STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	**1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 04/06/23 Census:109 Sample: 25 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:	F 576		5/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/30/2023

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.

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F 576	Continued From page 1 (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined that the facility failed to provide daily delivery of mail, to include Saturdays. This deficient practice was identified for 7 of 7 residents interviewed during the resident council group meeting (Resident #21, #30, #43, #72, #73, #91 and #100), and was evidenced by the following: On 04/03/23 at 10:30 AM, the surveyor attended a resident council group meeting with Residents #21, #30, #43, #72, #73, #91 and #100. The surveyor interviewed the residents regarding mail delivery and all the residents in attendance told the surveyor that mail was only delivered on Mondays and Fridays, with no other days during the week. On 04/04/23 at 11:45 AM, the surveyor interviewed the Activities Director (AD) regarding mail delivery. The AD told the surveyor that the process for the mail was that it gets delivered to the facility, the front desk goes through the mail	F 576	All residents are at risk to be affected by the deficient practice All mail addressed to residents #21, #30, #43, #72, #73, #91, #100 and all residents that received mail on 4/3/2023 was delivered on 4/3/2023 the day of deficient practice finding. All Department Heads educated on Federal Regulation 483.10(g)(7) and the importance of delivering residents mail promptly on the day it is received. Admin/Designee will audit mail delivery two times per week X4 weeks and then monthly X 3 months to ensure prompt mail delivery to the residents. Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as	

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F 576	Continued From page 2 and hands it over to the business office. From the business office, the mail then goes to the Social Worker (SW) who will go through the mail and the mail then gets placed in "a box" for the activities department to deliver. The AD told the surveyor that the mail was delivered "Monday and Friday unless a resident receives a package, then the resident would receive that on the day it gets delivered to the facility". The surveyor also confirmed with the AD that the SW was off on Saturdays and the activity staff had no access to the box holding the mail within the SW's office on the weekends. On 04/04/23 at 1:15 PM, the surveyor reviewed the April 2023 activity calendar. Mail delivery was listed on the schedule at 5:30 PM for Mondays and Fridays. There was no mail delivery included on the other days, nor was it scheduled for Saturdays. On 04/04/23 at 09:30 AM, the surveyor requested a policy or procedure regarding mail delivery from the AD and the facility could not provide one. NJAC 8:39-4.1 (a)(19)	F 576	needed.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to	F 641	All residents are at risk to be affected by the deficient practice	5/5/23

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F 641	Continued From page 3 accurately complete the Minimum Data Set (MDS) for 1 of 26 residents reviewed, Resident #54. This deficient practice was evidenced by the following: The surveyor reviewed the Admission Record for Resident #54 which reflected that the resident was admitted with diagnoses that included Ex Order 26. 4B1 . The surveyor reviewed the smoking safety evaluation dated Ex Order 26. 4B1, which indicated that Resident #54 currently smokes. The surveyor reviewed Resident #54's Annual MDS dated Ex Order 26. 4B1. The section for current tobacco use was coded as Ex Order 26. 4B1, indicating that Resident #54 does not currently use tobacco. When interviewed on 4/3/23 at 12:38 PM, the MDS Coordinator stated that Resident #54's Annual MDS dated Ex Order 26. 4B1 should have been coded as Resident #54 currently using tobacco. When interviewed on 4/4/23 at 11:30 AM, the Director of Nursing acknowledged that the MDS for Resident #54 was coded incorrectly. . NJAC 8:39-2(e)1	F 641	On Ex Order 26. 4B1 Resident #54 previous MDS assessment was modified and indicated that resident #54 used tobacco. All residents that currently smoke MDS were reviewed to confirm accuracy. MDS Coordinator was re-educated on the importance of accurate MDS coding. DON/Designee will conduct an audit on 4 smoking residents MDS's weekly X4 weeks and then monthly X 3 months to ensure proper MDS coding. Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		5/5/23

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F 658	Continued From page 4 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review it was determined the facility failed to maintain professional standards of clinical practice for 1 of 28 residents reviewed (Resident # 206) by failing to document the transfer of a resident to the Ex Order 26. 4B1 following a fall. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 658	All residents are at risk to be affected by the deficient practice. The facility cannot retroactively go back and correct the deficient practice in regarding to resident #206. Facility nurse who failed to call Ex Order was identified and in-serviced on facility Policy for Transfer or Discharge Emergency on Ex Order 26. 4B1. All nursing staff re-educated on facility policy for Transfer or Discharge Emergency. DON/Designee will conduct a record review for 2 resident Emergency transfers X4 weeks and then monthly X 3 months to ensure that facility policy was followed. Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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F 658	Continued From page 5 According to the facility Admission Record, Resident #206 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included, but were not limited to; Ex Order 26. 4B1 . On 04/04/23 at 10:20 AM, the surveyor reviewed the annual Minimum Data Set (MDS), an assessment tool, dated Ex Order 26. 4B1. Resident #206 had a Ex Order 26. 4B1 score of Ex Ord, which indicated the resident had Ex Order 26. 4B1. Review of Section Ex O of the MDS, functional status revealed Resident #206 ambulated without assistance from staff. On 04/04/23 at 10:36 AM, the surveyor reviewed an Incident Report (IR) dated Ex Order 26. 4B1 at 7:00 PM. The IR revealed Resident #206 was found lying face down in the hallway in front of room 231. The resident was assisted off the floor and back to the room by the Unit Manager (UM) and Certified Nurse Assistant (CNA). A full body assessment was completed and a raised area was noted to the right side of the Ex Order 26. 4B1. It was also documented that the resident had a Ex Order 26. 4B1. Pain medication was given and a call was made to the physician on the same date at 7:00 PM. The physician gave an order to send Resident #206 to the Ex Order 26. 4B1 for evaluation. Further review of the incident report revealed that the family was notified on Ex Order 26. 4B1 at 1:35 AM. At the same time, the surveyor reviewed an Incident note (IN) dated Ex Order 26. 4B1 at 7:33 PM,	F 658		

