STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 STANDARD SURVEY: Recertification CENSUS: 103 SAMPLE: 28 COMPLAINT INTAKE #: NJ153073, NJ153306, NJ154286, and NJ154537. 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, it was determined the facility failed to assess 1 (Resident #62) of 5 residents reviewed for self-administration of medication. Findings included: Review of a facility policy, titled, "Self-Administration of Medication," revised February 2021, revealed, "Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1.	F 554	Spring Hills Post-Acute Care Woodbury Plan of Corrections April 14th Annual Survey F554 Resident Self-Admin Meds □ Clinically Appropriate CFR(s): 483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by 483.21(b)(2)(ii), has determined that this practice is clinically appropriate. I. During the annual survey, it was determined that the facility failed to	5/10/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/10/2023

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 1 As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident." The policy further indicated, "3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan" and "8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents." Review of Resident #62's "Admission Record" revealed the facility admitted the resident with diagnoses of EX. Order 26.(4) B1 and EX. Order 26.(4) B1. Review of Resident #62's admission Minimum Data Set (MDS), dated EX. Order 26.(4) B1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of EX. Ord which indicated the resident was EX. Order 26.(4) B1. Review of Resident #62's care plan for their EX. Order 26.(4) B1 admission revealed the resident was at risk for EX. Order 26.(4) B1 EX. Order 26.(4) B1. This care plan directed staff to administer medication EX. Order 26.(4) as ordered and monitor for effectiveness and side effects. Further review of Resident #62's care plan revealed the resident self-administered their medications. Care plan interventions directed staff to see Resident #62's physician orders for the medications the resident could self-administer. Review of Resident #62's "Order Summary Report," revealed an order dated EX. Order 26.(4) B1 which indicated the resident could self-administer	F 554	assess one (Resident #62) of 5 residents reviewed for self-administration of medication. Resident #62 was assessed by IDT team and determined that it was clinically appropriate for them to self-administer their EX. Order 26.(4) B1 treatments. A doctor order was obtained for patient to self-administer their EX. Order 26.(4) B1 treatments. The care plan was updated accordingly. Nursing staff were in-serviced on the Policy/Procedures for Self-Administration of Medication. II. All residents have the potential to be affected by this deficient practice. An audit of ten charts was conducted, with no additional deficient practices found. III. All nursing staff were educated on facility policy on Self-Administration of Medication. The Director of Nursing or designee will review new admission charts each morning prior to morning meeting to ensure that assessment was completed. IV. Director of Nursing or designee will audit charts weekly for (4) four weeks, then monthly for (3) three months to ensure compliance. Results will be forwarded to the QA committee monthly for (4) four months for tracking, trending and implementation of an action plan as necessary.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 2	F 554		

their EX. Order 26.(4) B1 two times a day for EX. Order 26.(4). Per the report, on EX. Order 26.(4) B1, the resident received an order for EX. Order 26.(4) B1 EX. Order 26.(4) B1 (EX. Order 26.(4) B1 ml EX. Order 26.(4) B1 every four hours as needed for EX. Order 26.(4) B1, and an order dated EX. Order 26.(4) B1 for EX. Order 26.(4) B1 EX. Order 26.(4) B1 EX. Order 26.(4) B1 ml EX. Order 26.(4) B1 four times a day. There was not an order that indicated the resident could self-administer the EX. Order 26.(4) B1 solution.

On 04/10/2023 at 11:44 AM, Resident #62 was observed sitting on the bed with a box of four EX. Orde mg EX. Order 26.(4) B1 solution on the bedside cabinet and a EX. Order 26.(4) B1 machine on the bedside table. Resident #62 stated they administered the EX. Order 26.(4) B1 three times a day. Resident #62 stated that when the nurses brought in the EX. Order 26.(4) B1 treatment they did not stay in the room when the resident administered their EX. Order 26.(4) B1 During the observation, Registered Nurse (RN) #12 entered the resident's room and acknowledged the EX. Order 26.(4) B1 solution in Resident #62's room. RN #12 stated Resident #62 did not have an order to self-administer EX. Order 26.(4) B1, and she did not know if the resident had a self-administration assessment completed for the EX. Order 26.(4) B1. RN #12 stated she did not know why the EX. Order 26.(4) B1 was in the resident's room. RN #12 said she was just in Resident #62's room to do vitals but did not look for medications at the bedside. She stated that when she administered the EX. Order 26.(4) B1 she started the resident's treatment, left, and came back to check on Resident #62 when the resident finished their treatment.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 3	F 554		

