

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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: COMPLAINT #: NJ00164703</p> <p>CENSUS: 50</p> <p>SAMPLE SIZE: 6</p> <p>TYPE OF SURVEY: Standard Survey of 77 residential units</p> <p>The facility is not in substantial compliance with all 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> <p>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.</p>	A 000		
A 891	<p>8:36-10.5(a) Dining Services</p> <p>(a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.</p>	A 891		

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

TITLE

(X6) DATE

01/05/26

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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 891	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility document review, and facility policy review, the facility failed to ensure dishes were properly sanitized before they were used for residents' meal service. Specifically, after the facility's dishwasher had a high-temperature mechanism failure, the unit was converted to a low-temperature sanitization system and the facility failed to ensure staff were properly trained to perform chemical testing of the dish machine, failed to ensure chemical test strips were readily available for use, and failed to documentation evidence of routine checks verifying the sanitizer concentration was at the required level to ensure proper sanitization of dishes used to prepare and serve resident meals. This failure had the potential to affect all residents who received meals from the kitchen and placed residents in imminent danger.</p> <p>It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, harm, impairment, or death to residents.</p> <p>On 11/13/2025, the New Jersey Department of Health determined that the failed practice represented an immediate threat to residents' health and safety. The facility's Executive Director was verbally informed of the immediacy of the situation involving the sanitization of dishes used to prepare and serve resident meals.</p> <p>Findings included:</p> <p>The United States Food and Drug</p>	A 891		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD</b> <b>GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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 891	<p>Continued From page 2</p> <p>Administration's "2022 Food Code," effective 01/18/2023, revealed a section titled, "4-501.18 Ware washing Equipment, Clean Solutions," that specified, "Failure to maintain clean wash, rinse, and sanitizing solutions adversely affects the ware washing operation. Equipment and utensils may not be sanitized, resulting in subsequent contamination of food."</p> <p>An undated facility policy titled, "Dish Washing Policy and Procedure" revealed a procedure that specified, "Initial wash must reach a Temperature of 160 degrees" and "The final Rinse (sanitation) must reach 180 degrees." The policy revealed, "If for any reason these are not being meet [sic] you must notify your supervisor immediately." The policy revealed, "All dish machine temps [temperatures] must be recorded on a daily basis after each meal time."</p> <p>An undated facility policy titled, "Kitchen Sanitation Policy," revealed a section titled, "Responsibilities," that specified, "- The Kitchen Manager is responsible for implementation, oversight, documentation, and training. - All kitchen/food service staff must follow the sanitation practices, complete required training, and report any sanitation or equipment concerns immediately." The policy revealed, "- The Administrator will ensure adequate resources (supplies, equipment, staff) for compliance." The policy also revealed, "- All food-service shall receive training in food safety, sanitation, cross contamination, food temperature control, and therapeutic diets. - Refresher training shall be provided at least annually and when procedures or regulations change." The policy revealed a section titled, "Kitchen &amp; Food Preparation Area Sanitation," that specified, "2. After each use, utensils, dishes, glasses, flatware must be</p>	A 891		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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 891	<p>Continued From page 3</p> <p>washed according to regulatory standards." The policy revealed a section titled, "Equipment Maintenance &amp; Facility Conditions," that specified, "- All major kitchen appliances (refrigerator, freezer, oven cooktop) must be in good working order, regularly maintained." Further review revealed, "- Immediately address and repair any leaks, water damage, mold formation, or other hazards." The policy revealed a section titled, "Documentation &amp; Monitoring," that specified, "- Daily logs for refrigeration/freezer temperatures, equipment cleaning, dish-washing cycles, pest control checks. - Maintain records of staff training, sanitation schedules, equipment maintenance, corrective action." The policy revealed a section titled, "Non-compliance &amp; Corrective Action," that specified, "If any equipment fails (e.g. [exempli gratia, for example], fridge not at correct temperature), immediately remove affected food from service, document the incident, correct condition, and notify Administrator,"</p> <p>A facility document titled, "[Brand name] Hot Water Sanitizing Single-Tank Door Dishmachine [sic] Installation, Operation and Service Manual," dated 03/02/1998, revealed the manual did not include instructions on conversion of the machine from a high temperature to a low temperature chemical sanitation machine nor operation during the wash and rinse cycles to include proper temperatures or chemical concentration after the machine was converted.</p> <p>During a concurrent observation and interview on 11/12/2025 at 12:01 PM, Dishwasher (DW) #2 stated that the facility's dishwashing machine was a high-temperature machine. During the observation DW #2 ran the dishwasher to complete a cycle for temperature verification to</p>	A 891		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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 891	<p>Continued From page 4</p> <p>determine if the machine was meeting the required temperature for sanitation. During the observation, the wash cycle temperature gauge reached 160 degrees Fahrenheit (F) and the rinse cycle temperature gauge, which displayed a minimum temperature of 100 degrees F, did not appear to move. DW #2 repeated the cycle and had the same results. DW #2 stated that he had already completed washing the dishes from breakfast. DW #2 stated that he completed temperature logs that morning, which revealed the wash temperature reached 161 degrees F and the rinse temperature reached 181 degrees F. He stated the dish machine was working earlier in the shift. DW #2 stated that he never tested the chemical concentration of the dishwasher.