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F 658	Continued From page 6 written by Licensed Practical Nurse #1 (LPN#1) which revealed LPN #1 assessed the resident and documented that the resident would be monitored for any changes. The transporation company was notified with an estimated pick up time of one hour and the family was notified. On 04/04/23 at 11:15 AM, the surveyor reviewed a progess note dated Ex Order 26. 4B1 at 7:26 AM, by LPN #2 which revealed that at 2:45 AM, the Ex Order 26. 4B1 called the facility, to inform them that the resident sustained a Ex Order 26. 4B1 . At 3:00 AM on the date Resident #206 was returned to facility via ambulance. Further review of the progress note did not reveal any documentation to show the time that the resident was picked up by transportation to the Ex Order 26. 4B1 or documentation of the delay in transportation. No documentation was provided to show that a call was made to the physician informing of the delay in transport. No additional information or documentation was provided by the facility. On 4/5/23 at 10:00 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) regarding the process when staff receive a verbal order from a physician. The DON stated "in this case, the staff should have called Ex Order 26. right away." The DON further stated that the resident should have been taken to the Ex Order 26. 4B1 immediately after hitting their Ex Order 26. and if the nurse waited for transport (since the resident was stable), there should have been a follow up with transport after the estimated wait time. The resident should have been reassessed	F 658		

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F 658	Continued From page 7	F 658		

and then Ex Order 26.4 should have been called at that time.

At the same time, the surveyor requested the time and date that Resident #206 was transported to the Ex Order 26. 4B1. During the interview with the surveyor, the LNHA stated the date was Ex Order 26. 4B1 and the time was from 7:33 PM until right before 12 midnight. The surveyor stated there was nothing to support that Resident #206 was transported before midnight on Ex Order 26. 4B1 and asked for documentation to confirm when Resident #206 was picked up from the facility.

The facility was unable to provide any further documentation to confirm the date and time Resident #206 was transported to the Ex Order 26. 4B1.

Review of the Ex Order 26. 4B1 registration documents confirmed that Resident #206 arrived at the Ex Order 26. 4B1 on Ex Order 26. 4B1 at 12:33 AM, indicating a 5 hour and 33 minute delay from when the facility received the physician order on Ex Order 26. 4B1 at 7 PM, to send Resident #206 to the Ex Order for evaluation.

On 4/5/2023 at 1:25 PM, during an interview with the surveyor, the LNHA provided the surveyor with a Ex Order 26. 4B1 transfer list with a date of Ex Order 26. 4B1, Resident #206 Ex Order 26. 4B1 transfer date, and the facility's transfer policy.

On 04/05/23 at 02:00 PM, the surveyor reviewed the facility's policy "Transfer or Discharge, Emergency", dated Ex Order 26. 4B1 which revealed that Ex Order 26. 4B1 transfers or discharges may be necessary to protect the health and/or wellbeing of the resident(s). Number Ex on the policy stated that Should it become necessary to make an

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F 658	Continued From page 8 Ex Order 26. 4B1 transfer or discharge to a Ex Order 26. 4B1 or other related institution, our facility will implement the following procedures: b. notify the receiving facility that the transfer is being made; c. prepare the resident for transfer; d. prepare a transfer form to send with the resident; and f. assist in obtaining transportation. NJAC 8:39-27.1	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		5/5/23