During a concurrent observation and interview on 04/10/2023 at 11:57 AM, RN #12 entered Resident #62's room and showed a box of EX. Order 26.(4) B1 solution and stated she gave the EX. Order 26.(4) B1 from the medication cart. RN #12 informed Resident #62 she needed to lock up the EX. Order 26.(4) B1 found in the room. Resident #62 stated, "This is the medication I have had in my room and been taking since I have been admitted here and you haven't said anything before."

On 04/13/2023 at 2:52 PM, RN #13 stated Resident #62 was not previously assessed to self-administer any of their medications. She stated Resident #62 had EX. Order 26.(4) B1 in their room until five days ago and administered the EX. Order 26.(4) B1 themself. RN #13 stated that today Resident #62 wanted her to leave the EX. Order 26.(4) B1 on the table, but she did not. Per RN #13, she placed the NJ Exec. Order 26:4.b. in the EX. Order 26.(4) B1, left the room while the resident EX. Order 26.(4) the medication and came back to the resident's room when they were done. RN #13stated she should have stayed with Resident #62 for the whole EX. Order 26.(4) B1 treatment. RN #13 stated she expected safe administration practices, for medications to be administered per physician's order and the resident to be deemed safe through assessment before self-administration.

On 04/13/2023 at 7:24 PM, in a telephone interview, RN #12 stated she looked in Resident #62's medical record and did not find an assessment for Resident #62 to self-administer medications. RN #12 stated she expected safe medication practices and that before residents self-administered their medication, the residents should be assessed, have a physician's order,

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 4	F 554		

and be care planned.

On 04/14/2023 at 12:15 PM, the Assistant Director of Nursing (ADON) stated Resident #62 was only able to self-administer their EX. Order 26.(4) EX. Order 26.(4) Per the ADON, she expected the nurse, when administering a EX. Order 26.(4) B1 treatment, to introduce themself, make sure it was the correct resident according to the medical record, put the medication in the EX. Order 26.(4) B1, explain to the resident the treatment, and put a EX. Order 26.(4) B1 or EX. Order 26 on the resident. She stated that typically the nurse would exit the room and then come back to make sure the EX. Order 26.(4) B1 treatment was fully administered. The ADON stated that after she thought about it, the nurse should be present in the room during the EX. Order 26.(4) B1 treatment to make sure nothing happened.

On 04/14/2023 at 1:15 PM, the Administrator in Training (AIT) stated medication should not be at the bedside of a resident if the resident was not assessed to self-administer. He stated he did not know if Resident #62 had a physician's order and assessment to self-administer medications. He stated he expected, for a resident who took EX. Order 26.(4) B1 treatment, the nurse to take the medication into the room and stay in the room the whole time until completion of the medication to assess for adverse reactions. He stated he expected safe medication administration practices and residents to be assessed before allowing self-administration.

