	
ITE	М		DATE	ITEM		DATE	ITEM			DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix	A0749		Correction	ID Prefix	A1187	Correction	ID Prefix			Correction
Reg.#	8:36-7.3(a)		Completed	Reg.#	8:36-17.3(a)(1)	Completed	Reg. #			Completed
LSC			12/30/2020	LSC		01/04/2021	LSC			
ID Prefix	_		Correction	ID Prefix	_	Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #		Completed	Reg. #			Completed
LSC			-	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #		Completed	Reg.#			Completed
LSC			-	LSC			LSC _			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#			Completed	Reg.#		Completed	Reg. #			Completed
LSC			_	LSC			LSC _			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #		Completed	Reg. #			Completed
LSC			-	LSC			LSC _			
STATE AC		(INITIALS		DATE	SIGNATU	RE OF SURVEYOR			DATE	
REVIEWE CMS RO	D BY	REVIEW (INITIALS		DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/29/2020				CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						

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