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F 755	Continued From page 9 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure expired controlled substance (narcotic) medications were detected, removed, and disposed from the emergency (back-up) supply identified for 1 of 1 back up box. This deficient practice was evidenced by the following: On 4/3/23 at 10:30 AM, the surveyor and the Assistant Director of Nursing (ADON) entered the room that contained the narcotic back up medications which was stored in a locked box in a locked room on the second floor. At 10:34 AM, the surveyor with the ADON began the inspection of the narcotic medications in the back up box. At 10:36 AM, in the presence of the ADON, the surveyor observed five patches of Fentanyl 50 microgram/hour (mcg/hr.; a medication used to relieve the symptom of pain) which reflected a manufacturer expiration date of 8/2022. At that time, the ADON confirmed she observed five Fentanyl 50 mcg/hr. which reflected a manufacturer expiration date of 8/2022.	F 755	All residents are at risk to be affected by the deficient practice Expired medications were removed from back up box and discarded immediately on 4/3/2023 All back up boxes were audited to ensure medications were not expired. DON/ADON/Nursing Supervisors re-educated on facility policy for Controlled Substances. DON/Designee will audit back up boxes weekly X4 weeks and then monthly X 3 months to ensure there are no expired medications. Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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F 755	Continued From page 10 At 10:52 AM, in the presence of the ADON, the surveyor observed 8 tablets of Tramadol 25 milligram (mg; half tablets of Tramadol 50 mg tablets) (a medication used to relieve symptom of pain) which reflected a manufacturer expiration date of 02/14/23. At that time, the ADON confirmed she also observed 8 tablets of Tramadol 25 mg which reflected a manufacturer expiration date of 02/14/23. At 10:55 AM, during an interview with the surveyor, the ADON stated that the shift-to-shift Supervisors were responsible to ensure the narcotic counts were reconciled and the expired medications were identified and removed. The ADON stated she would remove the expired narcotic medications from the back-up box, educate the nurses and that she and the Director of Nursing would dispose of the narcotic medications. At that time, the ADON stated that expired narcotic medications should not have been present in the back-up box, "it should have been in date". At 11:01 AM, in the presence of the surveyor and Director of Nursing, the ADON stated expired medications would have decreased efficacy. On 4/4/23 at 12:52 PM, in the presence of the survey team, Licensed Nursing Home Administrator and the DON, the surveyor discussed the concerns about the expired narcotic medications found in the back-up box. A review of facility policy provided, Storage of	F 755		

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F 755	Continued From page 11 Medications reviewed/revised 12/2018 included under Policy Interpretation and Implementation section 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. A review of facility policy provided, Controlled Substances reviewed/revised 12/2018 included under Policy Statement; The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of Schedule II and other controlled substances. No further information was provided. NJAC 8:39-29.4 (g)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation performed on 3/31/23, the surveyors observed two (2) nurses administer medication to five (5) residents. There were 28 opportunities, and two (2) errors were observed, which calculated to a medication administration error rate of 7.14%.	F 759	All residents are at risk to be affected by the deficient practice Nurse(s) that were found to have made an error for medication administration for residents # 1 and #2 were identified and immediately re-educated on facility policy on Medication Administration. Resident # 1 and #2 MD was immediately notified with no new orders.	5/5/23

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F 759	Continued From page 12 This deficient practice was identified for 2 of 5 residents (Unsampled Resident #1, and Unsampled Resident #2) that were administered medications by 1 of 2 nurses. The deficient practice was evidenced by the following: On 3/31/23 at 8:21 AM, during the medication administration observation, the surveyor observed breakfast meal trays being collected from resident rooms, indicating breakfast had been served and consumed. The Licensed Practical Nurse (LPN) informed the surveyor at this time that Unsampled Resident #1 had already eaten breakfast. The surveyor observed the LPN as she prepared 11 medications for Unsampled Resident #1. Included in these medications was Ex Order 26. 4B1 tablet (tab) (Ex Order 26. 4B1). As the LPN reviewed the orders in the medication administration record (MAR) with the surveyor, she stated the physician's order (PO) for the Ex Order 26. 4B1 indicated that it was to be given before breakfast. At this point the LPN stated, "this should have been given before breakfast, but I will give it now." (Error #1) A review of the Admission Record face sheet reflected the resident was admitted to the facility in Ex Order 26. 4B1 and had diagnoses which included Ex Order 26. 4B1. A review of the resident's physician's order summary report reflected an active order with a start date of Ex Order 26. 4B1 for 'Ex Order 26. 4B1 give one tablet orally one time a day for NJ Exec. O give before breakfast."	F 759	All nursing staff re-educated on facility policy for Medication Administration and importance of following all steps. DON/Designee will conduct Medication Pass review of 5 residents per week X4 weeks and then monthly X 3 months to ensure all medications are properly administered. Findings will be reviewed at clinical meetings and submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

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F 759	Continued From page 13	F 759		

On 3/31/23 at 9:29 AM, during a continued medication administration observation, the surveyor observed the LPN enter Unsampled Resident #2's room and check the resident's blood pressure and heart rate using a Ex Order 26. 4B1 . The LPN showed the surveyor the Ex Order 26. 4B1 reading to be Ex Order 26. 4B1 over Ex Order 26. 4B1 and the Ex Order 26. 4B1 . The LPN then proceeded to the medication cart to check the resident's orders in the MAR and gather the medication to be administered to this resident. The LPN informed the surveyor that she would be withholding the resident's Ex Order 26. 4B1 stating, "I'm holding Ex Order 26. 4B1 because the Ex Order 26. 4B1 , and the order states to hold it if the Ex Order 26 is below Ex Order and the Ex Order 26. 4B1 is below Ex Ord. I'm using nursing judgement and holding it since the Ex Order 26. 4B1 is below Ex Ord." The LPN then proceeded to prepare and administer six other scheduled medications to Unsampled Resident #2. (Error #2)

A review of the Admission Record face sheet reflected the resident was admitted to the facility in Ex Order 26. 4B1 with diagnosis which included Ex Order 26. 4B1

A review of the resident's physician's order summary report reflected an active order with a start date of Ex Order 26. 4B1 for 'Ex Order 26. 4B1 give 1 tablet orally two times a day for Ex Order 26 hold for Ex Order 26 less than (<) Ex Order & (and) Ex Order < Ex Ord."