On 04/14/2023 at 2:20 PM, the Director of Nursing (DON) revealed she expected nurses who administered EX. Order 26.(4) B1 treatments to stay in the room until the treatment was completed. The DON stated if medication was found at the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 5 bedside, the nurse should talk to the family or patient, and if the resident was able to self-administer medication, complete an assessment and teach the resident how to self-administer.	F 554		
F 640 SS=D	New Jersey Administrative Code § 8:39-29.2 (c) Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to	F 640		5/10/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 6 the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, facility policy review, and the "Centers or Medicare & Medicaid [CMS] Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual," it was determined the facility failed to encode and transmit a discharge Minimum Data Set (MDS) assessment for 1 (Resident #43) of 28 residents reviewed for MDS requirements. Findings included: Review of a facility policy titled, "Resident Assessments," revised March 2022, revealed, "A comprehensive assessment of every resident's needs is made at intervals designated by OBRA [Omnibus Budget Reconciliation Act] and PPS [Prospective Payment System] requirements." Further review of the policy revealed, "1. The	F 640	Spring Hills Post-Acute Care Woodbury Plan of Corrections April 14th Annual Survey F640 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) I. During the annual survey, it was determined that the facility failed to encode and transmit a discharge MDS assessment for 1 (Resident #43) of 28 residents reviewed for MDS requirements. II. All residents have the potential to be	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 7 resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews," including "(7) Discharge assessment (return anticipated and return not anticipated)." The facility policy indicated "2. The RAI User's Manual (Chapter 2) provides detailed information on timing and submission of assessments." Review of the "Centers or Medicare & Medicaid Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual," "Chapter 2: Assessments for the RAI," dated October 2019, revealed, discharge assessments "must be completed (item Z0500B) within 14 days after the discharge date" and "must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days)." Review of Resident #43's "Admission Record" indicated the resident was admitted with diagnoses of EX. Order 26.(4) B1 and EX. Order 26.(4) B1 Review of a nursing "Progress Note," dated EX. Order 26.(4) B1 at 11:00 PM, revealed Resident #43 was discharged to a local hospital. Review of Resident #43's discharge MDS revealed the resident was discharged from the facility on EX. Order 26.(4) B1, but the assessment was not completed (Z0500B) until EX. Order 26.(4) B1. During an interview on 04/14/2023 at 9:11 AM, the Minimum Data Set Coordinator (MDSC) stated Resident #43 discharged to the hospital in EX. Order 26.(4) B1. She stated the discharge MDS was not completed and transmitted timely	F 640	affected by this deficient practice. An audit was conducted, with no additional MDS assessments found to be out of compliance. III. MDS staff were educated on facility policy on Resident Assessments and ensuring MDS assessments are encoded and transmitted timely. The MDS Director or designee will review discharges each day to ensure that assessments are completed as required. IV. Director of MDS or designee will audit charts weekly for (4) four weeks, then monthly for (3) three months to ensure compliance. Results will be forwarded to the QA committee monthly for (4) four months for tracking, trending and implementation of an action plan as necessary.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 8	F 640		

because it was just missed. She stated the timeframe to submit the discharge assessment was 14 days after discharge. She stated she followed the RAI manual for encoding, completing, and transmitting MDS assessments. She stated she expected MDS assessments to be encoded, completed, and transmitted by the timeframe indicated in the RAI manual. She stated Resident #43's discharge assessment was not submitted until [redacted]

During an interview on 04/14/2023 at 12:38 PM, the Assistant Director of Nursing (ADON) revealed the facility followed the RAI manual for encoding, submission, and transmission of MDS assessments. She stated she expected MDS assessments to be completed timely per the RAI manual and facility policy.

During an interview on 04/14/2023 at 1:09 PM, the Administrator in Training (AIT) stated he expected MDS assessments to be encoded, completed, and transmitted in a timely manner. He stated the facility followed the RAI manual.

During an interview on 04/14/2023 at 2:17 PM, the Director of Nursing (DON) stated a discharge assessment should be completed within 14 days of discharge. She stated she was not aware that Resident #43's discharge MDS was not completed and submitted. She stated the facility followed the RAI manual for encoding, transmitting, accuracy, and completion timeframes. She stated she expected all MDS assessments to be completed in a timely manner per the RAI manual and CMS rules.