</p> <p>During an observation of Dining Room A on 11/12/2025 at 12:32 PM, nine residents were seated at tables and eating their lunch meal served on the facility's dishware.</p> <p>During a concurrent observation and interview on 11/12/2025 at 12:05 PM, the Food Services Director (FSD) stated the facility's dishwashing machine was a low-temperature, chemical dishwasher, and the sanitizer used was bleach. The FSD stated he did not have chemical testing strips available and was unable to complete a test of the chemical concentration for demonstration. The FSD acknowledged and stated he was unable to verify the sanitation of the dishes used during the breakfast meal which were used to serve the lunch meal.</p> <p>During an interview on 11/12/2025 at 1:17 PM, the Territorial Sales Manager (TSM) from the company that serviced the facility's dishwasher stated the facility's dishwasher was a</p>	A 891		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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 891	<p>Continued From page 5</p> <p>low-temperature machine, which required a chemical sanitizer and the wash and rinse cycles temperatures should reach 120 degrees Fahrenheit. He stated he serviced the dishwasher monthly, but the facility should be testing the chemicals on a daily basis with chlorine test strips. He stated that if the chemicals did not reach 50-100 parts per million (ppm) when tested, then the machine was not sanitizing correctly.</p> <p>During a concurrent observation and interview on 11/12/2025 at 1:45 PM, the FSD stated he had obtained chemical testing strips to check the chemical concentration of the dishwasher. The FSD then observed the packaging of the chemical testing strips and stated that they were not chlorine testing strips needed to properly check the dish machine's chemical concentration.</p> <p>During a concurrent observation and interview on 11/12/2025 at 2:10 PM, the FSD stated he had obtained test strips for chlorine bleach but was not trained in how to use the test strips to test the chemical concentration. The FSD initially placed the test strip in the dishwasher and ran the machine cycle for 10 seconds, and the test strip did not change colors to reflect the concentration of the chemicals in the machine. The FSD ran an additional cycle of the dish machine and tested the water in a bowl; however, the test strip again did not change colors to indicate a reading of the concentration of the chemicals presently in the dish machine. During the observation, the bottle of chemicals hanging on the wall labeled as Sodium Hypochloride did not appear to change levels of liquid after the cycles had been run in the dish machine.</p> <p>During a follow-up interview on 11/12/2025 at</p>	A 891		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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 891	<p>Continued From page 6</p> <p>2:05 PM, the TSM stated the dishwashing machine was originally designed as a hot water sanitization machine from the factory; however, the machine was modified to be low-temperature chemical sanitization machine due to the booster (a device which allows the machine to reach a temperature of 180 degrees Fahrenheit for non-chemical sanitation) malfunction.</p> <p>During an interview on 11/12/2025 at 4:00 PM, DW #3, who worked the second shift, stated that no other employees wash dishes other than dishwashers across different shifts. DW #3 stated that he did not use chemical test strips to test the dishwasher. He stated the dishwasher temperatures should reach 100 to 120 degrees F, but he could not specify if that was for the wash or rinse cycle. DW #3 stated that staff used a thermometer to take the dishwasher temperatures, however; he then stated that he did not use a thermometer, and maintenance staff checked the temperatures once a week. DW #3 then stated that monitoring the temperatures of the dishwashing machine was not his responsibility.</p> <p>During an interview on 11/13/2025 at 11:50 AM, Cook #4 stated he was rarely required to perform duties to include dish washing; however, he stated that he knew to complete the dishwasher temperature log and perform chemical testing in the 3-in-1 sanitizer sink. He stated that he did not use test strips for the dishwashing machine to test the chemical concentration.</p> <p>During an interview on 11/12/2025 at 4:24 PM, the Assisted Living Charge Nurse (ALCN) stated she expected the dietary staff to maintain sanitation in dishwashing and follow proper infection control procedures for dishwashing. She</p>	A 891		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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 891	Continued From page 7  stated she was not knowledgeable about the specifics for the machine usage; however, she would expect all dishes to be properly sanitized before use. The ALCN stated she expected the FSD to complete training with employees on hire and annually on how to properly use the dish machine. The ALCN stated the facility utilized the same dish machine for a long time, and sanitation of dishes was important to ward off germs to prevent residents from getting sick from raw food and contamination.  During an interview on 11/12/2025 at 4:16 PM, the Executive Director stated that he expected kitchen staff to ensure the dishwasher was sanitizing correctly and that staff were trained by the FSD on kitchen sanitation and infection control. He stated that if dishes were not sanitized correctly, then there was a risk of bacteria remaining on the dishes and causing residents to get sick.	A 891		
A1041	8:36-14.3(a) Emergency Services and Procedures  (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually,	A1041		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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