A Review of the most recent pharmacy consultant visit review and recommendations dated Ex Order 26. 4B1 indicated, "please note that Ex Order 26. 4B1 hold

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	315305	A. BUILDING ______ B. WING ______	04/06/2023

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SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

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F 759	Continued From page 14	F 759		

parameters read to hold if both Ex Order AND Ex Order are below a certain value. It appears medication was held this month when only 1 was outside value. This is not consistent with the medication order. Please review with nursing and correct." This recommendation was acknowledged by the facility with a hand-written "corrected" statement on the recommendation.

On 3/31/23 at 10:48 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. When asked about the medication which was ordered but held for unsampled Resident #2, the DON stated that this medication should have been given based on the PO and the pharmacy consultant recommendation documentation but would double check and get back to the surveyor.

On 03/31/23 at 11:00 AM, the DON returned to the survey team accompanied by the second-floor Licensed Practical Nurse Unit Manager (LPN/UM). The LPN/UM stated that the corrective action taken for the pharmacy consultant's recommendation was that she in-serviced all the nurses on the second floor on how to properly read and determine parameters indicated in medication orders. The LPN/UM further stated that she would have also held this medication based on "nursing judgement" despite the pharmacy consultant recommendation and physician ordered parameters. The surveyor then asked the LPN/UM if the physician was contacted to clarify this order and if not, why not, to which the LPN/UM had no response. At this point, the DON stated since the Ex Order 26. 4B1 was held "this order was not followed, now we should call the doctor to clarify."

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	315305	A. BUILDING ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

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F 759	Continued From page 15 On 4/4/23 at 12:40 PM, the surveyor interviewed the DON in the presence of the survey team and the Licensed Nursing Home Administrator (LNHA), regarding Unsampled Resident #1's Ex Order 26. 4B1 medication not being administered before breakfast as ordered, the DON agreed that was too was not consistent with following the physician's order. A review of the facility's "Administering Medications" policy dated reviewed/revised 12/2022, included: "3. Medications must be administered in accordance with the orders, including any required time frame ...7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 8. The following information must be checked/verified for each resident prior to administering medication: a. Allergies to medication; and b. vital signs, if necessary per physician's order. NJAC 8:39-11.2(b)	F 759		
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	F 812		5/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING ______ B. WING ______	04/06/2023

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F 812	Continued From page 16 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 observation, interview and review of facility documentation, it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) properly wash hands and c.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was evidenced by the following: On 03/27/2023 at 9:40 AM, the surveyor toured the kitchen, in the presence of the Regional Food Service Director (RFSD) and the Food Service Director (FSD) and observed the following: The surveyor observed an unlabeled box filled with seven logs of frozen ground beef in the freezer. Upon interviewing the dietary aide (DA), the DA stated the older meat was placed in the same box on top of the newer meat and informed the surveyor that they could tell the difference because the older meat had a darker discoloration. The surveyor asked how they could identify the date that the older or newer meat came in to which neither the DA, RFSD, nor the	F 812	All residents are at risk to be affected by the deficient practice A) Frozen ground beef logs were removed and discarded on 3/27/23 B) Coffee filters, tea bags & Misc items were placed in a closed container on 3/27/23 C) Grinder base cleaned and covered properly on 3/27/23 D) Kitchen staff there were not wearing masks properly were identified and placed masks on correctly on 4/4/23 E) Kitchen staff who were not following proper hand washing and safe food handling policies were identified and corrected on 4/4/23 All Kitchen staff re-educated on facility policy for Food Preparation and Service. Food Service Director/ Designee will: A) Audit frozen meat items weekly X4 weeks , then monthly X3 months to ensure proper labeling is in place . B) Audit dry goods storage weekly X4 weeks , then monthly X3 months to ensure proper storage is adhered.	

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F 812 Continued From page 17

FSD could provide an answer.

In the dry storage room, there was a tote filled with coffee filters that were uncovered and exposed to air, there was also a box of tea bags and a couple of miscellaneous items that were unlabeled. These items were observed and confirmed by the FSD.

In the cleaned food preparation area, there was a meat grinder which the FSD and DA confirmed was clean. The grinder was unplugged with crumbs and food particles that were under the grinder and left on the base. The grinder appeared to have been cleaned at some point but was left uncovered and not properly stored after it was cleaned.

