STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	**1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ 169458, 173993, 176442,178844,178871,181815, 183719,184224 Survey Date: 4/15/2025 Census: 120 Sample: 24 +3 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/10/25

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

Electronically Signed | 05/09/2025

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent facility documentation, it was determined that the facility did not maintain the dignity of a resident specifically, by transporting the resident backward in a [redacted] chair NJ Exec Order 26.4b1 [redacted] down the hallway. This deficiency was identified in 1 of the 36 residents (Resident # 2) reviewed. This deficient practice was evidenced by the following: On 01/13/2025 at 10:15 AM, the surveyor observed Certified Nurse Aide #1, pulling the resident in a [redacted] chair backward down the NJ Exec Order 26.4b1	F 550	1. Resident #2 had no negative effect from being transported in [redacted] chair backwards. However, Certified Nurse Assistant #1 (CNA #1) assisting Resident #2 was re-educated by Director of Nursing (DON) on proper techniques of maneuvering [redacted] chair in a way that promotes Resident #2's dignity. 2. All residents utilizing geriatric chairs have the potential to be affected by the deficient practice. 3. DON will educate staff members who are responsible for transporting residents in geriatric chairs on resident rights focusing on dignity as well as proper techniques of maneuvering geriatric chairs in the hallway.	

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F 550	Continued From page 2 During an interview with the surveyor on 04/14/2025 at 11:22 AM, the Licensed Practical Nurse/Unit Manager #1 said that residents should not be pushed backward in their [redacted] chairs as it is a dignity concern. During an interview with the surveyor on 04/15/2025 at 10:04 AM, the [redacted] said that residents should not be pushed backward in a [redacted] chair it is a dignity issue. A review of a facility policy dated 01/2025 titled, "Quality of Life -Dignity", revealed, "Residents shall be treated with dignity and respect at all times." N.J.A.C. 8:39-4.1(a)(16)	F 550	4. DON or designee will audit five (5) residents who utilize geriatric chairs and observe staff during the task to ensure that proper technique is used, and residents' dignity is maintained. The audit will be completed weekly for four weeks, and then monthly for two months. Findings will be reported to the monthly Quality Assurance and Performance Improvement Committee (QAPI), and interventions will be readjusted if needed based on the Committee recommendations.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		6/10/25

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F 584	Continued From page 3 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean, safe and sanitary environment for 2 of 3 units, the second floor and the third floor. This deficient practice was evidenced by the following: During initial tour on 04/09/2025 at 10:56 AM surveyor #1 observed the wall behind bed 1 in room [redacted] which had two strips of black sticky tape with what appeared to be white foam on them that looked to have been used to anchor an object to the wall.	F 584	1. Two strips of black sicky tape were removed from the wall in room [redacted] Broken trim with sharp edges behind residents bed was immediately removed and replaced with a new trim in room [redacted] Resident #2s was provided with another [redacted] chair while the original [redacted] chair was evaluated and fixed by maintenance. A piece of white cloth caught in one of the back wheels was removed, and the wheel was checked for proper functioning. Furthermore, Resident #2s original [redacted] chair was deep	

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F 584	Continued From page 4 During a room visit on 04/10/2025 in room [NJ Exec O] bed 2, surveyor #1 observed broken trim with sharp edges along the center of the wall behind the resident's bed. The resident was unsure of how long the trim had been broken. During an interview on 04/14/2025 at 11:56 AM with surveyor #1, the [US FOIA (b)(6)] said that rounds on the resident's room were done daily to see if anything was in need of repair. The [US FOIA] said that he would talk to the residents to see if there were any problems in their rooms and that the nurses would put the concerns in the maintenance computer system. The [US FOIA] said he had not been made aware of any concerns in rooms [NJ Exec O] and [NJ Exec O]. Once shown the pictures the [US FOIA] stated, "they should not look like that". During an interview on 04/15/2025 at 09:58 AM with surveyor # 1, the [US FOIA (b)(6)]) said there should not be anything broken in the residents' rooms. A review of an undated facility provided policy revised on 01/2025 and titled "Quality of Life - Homelike Environment", revealed, "Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. On 04/09/2025 at 10:15 AM, Surveyor #2 observed Resident #2 seated in a [NJ Exec Order 26.4b] chair [NJ Exec Order 26.4b1]. The chair had a piece of white cloth caught in one of the back	F 584	cleaned and disinfected by the housekeeping department to remove stains of brown debris on the inside. The shower room on the third floor was deep cleaned including but not limited to removal of hair found in the shower drain as well as piece of brown paper in the stall. 2. All residents have the potential to be affected by the deficient practice. 3. DON will educate the nursing team to promptly report any disrepairs to maintenance personnel as well as areas in need of cleaning/disinfection to housekeeping personnel via electronic work order system or verbally if immediate assistance is needed. The Maintenance Director (MD) will educate the maintenance team about timely response to any disrepairs reported by other team members. The Environmental Services Director (ESD) will educate the housekeeping team about timely response to any areas and equipment requiring cleaning reported by other team members. In addition, ESD created and implemented Residents Equipment Cleaning Schedule to promote and maintain cleanliness of durable medical equipment (DME) such as geriatric chairs. ESD implemented shower room cleaning sign-off checklist for housekeepers to complete each time shower cleaning is completed.	