New Jersey Administrative Code § 8:39-11.2 (e) 3

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, it was determined that the facility failed to provide care and treatment after a NJ Exec for 1 (Resident #281) of 3 residents. Specifically, the facility failed to conduct routine NJ Exec. Order 26 4.b.1 examinations NJ Exec. Order 26:4.b.1) for Resident #281 after a NJ Exec. O on 04/10/2022. Findings included: Review of the facility undated "EX. Order 26.(4) B1 Check Flowsheet," revealed EX. Order 26. checks should be completed every EX. Order 26.(4) B1, then every EX. Ord minutes for EX. Order hours, then every EX. Order 2 for EX. Orde hours, then once per shift for a total of EX. O hours. A review of an "Admission Record" indicated the facility admitted Resident #281 with diagnoses that included EX. Order 26.(4) B1 [redacted]	F 684	Spring Hills Post-Acute Care Woodbury Plan of Corrections April 14th Annual Survey F684 Quality of Care CFR(s): 483.25 I. During the annual survey, it was determined that the facility failed to provide care and treatments after a EX. Or for 1 (resident #281) of 3 residents. Specifically, the facility failed to conduct routine EX. Order 26.(4) B1 examinations NJ Exec. Order 26 [redacted] for resident #281 after EX. Order 2 on EX. Order 26.(4) B. EX. Order 26.(checks were completed; however, documentation was missed two times as required per the flowsheet. Resident #281 received NJ Exec. Order 26:4.b from their EX. Orde and was discharged home on EX. Order 26.(without incident.	5/10/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 Review of Resident #281's care plan initiated on EX. Order 26.(4) B1 revealed the resident was at risk for NJ Exec. O and had a EX. Orde on EX. Order 26.(4) B1. The facility developed interventions that directed staff to ensure the resident's call light was within reach and encourage the resident to call for assistance as needed; ensure the resident wore appropriate footwear during ambulation/transfers as needed; and ensure the environment was free of clutter. The admission Minimum Data Set (MDS) dated EX. Order 26.(4) B1 revealed Resident #281 had a Brief Interview for Mental Status (BIMS) score of EX. Ord which indicated the resident was EX. Order 26.(4) B1 EX. Order 26. Resident #281 required limited assistance of one person for most activities of daily living. According to the MDS, Resident #281 sustained a EX. O with NJ Exec. Order 26:4.b since admission. A review of a facility incident report revealed on EX. Order 26.(4) B1 at 7:30 PM, Resident 281's physician was notified that the resident was found sitting on the floor next to the bed, in front of the recliner. The resident stated they attempted to ambulate without assistance. According to the report, Resident #281 had NJ Exec. Order 26:4.b.1. A review of Resident #281's "Progress Notes" dated EX. Order 26.(4) B1 at 12:24 PM revealed the resident's physician assessed the resident and noted the resident EX. Ord on EX. Order 26.(4) B1. The physician's note revealed the resident hit the EX. Order 2 of their EX. Order 2 on the EX. Order 26.(4) B1. A review of Resident #281's EX. Order 26 checks for EX. Order 26.(4) B1 revealed no documentation that the facility conducted EX. Order 26.(checks for the resident as required per the flowsheet on EX. Order 26.(4) B1 at 7:40 PM and 8:40 PM.	F 684	II. All residents have the potential to be affected by this deficient practice. An audit of ten charts was conducted, with no additional missing documentation, or deficient practices found. III. All nursing staff were educated on facility policy on EX. Order 26.(4) Checks after a resident has an EX. Order 26.(4) B1 and required documentation on the flowsheet. The Director of Nursing or designee will review incident reports each morning prior to morning meeting to ensure that documentation was completed as necessary for any EX. Order 2 IV. Director of Nursing or designee will audit charts weekly for (4) four weeks, then monthly for (3) three months to ensure compliance. Results will be forwarded to the QA committee monthly for (4) four months for tracking, trending and implementation of an action plan as necessary.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11	F 684		

During an interview with Registered Nurse (RN) #2 on 04/12/2023 at 2:30 PM, she stated if a resident had an EX. Order 26.(4) B1, the facility conducted EX. Order 26. checks for EX. Ord hours. She stated if something was not documented, the facility could not verify it was done.

During an interview with RN #3 on 04/12/2023 at 10:50 PM, she stated if a resident had an EX. Order 26.(4) B1, the facility would start EX. Order 26. checks.

During an interview with Licensed Practical Nurse (LPN) #4 on 04/13/2023 at 2:12 PM, she stated after an EX. Order 26.(4) B1, the facility completed EX. Order 26.4 checks per the flow sheet for EX. Ord hours.

During an interview with LPN #5 on 04/14/2023 at 11:54 AM, she stated if there was an EX. Order 26.(4) B1 EX. Ord, the facility would initiate EX. Order 26.4 checks and EX. Order 26. checks were conducted for EX. OOrder days.

During an interview with the Assistant Director of Nursing (ADON) on 04/14/2023 at 1:12 PM stated she expected nurses to follow the EX. Order 26.4 check flowsheet for the completion of EX. Order 26. checks for residents who had EX. Order 26.(4) B1.