On 04/04/2023 at 10:04 AM, during the second tour of the kitchen, the surveyor observed three dietary aids not wearing face masks properly while preparing food, there was also two staff who were not wearing gloves while preparing food, one was putting dessert in bowls and preparing coffee cups while the other was preparing coffee.

The surveyor further observed handwashing for three staff, two performed their handwashing properly but the third did not follow the proper handwashing procedure. This was observed and confirmed by the RFSD and FSD.

Review of the facility's "Food Preparation and Service" policy with a review date of July 2023 included "Food service employees shall prepare and serve food in a manner that complies with safe food handling practices... 1. e. food preparation staff will adhere to proper hygiene

F 812 (Plan of Correction)

C) Audit meat grinder base weekly X4 weeks , then monthly X3 months to ensure the area is cleaned and covered.
D) Conduct kitchen staff observations of 4 staff members weekly X4 weeks , then monthly X3 months to ensure proper use of masks.
E) Conduct Kitchen staff observation of 4 staff members weekly X4 weeks , then monthly X3 months to ensure proper hand washing and safe food handling practices are being observed.

Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.

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	315305	A. BUILDING ______ B. WING ______	04/06/2023

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F 812	Continued From page 18 and sanitary practices to prevent the spread of foodborne illnesses... 5. f. Bare hand contact with food is prohibited. Gloves must be worn when handling food directly... 6.a. Perishable foods must be stored in a covered container and clearly labeled with item name, date, and use by date (using the 7 day rule)... the kitchen will assure food safety by maintaining proper dates and labels for all ready to eat products, and all food items will be labeled with a received date upon acceptance of delivery". Review of the facility's "Hand Washing Techniques and Hand Hygiene Procedure" policy, under the section titled interpretation and implementation included the following: "IV. Procedure: A. Turn on faucet, B. Keeping fingertips down; completely wet own hands and wrists under warm running water, C. Apply soap and spread over both hands and wrists including between fingers and under nails." NJAC 8:39-17.2	F 812		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061201	A. BUILDING: ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 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 the Provisions of the 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 interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 14 of 14 day shifts. 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	S 560	All residents have the potential to be affected. Staffing coordinator was immediately re in-serviced on staffing ratio requirements. Staffing Agency contracted to add staff. Job Fair scheduled for 6/19/2023 and quarterly x 2. LNHA will review staffing schedules weekly for 3 months. DON or LNHA will review open positions and applications plus results of any interviews weekly to look for opportunities to hire. Findings of review will be presented by LNHA at quarterly QAPI meeting.	5/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061201	A. BUILDING: ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) 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 CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 03/12/2023 to 03/18/2023 and 03/19/2023 to 03/25/2023, the staffing-to-resident ratio did not meet the minimum requirements and is documented below: -03/12/23 had 10 CNAs for 107 residents on the day shift, required 13 CNAs. -03/13/23 had 10 CNAs for 107 residents on the day shift, required 13 CNAs. -03/14/23 had 12 CNAs for 107 residents on the day shift, required 13 CNAs. -03/15/23 had 12 CNAs for 107 residents on the day shift, required 13 CNAs. -03/16/23 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. -03/17/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs. -03/18/23 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. -03/19/23 had 10 CNAs for 108 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061201	A. BUILDING: ______ B. WING ______	04/06/2023

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S 560	Continued From page 2 day shift, required 13 CNAs. -03/20/23 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. -03/21/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs. -03/22/23 had 10 CNAs for 107 residents on the day shift, required 13 CNAs. -03/23/23 had 10 CNAs for 107 residents on the day shift, required 13 CNAs. -03/24/23 had 10 CNAs for 107 residents on the day shift, required 13 CNAs. -03/25/23 had 9 CNAs for 107 residents on the day shift, required 13 CNAs. On 04/05/2023 at 10:58 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who was filling in for staffing while the staffing coordinator was away on vacation. The surveyor asked the ADON if she was aware of the staffing regulations and the ADON was able to tell the surveyor the required Certified Nursing Assistant to resident ratio. The ADON told the surveyor that if the schedule was "short on CNA's", they would call in other staff or tell the Administrator and they would sometimes get staff from the company's other facilities. The ADON told the surveyor that the facility did not use agency "that often". On 04/05/2023 at 11:15 AM, the surveyor reviewed the policy titled, "Staffing" dated 12/2022. Under the section Policy Interpretation and Implementation, number 2 indicated that staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. NJAC 8:39-5.1 (a)	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315305		6/14/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

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 F0576 Reg. # 483.10(g)(6)-(9) LSC	Correction Completed 05/05/2023	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 05/05/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 05/05/2023
ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 05/05/2023	ID Prefix F0759 Reg. # 483.45(f)(1) LSC	Correction Completed 05/05/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 05/05/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 4/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061201	A. Building B. Wing	6/14/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/05/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 4/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: Q5KZ12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING **01** B. WING ______	C **04/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	**1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861**