A1041	<p>Continued From page 8</p> <p>and selected residents may participate in drills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and facility document and policy review, it was determined that the facility failed to ensure staff participated in at least one drill annually for 2 (Certified Medication Assistant [CMA] #5 and Assisted Living Manager [ALM] #6) of 5 personnel files reviewed. Additionally, the facility failed to conduct at least one drill of the emergency plans every month. The deficient practice was evidenced by the following:</p> <p>Findings included:</p> <p>1. An undated facility document titled, "Emergency and Fire Drills," indicated, "Emergency and fire drills are conducted at least monthly. They are conducted at varying times, including evenings, nights are [sic] weekends, so that all staff participate in at least one (1) drill per year." The facility documented also indicated "Facility staff is [sic] required to prepare and file written reports of all emergency and fire drills."</p> <p>CMA #5's employee file revealed no evidence that CMA #5 had participated in an annual fire drill.</p> <p>ALM #6 employee file revealed no evidence that ALM #6 had participated in an annual fire drill.</p> <p>Facility documents titled, "Fire Drills Attendance Record" and "Fire Drill Attendance Record" for the timeframe from 11/2024 through 10/2025</p>	A1041		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD</b> <b>GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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
A1041	<p>Continued From page 9</p> <p>revealed no evidence of documentation that CMA #5 and ALM #6 had participated in a fire drill.</p> <p>During a telephone interview on 11/13/2025 at 4:22 PM, ALM #6 stated she could not recall whether she had participated in a fire drill in the past year or not; however, she indicated she signed a document each time she participated in a fire drill.</p> <p>During an interview on 11/13/2025 at 11:55 AM, the Maintenance Director stated that the last documented fire drill for ALM #6 was on 06/11/2024. He stated that ALM #6 should have had another one before 06/11/2025.</p> <p>During a subsequent interview on 11/13/2025 at 12:02 PM, the Maintenance Director stated he reviewed documented fire drills for the year 2024 and was unable to locate documentation as to whether CMA #5 had participated in any fire drills.</p> <p>During an interview on 11/13/2025 at 4:00 PM, the Assisted Living Charge Nurse (ALCN) stated she expected all staff to participate in a fire and emergency drill annually.</p> <p>During an interview on 11/13/2025 at 12:42 PM, the Executive Director stated that he expected all staff to participate in a fire drill at least annually.</p> <p>2. On 11/14/25 in the presence of the Executive Director (ED) and Maintenance Director (MD), the surveyor reviewed the facility's emergency plans which revealed that an emergency plans drill was not conducted in the month of February or July of 2025.</p> <p>During surveyor interview with the MD regarding</p>	A1041		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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
A1041	Continued From page 10 the emergency plans, the MD confirmed that drills were not conducted in February or July of 2025.	A1041		
A1089	<p>8:36-16.3(b) Physical Plant</p> <p>(b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that a means of ventilation was provided either by a window with an openable area or by mechanical ventilation for every bathroom or water closet. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>On 11/14/2025, from 10:21 a.m. to 11:35 a.m., in the presence of the Executive Director (ED), the surveyor observed that the ventilations in resident room #s: <b>NJ Exec Order 26, 4B1</b> were not functioning when tested by the ED.</p> <p>During surveyor interview with the ED regarding above concern, the ED confirmed that the ventilations were not functioning.</p>	A1089		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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
A1095	<p>8:36-16.5(b) Physical Plant</p> <p>(b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the automatic fire detection system was Inspected, Tested and Maintained (ITM) in accordance with NFPA 72. This deficient practice was evidenced by the following:</p> <p>On 11/14/2025 at 10:00 a.m., in the presence of the Executive Director (ED) and Maintenance Director (MD), the surveyor observed that the fire alarm panel was actively indicating a "Trouble" signal.</p> <p>During surveyor interview with the ED regarding the fire alarm panel, the ED confirmed that the fire alarm panel was actively indicating a "TROUBLE" signal and stated that he was not sure why.</p> <p>Additionally, the surveyor interviewed the MD and asked why the fire alarm panel was currently indicating a "trouble" signal. The MD stated that it was from a failed battery that needed to be</p>	A1095		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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
A1095	<p>Continued From page 12</p> <p>replaced but not the same batteries from the fire alarm inspection report.</p> <p>Surveyor record review of the semi-annual fire alarm inspection conducted on 06/11/2025 revealed that the report indicated: "FAIL-Batteries failed load test" for 3 fire alarm system batteries.</p> <p>The surveyor interviewed the MD regarding the deficiency identified by their fire alarm vendor. The MD stated that the batteries failed the semi-annual inspection and that the batteries were replaced. The MD informed the surveyor that he would provide documentation of the battery replacement.</p> <p>However, the facility failed to provide the surveyor documentation to show that the batteries from the 6/11/2025 inspection report were replaced.</p>	A1095		
A1097	<p>8:36-16.6 Physical Plant</p> <p>All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was</p>	A1097		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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
A1097	<p>Continued From page 13</p> <p>determined that the facility failed to ensure that the Inspection, Testing and Maintenance (ITM) of the fire suppression system was in accordance with NFPA 25. This deficient practice was evidenced by the following:</p> <p>On 11/14/25 in the presence of the Executive Director (ED) and Maintenance Director (MD), the surveyor reviewed the quarterly sprinkler inspection reports provided by the MD. The record review revealed that the quarterly dry sprinkler inspection report conducted on 10/23/24 indicated: "Deficiency Summary, Dry head testing due".</p> <p>During surveyor interview with the MD regarding the quarterly sprinkler reports, the MD confirmed that the dry sprinkler heads were due for testing and stated that they have not sent them out for sampling yet.</p>	A1097		
A1249	<p>8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance</p> <p>The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.</p>	A1249		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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
--------------------	--	---------------	---	--------------------