During an interview with the Director of Nursing (DON) on 04/14/2023 at 2:25 PM, she stated she expected staff to do resident EX. Order 26. checks per the flowsheet.

During an interview with the Administrator on 04/14/2023 at 6:50 PM, he stated he was aware there was missing documentation, but he expected staff to document the tasks they completed. He stated he also expected staff to

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 complete all documentation and assessments as required. New Jersey Administrative Code § 8:39-27.1 (a)	F 684		
F 812 SS=F	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 document review, interview, and facility policy review, it was determined that the facility failed to ensure staff consistently monitored the refrigerator temperature for safe temperature ranges. This had the potential to affect all residents who received food from the kitchen. Findings included: A review of an undated facility policy titled, "Food	F 812	Spring Hills Post-Acute Care Woodbury Plan of Corrections April 14th Annual Survey F812 Food Procurement, Store/Prepare/Serve -Sanitary CFR(s): 483.60(i)(1)(2) I. During the annual survey on the initial	5/10/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 13 Safety Requirements," revealed, "Food will be stored, prepared, distributed, and served in accordance with professional standards for food safety." The policy indicated "Practices to maintain safe refrigerated storage include: i. Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation." During the initial tour of the kitchen on 04/10/2023 at 10:04 AM, it was noted the April 2023 "Refrigerator/Freezer Temperature Log" for the refrigerator had not been updated since 04/05/2023. During an interview on 04/10/2023 at 1:19 PM, the Dining Services Director said he expected his staff to ensure the temperature logs were up to date. New Jersey Administrative Code § 8:39-17.2 (g)	F 812	tour of the kitchen on 4/10/23 at 10:04am, it was noted that the April 2023 Refrigerator/Freezer Temperature Log for the refrigerator had not been updated since 4/5/23. Temperatures were taken that day, and all refrigerators and freezers were within acceptable temperature ranges. Dietary staff were immediately in-serviced on the Policy/Procedures for the daily temperature logs, and the importance on ensuring that these are done daily as required. II. All residents have the potential to be affected by this deficient practice. An audit of all temperature logs showed no other missing temps from the various refrigerator and freezer logs. III. All dietary/kitchen staff were educated on facility policy on daily documentation of temperature logs for all freezers and refrigerators in the kitchen. The Food Service Director or designee will review daily temperature log documentation each morning prior to morning meeting to ensure that documentation is completed. IV. Food Service Director or designee will audit temperature log documentation weekly for (4) four weeks, then monthly for (3) three months to ensure compliance. Results will be forwarded to the QA committee monthly for (4) four months for tracking, trending and implementation of an action plan as	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 14	F 812	necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Census: 103 Sample Size: 28 TYPE OF SURVEY: Recertification The facility is not in substantial compliance with all of 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 provisions of 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistants (CNA) staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 2 of 7 evening shifts for the week of 01/02/2022 - 01/08/2022. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 2 of 7 evening	S 560	Spring Hills Post-Acute Care Woodbury Plan of Corrections April 14th Annual Survey S560 8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. I. During the annual survey it was	5/10/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 shifts for the week of 01/09/2022 - 01/15/2022. The facility was deficient in CNA staffing for residents on 3 of 7 day shifts and deficient in CNAs to total staff on 3 of 7 evening shifts for the week of 04/03/2022 - 04/09/2022. The facility was deficient in CNA staffing for residents on 6 of 7 day shifts for the week of 04/10/2022 - 04/16/2022. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 2 of 7 evening shifts for the week of 03/26/2023 - 04/01/2023. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts for the week of 04/02/2023 - 04/08/2023. This deficient practice had the potential to affect all residents. Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 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 aid 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 certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and	S 560	determined that the facility failed to ensure that minimum staffing ratios were adequately met during the weeks of 1/2/22 – 1/8/22, 1/9/22 – 1/15/22, 4/3/22 – 4/9/22, 4/10/22 – 4/16/22, 3/26/23 – 4/1/23 and 4/2/23 – 4/8/23 on day shift and evening shift for the weeks that were reviewed. No residents were identified nor immediately affected by the failure to provide minimum staffing levels. II. All residents have the potential to be affected by this deficient practice. III. The facility made over 40 CNA hires between June 2022 and January 2023 to bolster staffing ratios. In addition, contracts with 3 different agencies have been signed, so that the facility may supplement with agency staff when needed. Sign on bonuses, as well as referral bonuses were offered in order to assist in recruitment of CNAs, as well as the addition of shift differentials being paid for evening shifts. The staffing coordinator will inform DON or designee of any call out(s) that result in insufficient staffing levels. This will be reported as soon as possible. Any staffing deficiencies will be filled prior to the start of the shift with other associates or agency as needed. IV. The DON or designee will report any staffing issues daily to the administrator or designee. Any findings will be followed up and documented on and then reported during the quarterly QAPI meetings for one year's time, or until staffing levels are no longer an issue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 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 certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the week of 01/02/2022 - 01/08/2022, revealed staff-to-resident ratios that did not meet minimum requirements. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 2 of 7 evening shifts as follows: - 01/02/2022 had 5 CNAs for 88 residents on the day shift, required 11 CNAs. - 01/03/2022 had 7 CNAs for 87 residents on the day shift, required 11 CNAs. - 01/04/2022 had 6 CNAs for 87 residents on the day shift, required 11 CNAs. - 01/04/2022 had 4 CNAs to 10 total staff on the evening shift, required 5 CNAs. - 01/05/2022 had 5 CNAs for 87 residents on the day shift, required 11 CNAs. - 01/06/2022 had 6 CNAs for 87 residents on the day shift, required 11 CNAs. - 01/07/2022 had 6 CNAs for 87 residents on the day shift, required 11 CNAs. - 01/08/2022 had 8 CNAs for 90 residents on the day shift, required 11 CNAs. - 01/08/2022 had 5 CNAs to 12 total staff on the evening shift, required 6 CNAs. 2. The week of 01/09/2022 - 01/15/2022, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 2 of 7 shifts as follows:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 - 01/09/2022 had 7 CNAs for 90 residents on the day shift, required 11 CNAs. - 01/09/2022 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs. - 01/10/2022 had 6 CNAs for 90 residents on the day shift, required 11 CNAs. - 01/11/2022 had 9 CNAs for 90 residents on the day shift, required 11 CNAs. - 01/12/2022 had 10 CNAs for 90 residents on the day shift, required 11 CNAs. - 01/13/2022 had 8 CNAs for 101 residents on the day shift, required 13 CNAs. - 01/14/2022 had 9 CNAs for 101 residents on the day shift, required 13 CNAs. - 01/14/2022 had 5 CNAs to 13 total staff on the evening shift, required 6 CNAs. - 01/15/2022 had 5 CNAs for 101 residents on the day shift, required 13 CNAs. 3. A review of the "Nurse Staffing Report," completed by the facility for the week of 04/03/2022 - 04/09/2022, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 3 of 7 day shifts and deficient in CNAs to total staff on 3 of 7 evening shifts as follows: - 04/03/2022 had 10 CNAs for 94 residents on the day shift, required 12 CNAs. - 04/04/2022 had 8 CNAs for 94 residents on the day shift, required 12 CNAs. - 04/06/2022 had 10 CNAs to 23 total staff on the evening shift, required 11 CNAs. - 04/08/2022 had 8 CNAs to 20 total staff on the evening shift, required 10 CNAs. - 04/09/2022 had 8 CNAs for 102 residents on the day shift, required 13 CNAs. - 04/09/2022 had 7 CNAs to 16 total staff on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 the evening shift, required 8 CNAs. 4. The week of 04/10/2022 - 04/16/2022, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: - 04/10/2022 had 8 CNAs for 102 residents on the day shift, required 13 CNAs. - 04/12/2022 had 9 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/13/2022 had 8 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/14/2022 had 7 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/15/2022 had 9 CNAs for 118 residents on the day shift, required 15 CNAs. - 04/16/2022 had 10 CNAs for 117 residents on the day shift, required 15 CNAs. 5. A review of the "Nurse Staffing Report," completed by the facility for the week of 03/26/2023 - 04/01/2023, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 2 of 7 evening shifts as follows: - 03/26/2023 had 7 CNAs for 104 residents on the day shift, required 13 CNAs. - 03/26/2023 had 5 CNAs to 12 total staff on the evening shift, required 6 CNAs. - 03/27/2023 had 8 CNAs for 108 residents on the day shift, required 13 CNAs. - 03/28/2023 had 8 CNAs for 103 residents on the day shift, required 13 CNAs. - 03/29/2023 had 9 CNAs for 103 residents on the day shift, required 13 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 - 03/30/2023 had 10 CNAs for 103 residents on the day shift, required 13 CNAs. - 03/31/2023 had 9 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/01/2023 had 9 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/01/2023 had 6 CNAs to 15 total staff on the evening shift, required 7 CNAs. 6. The week of 04/02/2023 - 04/08/2023, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: - 04/02/2023 had 9 CNAs for 105 residents on the day shift, required 13 CNAs. - 04/03/2023 had 7 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/04/2023 had 9 CNAs for 102 residents on the day shift, required 13 CNAs. - 04/05/2023 had 7 CNAs for 102 residents on the day shift, required 13 CNAs. - 04/06/2023 had 9 CNAs for 102 residents on the day shift, required 13 CNAs. - 04/07/2023 had 9 CNAs for 102 residents on the day shift, required 13 CNAs. - 04/08/2023 had 9 CNAs for 103 residents on the day shift, required 13 CNAs. On 04/12/2023 at 2:20 PM, the Staffing Coordinator (SC) stated the facility was short staffed for the weeks of 03/26/2023 to 04/01/2023 and 04/02/2023 to 04/08/2023. She stated there was a nationwide shortage of staff. The SC stated the facility conducted new hire orientation for all departments every Tuesday, offered referral bonuses and shift differentials, used agency staff, and posted on websites with sign-on bonuses. Per the SC, for the weeks of 03/26/2023 to	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6 04/01/2023 and 04/02/2023 to 04/08/2023, the facility had staff go to per diem and quit. The SC stated she expected the New Jersey minimum staffing ratios to be met. On 04/14/2023 at 12:26 PM, the Assistant Director of Nursing (ADON) stated she was aware the facility was deficient in staffing for the previous two weeks of 03/26/2023 to 04/01/2023 and 04/02/2023 to 04/08/2023. She stated the facility did open house, offered bonuses, and used agency staffing to meet minimum staffing ratios. The ADON stated the facility's goal was always to have adequate staffing. Per the ADON, she expected the New Jersey minimum staffing ratios to be met and followed. On 04/14/2023 at 2:08 PM, the Director of Nursing (DON) stated she was aware the facility was short staffed on 03/26/2023 to 04/01/2023 and 04/02/2023 to 04/08/2023. She stated the facility was short staffed due to call outs. According to the DON, she expected the facility to follow the New Jersey minimum staffing ratios and be sufficiently staffed. On 04/12/2023 at 2:50 PM, the Administrator in Training (AIT) stated the facility was deficient in staffing for 03/26/2023 to 04/01/2023 and 04/02/2023 to 04/08/2023 and did not meet the New Jersey minimum staffing guidelines. He indicated the facility had some staff that called out and quit for the weeks of 03/26/2023 to 04/01/2023 and 04/02/2023 to 04/08/2023. He stated the facility had hiring advertisements on different websites and offered sign on bonuses and shift differentials to obtain staff. He stated he expected the New Jersey minimum staffing ratios to be met.	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
315521 Y1	A. Building B. Wing Y2	5/16/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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 F0554	Correction	ID Prefix F0640	Correction	ID Prefix F0684	Correction
Reg. # 483.10(c)(7)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.25	Completed
LSC	05/10/2023	LSC	05/10/2023	LSC	05/10/2023
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/10/2023	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	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/14/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08008 Y1	A. Building B. Wing Y2	5/16/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/10/2023	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	
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	
4/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING **01** B. WING _____	**04/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	**467 COOPER STREET** **WOODBURY, NJ 08096**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) 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 04/13/2023 to 04/14/2023 and Atrium Post Acute Care of Woodbury was found to be in 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Atruim Post Acute Care of Woodbury is a one-story Type II Protected building that was built in 2016. The facility is divided into 10 smoke zones.	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/16/2023

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.