(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) COMPLETION DATE
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 03/30/2023 and 04/03/2023 and Spring Creek Healthcare Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Spring Creek Healthcare Center is a Three-story, Type II Protected building that was built in January 1980. The facility is divided into 9 smoke zones. The facility has one Diesel emergency generator.	K 000		
K 111 SS=E	Building Rehabilitation CFR(s): NFPA 101 Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)	K 111		4/29/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/30/2023

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 DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING 01 B. WING	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

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K 111	Continued From page 1 Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a fire barrier having a 1-hour fire resistance rating in place and continuously maintained in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.1.4.3, 19.1.1.4.4, 19.1.3.10, 19.3.2, 19.3.2.1, 19.3.2.1.2 8.4, 8.5, 4.6.10, 4.6.10.1 and 1135 waiver. The deficient practice could affect 50 of 159 residents at the time of the survey. Findings include: On 03/30/2023 (day one of survey) during the survey entrance at approximately 9:31 AM, a request was made to the Administrator (Admin) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested if the facility had done any construction since the last re-certification survey of 04/06/2021.	K 111	All residents are at risk to be affected by the deficient practice • Contractor was immediately instructed to install a fire barrier as per NFPA 101 section 43.8 • All fire barriers were immediately audited to ensure they comply with the requirements. • Maintenance director was re-educated on the requirements for fire barrier. • Maintnance director/Designee will audit all fire barriers weekly X4 weeks and then monthly X 3 months to ensure all barrier follow the requirements. • Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

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K 111	Continued From page 2 The Admin told the surveyor that they are doing renovations on the first floor now. A review of the facility provided lay-out identified the facility is a three-story building. Starting at approximately 9:48 AM on 03/30/2023 and continued on 04/03/2023 in the presence of the facility's Corporate Compliance Officer (CCO) and DOM a tour of the facility was performed. On 04/03/2023 at approximately 12:26 PM, during an inspection of the first floor construction area the surveyor observed that the wall separating the construction area from the occupied Residents' sleeping rooms had no known fire resistance rating. The surveyor observed the separation wall had one layer of 5/8 of an inch wall board on one side. The access door was a 20 minute hollow core door. The CCO and DOM confirmed the finding at that time. The surveyor informed the Administrator and CCO of the deficiency at the Life Safety Code exit conference on 04/03/2023 at approximately 1:41 PM. Fire hazard 8:31.2 (e).	K 111		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be	K 222		5/29/23

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K 222	Continued From page 3 equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised	K 222		

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K 222	Continued From page 4 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 03/30/2023 and 04/03/2023, it was determined that the facility failed to provide 1 of 8 exit discharges in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 03/30/2023 (day one of survey), during the survey entrance at approximately 9:31 AM, a request was made to the Administrator (Admin), Corporate Compliance Officer (CCO) and Director of Maintenance (DOM) to provide a copy of the facility's lay-out which identifies the various rooms and smoke compartments in the facility.	K 222	All residents are at risk to be affected by the deficient practice EVS director and Maintnance director were educated with the code to open the lock box. All locking doors were immediately audited to ensure they have the ability to be opened. Code to lock box was added to disaster plan. All staff were reeducated on the means to open lock box that contains the key to open the fire exit. Maintnance director/Designee will interview staff weekly X4 weeks and then monthly X 3 months to ensure the staff can open lock box in case of emergency. Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed	

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K 222	Continued From page 5	K 222		

A review of the facility provided lay-out identified the facility as a three-story building. There is also an outside gated Resident smoking area.

Starting at approximately 9:48 AM on 03/30/2023 and continued on 04/03/2023 in the presence of the facility's Corporate Compliance Officer (CCO), DOM and Environmental Service Supervisor (EVS), a tour of the facility was conducted.

On 04/03/2023 at approximately 11:25 AM, an inspection of the outside gated Resident smoking area was performed. The surveyor observed on the egress gate a keyed lock and a lock box located near the gate.

At this time, the surveyor asked all three staff, "Who has a key to this lock."
The EVS said that all housekeepers had a key to the gate lock. The surveyor asked the EVS to open the lock on the gate. The EVS attempted to use his keys but could not open the lock. The EVS also attempted to open the lock box. After several attempts he could not open the lock box.

A review of a posted evacuation diagram inside the building identified the Resident smoking area is the primary and or secondary egress path to reach a public way.

The CCO, DOM and EVS confirmed the findings at that time.

The surveyor informed the Administrator and CCO of the deficiency at the Life Safety Code exit conference on 04/03/2023 at approximately 1:41 PM.

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K 222	Continued From page 6 NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 03/30/2023 and 04/03/2023, in the presence of facility Management it was determined that the facility failed to ensure that 2 of 9 exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 03/30/2023 (day one of survey), during the survey entrance at approximately 9:31 AM, a request was made to the Administrator (Admin) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.	K 311	• All residents are at risk to be affected by the deficient practice • 3rd floor Center stairway door as well as door next to room #214 was fixed on 3/30/2023. • Audited all doors immediately to ensure that they do have positive latch. • Maintenance staff were reeducated on the need that all fire doors must have a positive latch. • Maintenance director/Designee will audit all fire doors weekly X4 weeks and then monthly X 3 months to ensure that all fire doors have positive latch. • Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	5/29/23

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K 311	Continued From page 7	K 311		

A review of the facility provided lay-out identified the facility as a three-story building. There are three (3) exit stairways.