A1249	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the building and grounds were kept free from fire hazards and other hazards to resident's health and safety. This deficient practice was evidenced by the following:</p> <p>On 11/14/25 at 10:15 a.m., in the presence of the Executive Director (ED) the surveyor observed that "Stair A's" door did not positive latch when tested by the ED.</p> <p>From 10:18 to 11:00 a.m., in the presence of the ED, the surveyor observed that the exits from Stairs A, B and C were not provided with a hard packed all-weather travel surface to a public way.</p> <p>At 11:46 a.m., in the presence of the ED, the surveyor observed that the Boiler/Sprinkler room door did not self-close and positive latch when tested by the ED.</p> <p>At 1:50 p.m., in the presence of the ED, the surveyor observed that a remote generator annunciator panel that was located outside of the generator room and at a work site observable by personnel was not provided.</p> <p>During surveyor interview at the time of the observations, the ED confirmed and acknowledged the following observations: stairway exits were not provided with a hardpacked surface to a public way; the boiler room door did not positively latch and a remote annunciator panel was not provided.</p> <p>The surveyor reviewed the generator logs, in the presence of the Maintenance Director (MD) which</p>	A1249		
-------	---	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>01a004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SPRING HOME AT GALLOWAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 WEST JIMMIE LEEDS ROAD</b> <b>GALLOWAY TOWNSHIP, NJ 08205</b>
--	---

(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
A1249	<p>Continued From page 15</p> <p>revealed that the monthly load testing of the generator were not conducted for at least 30 minutes at 30% of the name plate rating.</p> <p>During surveyor interview with the MD at the time of the record review, the MD confirmed and acknowledged that generator testing for at least 30 minutes at 30% of the name plate rating was not conducted.</p>	A1249		

POC# 3 received 1/15/26  
Accepted 1/15/26



Statement of Deficiencies and Plan of Correction

46 West Jimmie Leeds Rd

Galloway, NJ 08205

Facility License Number NJ Exec Order 26

**ID PREFIX TAG A891: Dining Services**

1. On 11/16/2025 the Food Service Director completed an in-service with all kitchen staff regarding sanitation and the correct temperatures for each rinse cycle performed by the dishwasher. The correct chemical strips were obtained on 12/04/2025 for the low-temperature dishwasher.
2. All residents had the potential to be affected by the failure to ensure dishes were properly sanitized before they were used for the resident's meal service.
3. On 11/16/2025 a log was put into place for the daily check of the correct temperature for each rinse cycle by the dishwasher. The log is overseen by the Food Service Director or designated staff member.
4. The Executive Director will use the Tuesday morning staff meeting to discuss the status of the exiting follow-ups and any potential new problems.

The completion date for this deficient practice was 12/04/2025.

NJ Exec Order 26

approved  
1/15/26

**ID PREFIX TAG A1041: Emergency Service Procedures**

1. The Executive Director held a fire drill on 01/08/2026 with employees CMA#5 and ALM#6. On 12/20/2025 the Maintenance Director held a fire drill.
2. All residents could have been affected by the deficient practice in the event of a true emergency due to the lack of staff training.
3. On 12/19/2025 the Executive Director educated the Maintenance Director on the importance of ensuring that all staff members participate in a fire drill yearly. The Maintenance Director will continue to hold monthly drills on a rotating basis and utilizing the staff roster to ensure that all employees participate in one drill per year.
4. The Executive Director will use the Tuesday staff meeting to discuss the status of existing follow-ups and any potential new problems.

The completion date for this deficient practice is 01/08/2026.

NJ Exec Order 26

approved  
1/15/26

**ID PREFIX TAG A1089: Physical Plant**

1. On 12/29/2025 The Mechanical systems company came to evaluate for repair the mechanical ventilations that were not functioning. The necessary parts were ordered on 12/29/2025 for rooms **NJ Exec Order 26, 4B1**. A facility wide audit was conducted on 01/08/2025 by the Executive Director and it was found that the ventilation was not working properly in rooms **NJ Exec Order 26, 4B1**. **NJ Exec Order 26, 4B1** The two motors ordered arrived on 01/09/2026 and will fix the mechanical ventilation in all the rooms. The repair is scheduled for 01/13/2026.
2. All residents could have been affected by the deficient practice.
3. On 12/19/2025 the Executive Director educated the Maintenance Director on the importance of ensuring that all mechanical ventilations are function properly. The Maintenance Director or designated staff member will check each wing monthly for proper ventilation for a period of three months and then be done quarterly.
4. The Executive Director will use the Tuesday staff meeting to discuss the status of existing follow-ups and any potential new problems.

The completion date for this deficiency is 01/13/2026.

**NJ Exec Order 26, 4B1**

approved  
1/15/26

**ID PREFIX TAG A1095: Physical Plant**

1. On 12/09/2025 **NJ Exec Order 26.4b1** installed a new power supply and replaced all batteries. The system has been restored, and the system status is normal.
2. All residents could have been affected by the deficient practice of the facility failing to ensure that the automatic fire detection system was Inspected, Tested and Maintained.
3. On 12/19/2025 the Executive Director educated the Maintenance Director on the importance of timely follow-up necessary repairs. The Maintenance Director will continue to have all required inspections done by **NJ Exec Order 26.4b1** and follow up to ensure that all equipment needing replacing is done so in a timely manner.
4. The Executive Director will use the Tuesday morning staff meeting to discuss the status of the existing follow-ups and any potential new problems.

12/09/2025 is the date that reflects when the deficient practice was corrected.

**NJ Exec Order 26,**

approved  
1/15/26

**ID PREFIX TAG A1097: Physical Plant**

1. On 12/30/2025 the fire protection company completed the dry head testing that was due from the 10/23/2024 deficiency. The necessary sprinkler heads were not sent out for testing but replacement sprinkler heads were ordered on 12/30/2025. On 01/19/2026 the sprinkler heads will be replaced.
2. All residents could have been affected by the deficient practice of the facility failing to ensure the Inspection, Testing and Maintenance of the fire suppression system.
3. On 12/19/2025 the Executive Director educated the Maintenance Director on the importance of timely follow-up on necessary repairs. The Maintenance Director will continue to have all required

inspections done by the fire protection company and follow up to ensure that all equipment needing replacing is done so in a timely manner.

