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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | ULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|---|-------------------------------|----------------------------|
| | | 315005 | B. WING | | _ | 01/05/2021 | |
| NAME OF PROVIDER OR SUPPLIER SPRING GROVE REHABILITATION AND HEALTHCARE CENTER | | | | STREET ADDRESS, CITY, ST 144 GALES DRIVE NEW PROVIDENCE, NJ | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFII TAG | ((EACH CORRECTED CROSS-REFERE | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 000 | · | | | F 000 | | (X6) DATE | |

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.

Electronically Signed

01/13/2021