Starting at approximately 9:48 AM on 03/30/2023 and continued on 04/03/2023 in the presence of the facility's Corporate Compliance Officer (CCO) and DOM, a tour of the facility was conducted. Along the two (2) day tour, the surveyor performed a closure test of nine (9) corridor exit access doors leading into exit stairways with the following results:

1. On 03/30/2023 at approximately 10:51 AM, during a closure test of the third (3rd.) floor Center stairway (near the Nursing station) corridor exit access door, the door did not positive latch into its frame. This test was repeated two additional times with the same results.
The surveyor observed that door had no means to positive latch.

2. On 03/30/2023 at approximately 11:48 AM, during a closure test of the second (2nd.) floor South stairway (near Resident room #214) corridor exit access door, the door did not positively latch into its frame. This test was repeated two additional times with the same results.

The stairwell doors would need to positively latch into its frame to maintain the fire rated construction to prevent fire, smoke, and poisonous gases to enter the exit stairwell in the event of a fire.

The CCO and DOM confirmed the findings at that time.

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K 311	Continued From page 8 The surveyor informed the Administrator and CCO of the deficiency at the Life Safety Code exit conference on 04/03/2023 at approximately 1:41 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 03/30/2023 and 04/03/2023, in the presence of the Administrator and Corporate Compliance Officer (CCO), it was determined that the facility failed to Inspect the fire alarm system on a semi-annual (every 6 months) inspection in accordance with NFPA 72. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: On 03/30/2023 (day one of survey), during the survey entrance at approximately 9:31 AM, a request was made to the Administrator (Admin) and Director of Maintenance to provide all Mandatory inspections from June 1, 2021 through	K 345	• All residents are at risk to be affected by the deficient practice • A Kitchen suppression inspection had been completed 12/13/2022. • Maintenance director was reeducated on requirements to have the Kitchen suppress inspection on a semi annual basis. • Maintnance director/Designee will conduct a audit on all required inspections weekly X4 weeks and then monthly X 3 months to ensure that all required inspections are being conducted on a timely basis. • Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as	5/29/23

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K 345	Continued From page 9 March 29, 2023 for review later. On 03/30/2023 at approximately 12:10 PM, a review of the facility provided semi-annual (every 6 months) kitchen suppression system inspections for the previous 22 months revealed that the system was inspected by a licensed vendor on 12/13/2022, 11/22/2021, and 05/07/2021. On 04/03/2023 at approximately 9:35 AM, during an interview with the facility's CCO, the CCO informed the surveyor that the first semi-annual (January 1, 2022 to June 30, 2022) kitchen suppression system inspections had not been conducted. The facility went 13 months between the inspections. The CCO and DOM confirmed the findings at that time. The surveyor informed the Administrator and CCO of the deficiency at the Life Safety Code exit conference on 04/03/2023 at approximately 1:41 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	needed.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		5/29/23

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K 351	Continued From page 10 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/30/2023 and 04/03/2023, it was determined that: 1) The Facility failed provide proper fire sprinkler coverage to all areas of the facility, 2) The Facility failed to ensure sidewall spray sprinklers were installed at the bottom of the elevator hoist-way not more than 2 ft (0.61m) above the floor of the pit that contained combustible hydraulic fluids, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following: On 03/30/2023 (day one of survey), during the survey entrance at approximately 9:31 AM, a request was made to the Administrator (Admin),	K 351	• All residents are at risk to be affected by the deficient practice • Work order for the sprinkler Head in the elevator shaft was placed on 3/30/2023. To be installed on 6/20/2023. Work order for the sprinkler Head in the 1st floor Stairwell was placed on 4/3/2023 To be installed on 6/20/2023. On 4/3/2023 the contractor was instructed to lower the gap in the therapy gym so it would be less than 12 inches and in compliance with state regulation to be completed on 5/19/2023. • Maintenance Director audited the entire building immediately for any faulty or missing sprinklers. • Maintenance Director was reeducated on the requirements for proper sprinkler coverage. • Maintenance director/Designee will audit all sprinklers to ensure they are in compliance with state regulation weekly X4 weeks and then monthly X 3 months. • Findings will be submitted to the	