4. The Executive Director will use the Tuesday morning staff meeting to discuss the status of the existing follow-ups and any potential new problems.

The completion date for this deficient practice is 01/19/2026.



approved 1/15/26

#### **ID PREFIX TAG A1249: Housekeeping-Sanitation-Safety-Maintenance**

1. **Element #1:** On 12/22/2025 the Maintenance Director completed the repair of "Stair A's" door latch. On 12/22/2025 the Maintenance Director repaired the latch on the Boiler/Sprinkler room door.

On 12/31/2025 a contractor was hired to install a hard packed all-weather travel surface to a public way from exits of Stairs A, B and C. The installation will be completed on 01/30/2026.

On 01/01/2026 the generator company installed a remote generator annunciator panel in our lobby which is a continuously staffed area.

On 01/01/2026 a load test was done on the generator for 30 minutes at 30% of the name plate rating

2. **Element #2:** All residents could have been affected by the deficient practice.
3. **Element #3:** On 12/19/2025 the Executive Director educated the Maintenance Director on the importance of ensuring that all exit and interior maintenance doors latch properly for the safety of our residents. On 11/14/2025 a full house audit was done on all exit doors to ensure they latch properly. No other issues were found. On 12/22/2025 a log was created for monthly checks to be done on all exit doors and interior maintenance doors to ensure they latch properly. This check will be completed by the Maintenance Director or designated staff member.

On 12/19/2025 the Maintenance Director was in-serviced by the Executive Director on all the travel surfaces from all exits of the building. On 12/19/2025 a full house audit was conducted to ensure that all exits of the facility have a hard packed all-weather surface to a public way. No other issues were identified. The Maintenance Director or designated staff will monitor the newly installed hard packed all weather travel surface for any signs of distress and log any issues for follow-up for a period of three months.

On 01/01/2026 the staff members responsible on each shift were educated on the remote generator annunciator panel in our lobby. The staff was instructed to address the alarm and notify the Maintenance Director or designated staff member who would then also notify the Executive Director.

On 12/19/2025 the Maintenance Director was educated by the Executive Director on the importance of timely follow up on necessary repairs and the importance of monthly load testing of the generator. A log has been created for the monthly load testing of the generator to be completed by the Maintenance Director or designated staff member.

4. Element #4: The Executive Director will use the Tuesday morning staff meeting to discuss the status of the existing follow-ups such as the monthly load testing of the generator, the monthly checks to ensure the exit and interior doors latch properly and the monthly checks for signs of distress on the newly installed hard packed all-weather surface. The meeting would also be used to discuss if the generator annunciator panel had alarmed, was the problem addressed and corrected and any potential new problems. The monthly checks on the exit and interior doors will go on indefinitely.

The completion date for these deficient practices is 01/30/2026.



approved  
1/15/20

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 01a004 <span style="float: right;">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/15/2026 <span style="float: right;">Y3</span>
NAME OF FACILITY SPRING HOME AT GALLOWAY	STREET ADDRESS, CITY, STATE, ZIP CODE 46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205	

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 A0891	Correction	ID Prefix A1041	Correction	ID Prefix A1089	Correction
Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-14.3(a)	Completed	Reg. # 8:36-16.3(b)	Completed
LSC	12/04/2025	LSC	01/08/2026	LSC	01/13/2026
ID Prefix A1095	Correction	ID Prefix A1097	Correction	ID Prefix A1249	Correction
Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-16.6	Completed	Reg. # 8:36-17.7	Completed
LSC	12/09/2025	LSC	01/19/2026	LSC	01/30/2026
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/14/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 01a004 <span style="float: right;">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/15/2026 <span style="float: right;">Y3</span>
NAME OF FACILITY SPRING HOME AT GALLOWAY		STREET ADDRESS, CITY, STATE, ZIP CODE 46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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 A1041	Correction	ID Prefix A1089	Correction	ID Prefix A1095	Correction
Reg. # 8:36-14.3(a)	Completed	Reg. # 8:36-16.3(b)	Completed	Reg. # 8:36-16.5(b)	Completed
LSC	01/08/2026	LSC	01/13/2026	LSC	12/09/2025
ID Prefix A1097	Correction	ID Prefix A1249	Correction	ID Prefix	Correction
Reg. # 8:36-16.6	Completed	Reg. # 8:36-17.7	Completed	Reg. #	Completed
LSC	01/19/2026	LSC	01/30/2026	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/14/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		