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F 584	Continued From page 5 wheels and there were stains of brown debris on the side. On 04/10/2025 at 12:23 PM, Surveyor #2 observed the shower room on the third floor, with hair in the shower drain and a piece of brown paper in the stall. During an interview with Surveyor #2 on 04/09/2025 at 11:05 AM, the US FOIA (b)(6) [redacted] said that the resident should not have had a piece of white cloth caught in one of the back wheels of the [redacted] chair or stains of brown debris on the side, as the facility strives to maintain a clean, home-like environment. During an interview with Surveyor #2 on 04/14/2025 at 11:04 AM, the US FOIA (b)(6) [redacted] said that the Certified Nurse Aides (CNAs) check the shower rooms for cleanliness in the morning and afternoon and notify housekeeping to sanitize the shower rooms when needed. Housekeeping is responsible for cleaning the shower stalls and drains if hair, debris, or trash is present. The CNAs are responsible for cleaning up residents' belongings after showers and informing housekeeping to sanitize the area. During an interview with Surveyor #2 on 04/15/2025 at 10:04 AM, the US FOIA (b)(6) [redacted] said that it is housekeeping's responsibility to clean the shower rooms after the CNAs shower the residents. A review of the dated facility provided policy revised on 01/2025 and titled, "Quality of Life - Homelike Environment", revealed, "Residents are provided with a safe, clean, comfortable, and	F 584	4. MD or designee will audit five (5) resident rooms on each unit to assess the condition of walls and trims, and to determine if repairs are needed/completed. The audit will be completed weekly for four weeks, and then monthly for two months. MD or designee will audit five (5) geriatric chairs to assess proper functioning. The audit will be completed weekly for four weeks, and then monthly for two months. ESD or designee will audit shower rooms on all units to ensure cleanliness. The audit will be completed weekly for four weeks, and then monthly for two months. ESD or designee will audit five (5) geriatric chairs to ensure cleanliness of the DME. The audit will be completed weekly for four weeks, and then monthly for two months. Findings will be reported to the monthly Quality Assurance and Improvement Committee, and interventions will be readjusted if needed based on the Committee recommendations.	

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F 584	Continued From page 6 homelike environment and encouraged to use their personal belongings to the extent possible." N.J.A.C. 8:39-31.4(a)	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		6/10/25

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F 656	Continued From page 7 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to develop and implement a care plan that meets the medical needs identified on the comprehensive assessment care for 1 of 24 residents reviewed for comprehensive care plans, Resident #36. This deficient practice was evidenced by the following: A review of Resident # 36's admissions record revealed that, Resident #36 was admitted with but not limited to NJ Exec Order 26.4b1 [redacted] There was no order for NJ Exec Order 26.4b1 [redacted] until brought to the facilities attention by the surveyor. A review of Resident #36's Electronical Medical Record revealed a physician's order with a state date of NJ Exec Order 26.4b1 [redacted] twice a day for NJ Exec Order 26.4b1. There were no	F 656	1. Resident #36 had NJ Exec Order 26.4b1 from the deficient practice. However, primary nurse immediately assessed Resident #36 for manifestations related to NJ Exec Order 26.4b1 use and Resident presented with NJ Exec Order 26.4b1. Diagnosis of NJ Exec Order 26.4b1 posed by hospital was verified with Resident #36's Primary Care Physician (PCP) and added to electronic medical record (EMR). Furthermore, order to monitor for adverse effects of NJ Exec Order 26.4b1 including but not limited to NJ Exec Order 26.4b1 [redacted] every shift was added. Care plan (CP) for NJ Exec Order 26.4b1 use was created. 2. All residents receiving anticoagulant therapy have the potential to be affected by the deficient practice. 3. DON will educate nurses on Anticoagulation Protocol focusing on the importance of documenting appropriate	