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K 351	Continued From page 11 Corporate Compliance Officer (CCO), and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility as a three-story building with two (2) elevators. Starting at approximately 9:48 AM on 03/30/2023 and continued on 04/03/2023 in the presence of the facility's Corporate Compliance Officer (CCO) and DOM, a tour of the facility was conducted. Along the two (2) day tour of the facility, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 03/30/2023, 1) At approximately 9:48 AM, during a tour of the building, the surveyor observed a Contracted Elevator Mechanic (CEM) had the outer elevator doors on the first floor level in the open position while he was working inside elevator #2 hoist-way. The surveyor observed that there were not fire sprinklers at the bottom of the hoist-way. The surveyor also observed a 5 gallon bucket of hydraulic fluid and several pieces of paper on the hoist-way floor. At this time, the surveyor asked the CEM mechanic, "Are there fire sprinklers at the top or bottom of the elevator hoist-way." The elevator CEM told the surveyor, no sprinklers there is only smoke detection.	K 351	monthly qapi committee for 3 months who will determine further interventions as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING 01 B. WING ______	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

(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) COMPLETION DATE
K 351	Continued From page 12 At this time, the CCO asked the CEM if there are sprinklers at the top of the hoist-way. 2) At approximately 10:01 AM, the CCO, CEM and surveyor went to the third floor. The CEM opened the hoist-ways outer doors and the surveyor observed inside the elevator hoist-way no evidence of fire sprinkler protection. On 04/03/2023, 3) At approximately 11:40 AM, the surveyor observed inside the 1st. floor stairwell (near the renovated Physical Therapy area) 4'-8" by 11"-9" landing area had no evidence of fire sprinkler coverage. 4) At approximately 12:09 PM, an inspection inside the newly renovated Physical Therapy area was performed. The surveyor observed no evidence of a fire sprinkler up inside the approximately 11"-4" wide by 27'-3" deep by 12" raised high ceiling area. At this time, the surveyor asked the CCO do you have a fire sprinkler in the high part of the ceiling area. The CCO said, no. The CCO and DOM confirmed the findings at that time. The surveyor informed the Administrator and CCO of the deficiency at the Life Safety Code exit conference on 04/03/2023 at approximately 1:41 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=D	Portable Fire Extinguishers	K 355		5/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING **01** B. WING ______	C **04/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	**1 LINDBERGH AVENUE** **PERTH AMBOY, NJ 08861**

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K 355	Continued From page 13 CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 03/30/2023 and 04/03/2023 in the presence of facility management, it was determined that the facility failed to: 1) Maintain 1 of 16 portable fire extinguisher in proper working condition. 3) Install fire extinguishers with in the required height for 1 of 16 fire extinguishers, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads: - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any	K 355	All residents are at risk to be affected by the deficient practice • Fire extinguisher in the 3rd. floor Kitchen/ Pantry was immediately lowered to correct Hight on 3/30/2023. Fire extinguisher in the Therapy gym was immediately replaced on 4/3/2023. • Maintenance staff reeducated on requirements for fire extinguishers to be at correct Hight and in operational condition. • Maintenance director/Designee will audit all fire extinguishers to ensure they follow the requirements weekly X4 weeks and then monthly X 3 months to ensure all facility fire extinguisher follow the requirements. • Findings will be submitted to the monthly qapi committee for 3 months who will determine further interventions as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING 01 B. WING	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

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K 355	Continued From page 14	K 355		

conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.

- 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers.

Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads,

- 6.1.3.8 Installation Height.

- 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor.

- 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches.

The findings include the following:

Starting at approximately 9:48 AM on 03/30/2023 and continued on 04/03/2023 in the presence of the facility's Corporate Compliance Officer (CCO) and Director of Maintenance (DOM), a tour of the facility was conducted.

Along the two day tour of the facility, the surveyor observed and inspected sixteen (16) portable fire extinguishers in various locations that were last annually inspected April 2022 with the following issues identified:

1) On 03/30/2023 at approximately 10:51 AM, the surveyor observed one ABC type fire

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING **01** B. WING ______	C **04/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	**1 LINDBERGH AVENUE** **PERTH AMBOY, NJ 08861**

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K 355	Continued From page 15 extinguisher in the 3rd. floor Kitchen/ Pantry area that appeared to be installed too high. At this time, the surveyor measured and recorded the fire extinguisher to be mounted to the wall at 5'- 3" to the center of the pressure indicator needle. 2) On 04/03/2023 at approximately 12 PM, the surveyor observed one ABC type fire extinguisher in the newly renovated Rehab. gym area that had evidence of the extinguisher pressure gauge was bent. Further inspection identified the pressure indicating needle was in the "RED" discharge zone on the gauge. This fire extinguisher would not function properly in the event of a fire. At this time, the surveyor requested that the DOM replace the fire extinguisher with an available facility spare fire extinguisher. The CCO and DOM confirmed the findings at that time. The surveyor informed the Administrator and CCO of the deficiency at the Life Safety Code exit conference on 04/03/2023 at approximately 1:41 PM. NFPA 10. NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		

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
315305 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	6/14/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTHCARE CENTER	1 LINDBERGH AVENUE PERTH AMBOY, NJ 08861

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 Reg. # NFPA 101 LSC K0111	Correction Completed 04/29/2023	ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 05/29/2023	ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 05/29/2023
ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 05/29/2023	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 05/29/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 05/29/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
4/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO