

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/03/2024
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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861
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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
S 000	<p>Initial Comments</p> <p>Initial inspection for Licensure of Renovated Long Term Care Facilities</p> <p>Inspection Date: 01/03/2024</p> <p>Census: 114</p> <p>No deficiencies were noted during the inspection of the Dining Room installation of new lighting, Lobby area, Admissions Office and renovated Therapy Gym.</p> <p>The above noted areas may not be occupied until formal notification by the Certificate of Need and Licensing Division has been received.</p>	S 000		

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

Electronically Signed

TITLE

(X6) DATE

01/19/24