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F 656	Continued From page 8 orders to monitor for any signs of [redacted] A review of the current Care Plan (CP) for Resident #36 did not include documentation of a CP focus area or interventions for the use of an [redacted] During an interview on 04/11/2025 at 10:41 AM with the surveyor the [redacted] said that all resident's on an [redacted] should have a relevant medical diagnosis, physician orders to monitor signs and symptoms of [redacted] and that the care plan should identify the medication. While the [redacted] was in Resident 36's chart, she was unable to find the diagnosis of [redacted] under the resident's medical record. During further investigation the [redacted] confirmed that Resident #36 had an [redacted] in the hospital and was ordered [redacted] She said the diagnosis should have been added to the resident's diagnosis and added it at that time. During the same interview the [redacted] was also unable to find an order to monitor for signs and symptoms of [redacted] She said the resident should have an order; I am putting it in now. During the same interview the [redacted] lastly said the resident was not care planed for the [redacted] and would update the care plan. During an interview on 04/15/2025 at 09:58 AM with the surveyor, the [redacted] said that residents on an [redacted] should have a diagnosis that reflects the need for the medication. The [redacted] also agreed that there should be orders to monitor for signs or	F 656	diagnosis / indication when anticoagulation medication is prescribed; order to monitor for side/adverse effects of anticoagulation use; and adding appropriate CP for anticoagulant use. Furthermore, DON will conduct house-wide audit of residents on anticoagulant therapy to ensure corresponding diagnosis, order for monitoring for side/adverse effects, and CP for anticoagulants use are present in their EMR. 4. DON or designee will audit five (5) residents who receive anticoagulation therapy for presence of corresponding diagnosis, order to monitor for side/adverse effects, and CP for anticoagulants use. The audit will be completed weekly for four weeks, and then monthly for two months. Findings will be reported to the monthly Quality Assurance and Performance Improvement Committee (QAPI), and interventions will be readjusted if needed based on the Committee recommendations.	

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F 656	Continued From page 9 symptoms of [redacted] and the resident should be care planned for [redacted] A review of a facility provided policy revised on 1/2025 and titled, "Anticoagulation-Clinical Protocol" revealed under, "Policy Guidelines" that, "1. Anticoagulants shall be prescribed by a physician or other authorized practitioner with clear indications for use. 4. Resident's plan of care shall alert staff to monitor for adverse consequences. 5. The residents plan of care shall include interventions to minimize risk of adverse consequences." A review of a facility provided policy revised on 01/2025 and titled "Care Plans. Comprehensive, Person-Centered" revealed, "8. The comprehensive, person-centered care plan will: 10. Incorporate identified problem areas. 11. Incorporate risk factors associated with identified problems. NJAC 8:39-27.1(a)	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 695	1. Resident #67 had [redacted]	6/10/25

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F 695	Continued From page 10 and review of pertinent facility documents, it was determined that the facility failed to provide NJ Exec Order 26.4b1 care consistent with professional standards of practice by not storing a NJ Exec Order 26.4b1 [redacted] properly and failed to document the use of NJ Exec Order 26 in Electronic Medical Record (EMR) for 1 of 2 residents (Resident #67) reviewed for NJ Exec Order 26.4b1 Care. The deficient practice was evidenced by the following: During the initial tour on 04/09/2025 at 10:09AM, Resident #67 was observed sitting in the wheelchair with NJ Exec Order 26 in use via a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted] The surveyor also observed a NJ Exec Order 26.4b1 NJ Exec Orde laying open to air on the resident's bed. On 04/10/2025 at 11:29 AM the surveyor observed Resident # 67 in the wheelchair with NJ Exec Order 26 in use via NJ Exec Order 26.4b1. The surveyor also observed a NJ Exec Order 26.4b1 laying open to air on the resident's bed with a plastic bag next to it. Resident # 67 said he/she uses NJ Exec Order 26 everyday when in their room and when sleeping. According to the Admission Record, Resident #67 was admitted to the facility with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted] A review of the Order Summary Report dated NJ Exec Order 26.4b1, revealed a physician order for NJ Exec Order 26.4b1 [redacted] every six	F 695	from the deficient practice. Resident #67 nursing evaluation indicated NJ Exec Order 26 [redacted] when on NJ Exec Order 26.4b. Resident #67 denied NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 at the time. As Needed (PRN) use of NJ Exec Order 26 was discussed with Primary Care Provider. Primary Care Provider's recommendation was to continue the same order. However, to correct the deficient practice, Assistant Director of Nursing educated Licensed Practical Nurse (LPN #1) on the importance of documentation when As Needed (PRN) NJ Exec Order 26 is utilized in Electronic Medical Record. In addition, Resident #67s As Needed (PRN) NJ Exec Order 26 order was updated in a way to prompt nurses to document NJ Exec Order 26.4b1 when in use. Furthermore, Resident #67s NJ Exec Order 26.4b1 and NJ Exec Order 2 were discarded. New NJ Exec Order 26 and NJ Exec Order 2 were provided and placed in a plastic bag for storage. Assistant Director of Nursing educated Resident #67 about the importance of keeping the Resident's NJ Exec Order 26.4b1 aside and in a plastic bag. Assistant Director of Nursing educated Licensed Practical Nurse (LPN #1) about appropriate disinfection and storage practices for NJ Exec Order 26.4b1 while not in use. 2. All residents on As Needed (PRN) oxygen therapy and receiving nebulizer inhalations have the potential to be affected by the deficient practice. 3. Director Of Nursing will educate nurses on the importance of As Needed (PRN)	

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	315305	A. BUILDING _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 11 hours. The Order Summary Report also revealed, and order dated NJ Exec Order 26.4b1 to administer NJ Exec Order 26 via NJ Exec Order 26.4b1 as needed for NJ Exec Order 26.4b1 of NJ Exec Order 26 A review of Resident #67's Medication Administration Record (MAR) for the month of NJ Exec Or revealed that the NJ Exec Order 26 order administration documentation was blank. During an interview on 04/11/2025 at 11:02 AM with the surveyor, the US FOIA (b)(6) said that when NJ Exec Order 26.4b1 and NJ Exec Orde are not in use, they should be stored in plastic bags with their names on them and in the top drawer of the nightstand for infection control purposes. During the same interview the US FO said as needed NJ Exec Order 26 use should be documented in the EMR or in vital signs. During an interview on 04/11/2025 at 11:05 AM with the surveyor, the Licensed Practical Nurse (LPN#1) said she saw Resident # 67 with NJ Exec Order 26 on NJ Exec Order 26.4b1 She said the resident uses NJ Exec Order 26 all the time. When asked where it was documented, LPN#1 said, "I didn't know, there was a place in the MAR [Medication Administration Record] to document it. I will start documenting." During an interview on 04/15/2025 at 09:58 AM with the surveyor, the US FOIA (b)(6) said that NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 should be kept in a plastic bag when not in use. The US FOIA (b) also said NJ Exec Order 26 should documented in the MAR when needed.	F 695	oxygen administration documentation in the Electronic Medical Record as well as nebulizer mask storage protocol. Furthermore, Director Of Nursing will conduct house-wide audit of residents with As Needed (PRN) oxygen order and re-adjust then in a way to prompt nursing documentation in the Electronic Medical Record, and house-wide audit of residents who use nebulizer to ensure proper storage of nebulizer masks when not in use. 4. Director Of Nursing or designee will audit five (5) residents who utilize As Needed (PRN) oxygen to ensure compliance with administration documentation in the Electronic Medical Record. Director Of Nursing or designee will conduct observational audits of five (5) residents who utilize nebulizer to ensure proper storage of nebulizer masks while not in use. The audit will be completed weekly for four weeks, and then monthly for two months. Findings will be reported to the monthly Quality Assurance and Performance Improvement Committee (QAPI), and interventions will be readjusted if needed based on the Committee recommendations.	

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F 695	Continued From page 12 A review of a facility provided policy revised on 1/2025 and titled "Oxygen Administration" revealed under, " Steps in the Procedure" to, "21. Replace entire set-up every seven days. Date and store in treatment bag when not in use." The policy also revealed under "Documentation" that, "After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time ... and 9. The signature and title of the person recording the data."	F 695		
F 812 SS=F	NJAC 8:39-27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 812	Misdated baked ziti, loaf of ryebread and	6/10/25

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F 812	Continued From page 13 review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 04/09/2025 from 9:59 AM until 10:37 AM the surveyor, who was accompanied by the US FOIA (b)(6) observed the following in the kitchen: 1. In the first refrigerator, there was baked ziti in a metal container covered with clear plastic wrap. It was dated 3/8/25. The US FOIA (b) said the baked ziti was probably misdated, however she will throw it away. 2. In the first refrigerator there was a loaf of rye bread dated 3/13/25 and a loaf of raisin bread dated 3/24/25. The US FOIA (b) said the bread is good for 30 days in the refrigerator. On 04/10/2025 at 12:11 PM, the US FOIA (b)(6) clarified that bread is good for 5 to 7 days in the refrigerator and the 2 loaves of bread were discarded. On 04/10/2025 at 11:29 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN#1), observed the following in the second-floor pantry: 1. A brown bag with a resident name with a container of leftover food that was not labeled or dated. The LPN said it should have been labeled and dated. She threw it out. 2. A sandwich in a brown bag that was not labeled or dated. The LPN#1 said it should be labeled and dated. The LPN#1 threw the	F 812	rains bread were discarded by the US FOIA (b)(6) the time of observation. Unlabeled or undated items in pantries on first, second and third unit which included brown bag with leftover food, a sandwich in a brown bag, an open plastic bag with a raw piece of fish, a black bag of staff members food, a container of soup, and variety of unlabeled containers were discarded by US FOIA (b)(6) at the time of observation. The chipped floor tile underneath the ice machine was replaced, backsplash was reattached, and cabinets were repaired in the second-floor pantry. The chipped cabinets and floor tiles as well as wall molding were repaired in the third-floor pantry. All residents have the potential to be affected by the deficient practice. US FOIA (b) was educated by the Administrator on the kitchen food storage protocol. Nursing staff were educated by the Director of Nursing (DON) about food storage protocol in floor pantries. The US FOIA (b) (6) was educated by the Administrator about the importance of conducting pantry repairs in a timely manner. The Administrator or designee will conduct a daily kitchen food storage audit for one (1) week, then weekly for three (3) months. DON or designee will conduct daily floor pantry food storage audit for one (1)	

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F 812	Continued From page 14 sandwich in the trash. 3. An opened plastic bag with a raw piece of fish that was not labeled or dated. The LPN#1 said the fish should have been labeled and dated. The LPN#1 threw the fish in the trash. 4. The floor tile under the ice machine was chipped, the cabinets were chipped and worn, and the backsplash was falling off the wall. The LPN#1 nurse acknowledged these and stated they were renovating. On 04/10/2025 at 11:36 AM, the surveyor, accompanied by the Unit Manager Licensed Practical Nurse (UMLPN#1), observed the following in the third-floor pantry: 1. In the refrigerator, there was a container with a resident name and room number. It was not dated. The UMLPN#1 said it should have been dated and threw it away. 2. In the refrigerator, a black bag of a staff member's food was not labeled or dated. The UMLPN#1 said the food should have been labeled and dated. 3. The cabinets were chipped, the tile flooring was cracked and there was molding missing from the wall to the right of the door. The UMLPN#1 acknowledged these findings and said the facility was doing renovations. On 04/10/2025 at 11:50 AM, the surveyor, accompanied by Unit Manager Licensed Practical Nurse2 (UMLPN#2), observed the following in the first-floor pantry:	F 812	week, then weekly for three (3) months. DOM or designee will conduct weekly repair audits in floor pantries for three (3) months. Audit findings will be reported to the QAPI Committee monthly for three (3) months. The Committee will readjust interventions if needed based on the findings.	

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F 812	Continued From page 15 1. In the refrigerator, there was a container of soup that was not labeled or dated. The UMLPN#2 said the soup should have been labeled and dated. She threw the soup in the trash. 2. In the refrigerator, there was a clear container with red lid that was not labeled or dated. The UMLPN#2 said the container should have been labeled and dated. She threw the container away. 3. In the refrigerator, there was a black container with a clear top that was not labeled or dated. The UMLPN#2 said the container should have been labeled and dated. She threw the container away. 4. In the refrigerator, there was a clear container with a burgundy lid that was not labeled or dated. The UMLPN#2 said the container should have been labeled and dated. She threw the container away. On 04/14/25 at 11:56 AM, during an interview with the surveyor, the US FOIA (b)(6) stated that he goes into the unit pantries once or twice a day to check the ice machines. He acknowledged that repairs were needed on the cabinets, tile floors, back splash, and molding. He said that he started the repairs. A review of the facility provided policy titled, "Food Safety Requirements", reviewed/revised 01/2025 reflected that food will also be stored, prepared and served in accordance with professional standards for food service safety and labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use by date.	F 812		

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F 812	Continued From page 16 A review of the facility provided policy titled, "Bread Handling and Storage Policy", revised 1/2025 reflected that bread should be stored in a cool, dry place, away from direct sunlight and moisture. The policy does not reflect how long bread can be kept in the refrigerator. A review of the facility provided policy titled, "Outside Food Policy", reviewed/revised 01/2025 reflected that refrigerated foods must be labeled with the resident's name and the date the food was brought in, and will be discarded by staff no more than three days after being brought in. NJAC 8:39-17.2(g)	F 812		

New Jersey Department of Health

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	061201	A. BUILDING: _____ B. WING _____	C 04/15/2025

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. 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 the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaints: NJ00178844, NJ00181815, NJ00169458, NJ00173993, and NJ00176442 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	No residents were affected by not meeting the State of NJ minimum staffing requirements as determined by routine monitoring and review on those dates that no significant changes were noted. All residents can be potentially affected by the deficient practice. Staffing Coordinator was re-educated on NJ Staffing Recruitment. Additionally, the facility hiring and retention efforts continue to include: Job fairs	6/10/25

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

Electronically Signed — 05/09/25

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 08/18/2024 to 08/24/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -08/18/24 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -08/19/24 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/20/24 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/21/24 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -08/24/24 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. 2. For the week of Complaint staffing from	S 560	Daily staffing meetings and weekly Regional Labor Management reviews Training mentor program to support retention Culture committee to improve and maintain staff morale Recruitment bonus and sign-on bonuses offered will be increased Completive wage analysis Weekend warrior program Cooperation with nursing and CNA schools Director of Nursing or designee will monitor staffing daily for one (1) week, weekly for three (3) weeks and monthly for three (3) months. Results will be presented to the Quality Assurance and Performance Improvement Committee monthly for continued review and recommendations.	

