

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/02/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205</b>
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(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) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ 00170562, NJ 00180745, NJ 00183459</p> <p>DATE OF SURVEY: 10/2/2025</p> <p>CENSUS: 97</p> <p>SAMPLE SIZE: 7</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE 8:36, STANDARDS FOR LICENSURE OF ASSISTED LIVING RESIDENCES, COMPREHENSIVE PERSONAL CARE HOMES AND ASSISTED LIVING PROGRAMS.</p>	A 000		

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

TITLE

(X6) DATE