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S 560	Continued From page 2 10/20/2024 to 10/26/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -10/20/24 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -10/21/24 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -10/23/24 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. 3. For the week of Complaint staffing from 12/01/2024 to 12/07/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -12/01/24 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/02/24 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. -12/03/24 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/06/24 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/07/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. 4. For the 2 weeks of Complaint staffing from 12/15/2024 to 12/28/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -12/15/24 had 13 CNAs for 127 residents on the day shift, required at least 16 CNAs. -12/16/24 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -12/17/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/18/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 3 -12/19/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -12/20/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -12/21/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -12/22/24 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/26/24 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -12/27/24 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. 5. For the week of Complaint staffing from 02/23/2025 to 03/01/2025, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -02/23/25 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -02/24/25 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. 6. For the 2 weeks of staffing prior to survey from 03/23/2025 to 04/05/2025, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -03/23/25 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs. -03/24/25 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/25/25 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/30/25 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -04/03/25 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/04/25 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 4 During an interview on 04/15/2025 at 10:24 AM with the surveyor, the Staffing Coordinator said that the facility is meeting staffing requirements and determines daily staffing levels based on required ratios, which are reassessed twice weekly. Staffing is adjusted in response to changes in facility census, with additional staff scheduled when the census is elevated. In the event of unanticipated callouts or staffing shortages, the facility utilizes staff overtime and agency personnel. A review of a facility provided policy, with a review date of 01/2025, titled "Sufficient Staffing" revealed under the section titled " Policy " that, " The facility will provide sufficient staffing to meet needed care and services for our residents population on a 24-hour basis." A review of a facility provided policy, with a review date of 01/2025, titled "Sufficient Staffing" revealed under the section titled " Procedure " that, "If required by the state where the facility operates, those nursing staff ratio guidelines should be followed."	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315305 Y1	A. Building B. Wing Y2	6/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0656	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	06/10/2025	LSC	06/10/2025	LSC	06/10/2025
ID Prefix F0695	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	06/10/2025	LSC	06/10/2025	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/15/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061201		6/12/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/10/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/15/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING **01** B. WING _____	**04/15/2025**

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SPRING CREEK HEALTHCARE CENTER	**1 LINDBERGH AVENUE** **PERTH AMBOY, NJ 08861**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/14/25 and 4/15/25. The facility was found to be in compliance with Appendix Z-Emergency Preparedness, 42 CFR 483.73, Requirements for Long Term Care Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/14/25 and 4/15/25 and Spring Creek Healthcare Center was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Spring Creek Healthcare Center is a Three-story, Type II Protected building that was built in January 1980. The facility is divided into 9 smoke zones. The facility has one Diesel emergency generator that powers 100% of the building. The current census is 122 of 179 certified licensed beds.	K 000		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically	K 223		6/10/25

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

Electronically Signed | 05/09/2025

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.

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K 223	Continued From page 1 closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 4/15/25 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that the automatic closing of roll down doors were tested and maintained in accordance with NFPA 80 Chapter 11 (Rolling Steel Doors) 11.4.1.1 through 11.4.1.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:40 AM revealed that the steel roll down door (approximately 4-foot by 4-foot) to the kitchen had a sticker from the facility's inspection vendor. The sticker did not have any information that was legible. The US FOIA (b)(6) indicated the roll down door would close in the event of a fire, but when he attempted to close the roll down door, it would not fully close to the bottom frame. The upper section of the door was observed to have a fusible link system that did not function properly as the door was manually operated by the US FOIA (b)(6) In an interview at the time, the US FOIA (b)(6) both confirmed the observation. No further documentation was provided at the	K 223	All residents had the potential to be affected by this deficient practice. 1. A Vendor was immediately scheduled to repair the door and repair was completed on 5/6/25. The door now closes fully to the bottom frame. Vendor successfully conducted inspection and Fire Test on 5/9/25. 2. A sweep of all doors with self-closing devices will be audited for automatic closing capability. 3. The US FOIA (b)(6) will be re-educated by Administrator/Designee on the NFPA-80 requirements of self- closing doors in a hazardous area enclosure. The Maintenance Director/Designee will conduct random audits on self-closing doors in hazardous area enclosures weekly x4 weeks and monthly x3 months. Any concerns will be corrected immediately. 4. Audit Findings will be given to the Administrator for review and submitted to the quarterly Quality Assurance and Performance Improvement (QAPI) Committee to determine if further intervention is needed.	

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K 223	Continued From page 2 time of the exit conference. The [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 4/15/25 at 1:45 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 223		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/15/25 in the presence of the [US FOIA (b)(6)] it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 1 of 4 areas, had the potential to affect 25 residents and was evidenced by the following: An observation at 11:52 AM revealed in the first floor occupied day room, that one wall light switch shut off all 25 ceiling light fixtures. In an interview, the [US FOIA (b)(6)] both confirmed the findings at the time of	K 281	25 residents had the potential to be affected by this deficient practice. 1. An emergency backup egress lighting fixture was immediately installed above the door to the first-floor dayroom. 2. A building sweep along all means of egress will be done to ensure emergency illumination that would operate automatically would be provided. 3. The [US FOIA (b)(6)] will be re-educated by Administrator/Designee on the NFPA 101 requirements to ensure emergency illumination that would operate automatically would be provided along all means of egress. The Maintenance Director/Designee will conduct random audits on Illumination of Means of Egress	6/10/25

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K 281	Continued From page 3 observations. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 4/15/25 at 1:45 PM. NJAC 8:39-31.2(e)	K 281	weekly x4 weeks and monthly x3 months. Any concerns will be corrected immediately. 4. Audit Findings will be given to the Administrator for review and submitted to the quarterly Quality Assurance and Performance Improvement (QAPI) Committee to determine if further intervention is needed	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/15/25 in the presence of the US FOIA (b) (6) [redacted], it was determined that the facility failed to maintain a battery back-up emergency light above the interior emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 2 interior transfer switches, had the potential to affect all residents and was evidenced by the following: An observation at 10:49 AM with the US FOIA (b)(6) [redacted] revealed in the electric fire pump transfer switch room, that the transfer switch was not equipped with battery backed-up emergency lighting of at least a 90 minute in duration. In an interview, the US FOIA (b)(6) [redacted] both	K 291	All residents had the potential to be affected by this deficient practice. 1. An emergency battery backup lighting of at least 90-minute duration was immediately installed in the electric fire ump transfer switch room. 2. A building sweep audit will be conducted of all areas required as per NFPA 101 to have emergency battery backup lighting of at least 90-minutes in duration. The US FOIA (b) (6) [redacted] will be re-educated by Administrator/Designee on the NFPA 101 requirements to have emergency battery backup lighting of at least 90-minutes in duration. 3. The Maintenance Director/Designee will conduct random audits on Emergency Lighting weekly x4 weeks then monthly x3 months. Any concerns will be corrected	6/10/25

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K 291	Continued From page 4 confirmed that the electric fire pump transfer switch room did not have battery back-up emergency lighting of at least a 90 minute in duration. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit on 4/15/25 at 1:45 PM. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	immediately. 4. Audit Findings will be given to the Administrator for review and submitted to the quarterly Quality Assurance and Performance Improvement (QAPI) Committee to determine if further intervention is needed.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		6/10/25

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K 363	Continued From page 5 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/15/25 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101: 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 3 of 32 resident rooms observed, had the potential to affect all residents and was evidenced by the following: Observations from 9:15 AM to 12:45 PM in the presence of the US FOIA (b)(6) [redacted] revealed resident room doors did not operate properly as follows: - Room # 204 - the door would not latch into its frame. - Room # 217 - the door would not latch into its frame. - Room # 225 - the door would not latch into its frame.	K 363	All residents had the potential to be affected by this deficient practice. 1. The doors to rooms 204, 217, 225 were immediately repaired and currently latch properly into the frame. 2. Audit will be conducted of all corridor doors to ensure that corridor doors are able to resist the passage of smoke in accordance with the requirements of NFPA 101. 3. The US FOIA (b)(6) [redacted] will be re-educated by Administrator/Designee on the NFPA 101 requirements that corridor doors are able to resist the passage of smoke in accordance with the requirements. The Maintenance Director/Designee will conduct random audits on corridor door closures weekly x4 weeks and monthly x3 months. Any concerns will be corrected immediately. 4. Audit Findings will be given to the Administrator for review and submitted to the quarterly Quality Assurance and	

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K 363	Continued From page 6 In an interview at 12:00 PM, the US FOIA (b)(6) confirmed the above findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 4/15/25 at 1:45 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	Performance Improvement (QAPI) Committee to determine if further intervention is needed.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 4/14/25 in the presence of the US FOIA (b)(6), it was determined that the facility failed	K 531	All residents had the potential to be affected by this deficient practice. 1. The missing monthly elevator Phase 1	6/10/25

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K 531	Continued From page 7 to conform with Firefighter's Service Requirements of ASME/ANSI A17.3 and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4.2 and 9.4.3. This included firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation for 2 of 2 devices. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview at 11:02 AM, the surveyor asked the [US FOIA] for the Phase I and Phase II firefighters monthly recall documentation for the two passenger elevators. The [US FOIA] stated that the required monthly testing was being performed, but could not provide a monthly testing log indicating: Phase 1 (Hall) and Phase 2 (In Car) was documented each month. There was no written record of elevators provided with firefighters' emergency operation subjected monthly to Phase I recall by use of the key switch to the lobby, and a minimum of one floor operation on Phase II and a minimum of one floor operation" "Pass" or "Fail", "Report of Findings" documented monthly. The [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 4/15/25 at 1:45 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	and Phase 2 firefighters recall testing documentation was found and conform with Firefighter's service Requirements of ASME/ANSI A17.3 and NFPA 101. 2. The [US FOIA (b)(6)] will be re-educated by Administrator/Designee on the Firefighter's service Requirements of ASME/ANSI A17.3 and NFPA 101. 3. The Maintenance Director/Designee will conduct monthly audits on elevator Phase 1 and Phase 2 firefighters recall testing x3 months then quarterly x3 quarters. Any concerns will be corrected immediately. 4. Audit Findings will be given to the Administrator for review and submitted to the quarterly Quality Assurance and Performance Improvement (QAPI) Committee to determine if further intervention is needed.	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:	K 741		6/10/25

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K 741	Continued From page 8 (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 4/15/25 in the presence of the US FOIA (b)(6) [redacted], a). it was determined that the facility failed to ensure that metal containers with self-closing cover devices were readily available to all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4, b). it was determined that the smoking area was not maintained free of combustible dried grass, leaves and cigarette butts, and c). it was determined that the smoking area failed to prohibit the practice of mixing cigarette butts and	K 741	All residents had the potential to be affected by this deficient practice. 1. A) Metal containers with self-closing devices were immediately ordered. B) The smoking area was immediately cleared of combustible dried grass, leaves and cigarette butts. C) The trash can was immediately removed from the gazebo and the smoking policy was reviewed with the residents that prohibits the practice of mixing cigarette butts and ash in trash	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING **01** B. WING _____	**04/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	**1 LINDBERGH AVENUE** **PERTH AMBOY, NJ 08861**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 9 ash in trash cans with other combustibles. This deficient practice had the potential to affect all residents and was evidenced by the following: a). An observation at 11:30 AM revealed a metal container with a self-closing cover device into which ashtrays can be emptied was not provided or readily available to the smoking area courtyard. In an interview at the time, the US FOIA (b)(6) both confirmed the observation. b). Observations at approximately 11:30 AM with the US FOIA (b)(6) revealed that there was dried grass and leaves at the outer perimeter of the smoking area. The surveyor observed 100-plus cigarette butts in that area, along with cigarette butts on the occupied concrete pad. The occupied resident smoking area courtyard was provided with 4-oasis type ashtrays. In an interview, the US FOIA (b)(6) both confirmed the observations in smoking courtyard. c). Observations at 11:39 AM in the presence of the US FOIA (b)(6) revealed the occupied smoking courtyard had a combustible gray dome top plastic garbage filled with 50 plus cigarette butts and combustible cups, paper and cigarette boxes. In an interview, the US FOIA (b)(6) both confirmed the observations in smoking courtyard. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 4/15/25 at 1:45 PM. N.J.A.C 8:39-31.2(e)	K 741	cans with other combustibles. 2. The US FOIA (b)(6) will be re-educated by Administrator/Designee on the Smoking regulations in accordance with NFPA 101. 3. Environmental Services Director/Designee will conduct daily audits on the smoking area x30 days then Weekly x4 weeks then monthly x3 months. Any concerns will be corrected immediately. 4. Audit findings will be given to the Administrator for review and submitted to the quarterly Quality Assurance and Performance Improvement (QAPI) Committee to determine if further intervention is needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING **01** B. WING _____	**04/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	**1 LINDBERGH AVENUE** **PERTH AMBOY, NJ 08861**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315305 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0223	06/10/2025	LSC K0281	06/10/2025	LSC K0291	06/10/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	06/10/2025	LSC K0531	06/10/2025	LSC K0741	06/10/2025
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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/15/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO