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 ______	C 10/18/2023

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 Complaint #: NJ#168144, NJ#168251, NJ#165464, NJ#164728 Survey Dates: 10/18/23 Census: 117 Sample Size: 6 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident	F 626		11/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/10/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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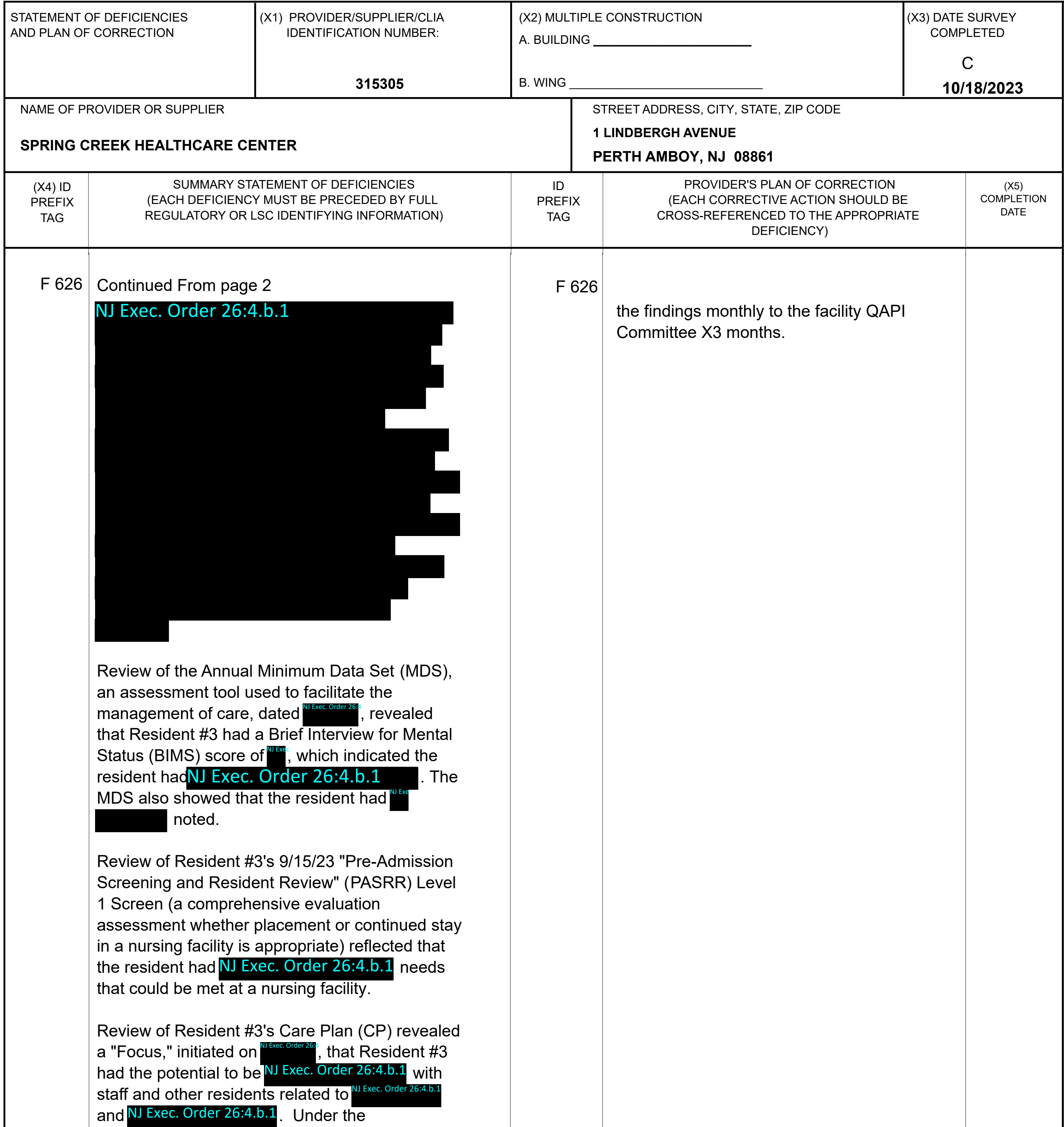
F 626	Continued From page 1 who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ168251 Based on interviews, medical record review, and review of other pertinent facility documentation on 10/17/23 and 10/18/23, it was determined that the facility failed to follow their policies and procedures for a facility-initiated discharge. A resident (Resident #3) was involved in an altercation with another resident and was sent to the hospital for a NJ Exec. Order 26:4.b.1. When the resident was discharged from the hospital, the facility would not permit the resident to return to the facility. The deficient practice was identified for Resident #3, 1 of 6 residents reviewed and was evidenced by the following: According to the "Admission Record," Resident #3 was admitted to the facility on NJ Exec. Order 26 with diagnoses which included but were not limited to:	F 626	All residents have the potential to be affected. Facility cannot retroactively correct the deficient practice as it pertains to resident #2 as he is no longer a resident of the facility. Administrator and Director of Nursing were re in-serviced on facility policy titled “Transfer or Discharge Documentation” and the need to issue a 30-day discharge notice when appropriate. Admin/Designee will audit Hospital transfer log for the last month to ensure there were not any improper denials. Regional Administrator will review hospital transfer log monthly x3 months to ensure compliance with facility policy and report	



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F 626	Continued From page 2	F 626	the findings monthly to the facility QAPI Committee X3 months.	

NJ Exec. Order 26:4.b.1

Review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec. Order 26:4, revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of NJ Exec, which indicated the resident had NJ Exec. Order 26:4.b.1. The MDS also showed that the resident had NJ Exec noted.

Review of Resident #3's 9/15/23 "Pre-Admission Screening and Resident Review" (PASRR) Level 1 Screen (a comprehensive evaluation assessment whether placement or continued stay in a nursing facility is appropriate) reflected that the resident had NJ Exec. Order 26:4.b.1 needs that could be met at a nursing facility.

Review of Resident #3's Care Plan (CP) revealed a "Focus," initiated on NJ Exec. Order 26:4, that Resident #3 had the potential to be NJ Exec. Order 26:4.b.1 with staff and other residents related to NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1. Under the

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F 626	Continued From page 3 "Interventions/Task" section, indicated to analyze key times, places, circumstances, triggers and what de-escalates behavior and document. The CP also reflected to assess the resident's understanding of the situation, allow time for the resident to express self and feeling towards the situation, monitor behaviors every shift and document observed behavior and attempted interventions. The CP revealed a "Focus," initiated on NJ Exec. Order 26:4, that Resident #3 had a physical altercation with another resident on NJ Exec. Order 26:4.b.1. Under "Interventions/Tasks" section indicated that Resident #3 was immediately separated from the other resident. A NJ Exec. Order 26:4.b.1 was completed and the NJ Exec. Order 26:4.b.1 was notified. Review of Resident #3's Incident Report, dated NJ Exec. Order 26:4 at 11:04 PM, completed by the Licensed Practical Nurse (LPN), revealed that she was notified by the Activities Staff that the resident had a physical altercation with resident (Resident #2). The Nurse Supervisor (NS) was contacted and the police were called. The residents were immediately separated and NJ Exec. Order 26:4.b.1 were completed for the residents. Resident #3 was sent out for evaluation. During an interview with the surveyor on 10/17/23 at 12:25 PM, the Maintenance Assistant (MA), stated that he was working on the first floor when he overheard a conversation between two residents in which they were yelling at each other. The MA heard a rustling of Resident #3's keys and saw the residents hitting each other. The MA ran over to the residents and separated them. He stayed with Resident #3 and notified the receptionist to call someone. The receptionist called the NS who reported to the first floor	F 626		

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F 626	Continued From page 4 hallway. Resident #3 was taken outside and then sent out to the hospital. During an interview with the surveyor on 10/17/23 at 1:25 PM, the Director of Nursing (DON) was asked about the incident between Resident #3 and Resident #2. The DON stated she was told by the NS that Resident #3 punched Resident #2 in the face, but she wasn't provided any specifics at that time. The NS completed an assessment, and NJ Exec. Order 26:4.b.1 were noted to Resident #2's face. The DON instructed the NS to send Resident #3 to the hospital for an evaluation, but Resident #3 refused to be sent out. The DON stated she spoke to Resident #3 and encouraged him/her to go, and the resident agreed. The surveyor asked the DON if there had been any previous altercations involving Resident #3 to which she replied, "she wasn't sure". The DON stated Resident #3 had NJ Exec. Order 26:4.b.1. The surveyor asked the DON how were Resident #3's behaviors being monitored and she stated, "Documentation would be in the nursing progress notes, and that's how it would be tracked." The surveyor asked the DON for reasons why Resident #3 could not be readmitted back to the facility. The DON stated she did not know why Resident #3 was not able to be readmitted to the facility and that, "The Licensed Nursing Home Administrator (LNHA) was the point of contact and would know more." During an interview with the surveyor on 10/17/23 at 1:54 PM, the LNHA stated that a facility-initiated emergency transfer was made for Resident #3, due to his NJ Exec. Order 26:4.b.1 at the time of the incident. The incident involved a resident-to-resident altercation between Resident #3 and Resident #2. Resident #3 had an	F 626		

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F 626	Continued From page 5	F 626		

involuntary admission to the hospital and was eventually discharged to the community. The LNHA further stated the hospital wanted to transfer Resident #3 back to the facility and that the resident wished to return. The LNHA stated that Resident #3 did not return to the facility because the team felt it would be unsafe for the other residents and Resident #2. The LNHA added that the Medical Director (MD) felt it was not safe for Resident #3 to be in the facility, however, if things changed, the resident could come back. He stated the facility did not issue a 30-day notice of discharge to Resident #3 because they "didn't get a chance." The LNHA added that he had a conversation with the Social Worker (SW) and the Ombudsman's office regarding Resident #3's safe placement. The Ombudsman explained to the LNHA about Resident #3's rights to return to the facility. The LNHA told the Ombudsman that it was not safe for the residents and others in the facility for Resident #3 to return.

During an interview with the surveyor on 10/18/23 at 9:57 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that Resident #3 had NJ Exec. Order 26:4.b.1. The LPN/UM stated Resident #3 was not polite to staff and would become NJ Exec. Order 26:4 when staff tried to deescalate a situation with him/her. The LPN/ UM further stated Resident #3 had NJ Exec. Order 26:4.b.1 with other residents, as far as she knew. The surveyor asked how was Resident #3's behavior monitored. The LPN/UM stated behavioral monitoring was done periodically and Resident #3 would have behaviors weekly, sometimes daily. The LPN/UM added when she observed behaviors she would document the behaviors in Resident #3's PNs. The surveyor asked the

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F 626	Continued From page 6 LPN/UM why there wasn't any documented behaviors in Resident #3's PNs and she replied, "I don't have an answer for that. During a follow-up interview with the surveyor on 10/18/23 at 11:07 AM, the LPN/UM stated Resident #3's behaviors would be documented in the PN and that was the only way to document behaviors for a resident. The LPN/UM reviewed Resident #3's PNs, in the presence of the surveyor, and noted there was a 9/4/23 incident when another resident ran over Resident #3's foot with the wheelchair. When asked by the surveyor, how is that a behavior, the LPN/UM stated, "Well, it's not really a behavior. He got his foot run over." The surveyor further inquired, how do you know he was having behaviors, to which the LPN/UM replied, "I just know, because I know the resident." The LPN/UM continued to check the Resident #3's PNs for other documented behaviors. She located a PN from 1/30/23 as the only other behavior documented in Resident #3's PNs. Review of Resident #3's "Progress Notes" (PN) from NJ Exec. Order 26:4.b.1 revealed a PN dated NJ Exec. Order 26:4 at 3:18 PM that Resident #3 had "NJ Exec. Order 26:4.b.1 " A second PN dated NJ Exec. Order 26:4 at 3:48 PM indicated, "RTF [Returned to Facility] at 3:30 PM - stable upon arrival." Further review of the PN revealed a NJ Exec. Order 2 at 5:50 PM PN that Resident #3 was observed dancing around in the dayroom. No signs or symptoms of distress noted. Resident in pleasant mood and laughing	F 626		

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F 626	Continued From page 7	F 626		

with other resident and staff. Resident #3's PN revealed a PN dated NJ Exec. Order at 3:54 PM, that Resident #3 was observed standing in the middle of the second-floor dayroom. While another resident was ambulating via wheelchair in the dayroom, he/she accidentally wheeled over Resident #3's left foot with the wheels of his/her wheelchair. Resident #3 began to scream really loud and curse inappropriately NJ Exec. Order 26:4.b.1. No NJ Exec. Order 26:4.b.1 observed, but NJ Exec. Order 26:4.b.1

The PN revealed a NJ Exec. Order 26:4 at 1:29 PM "Note Text" that Resident #3 was involved in an altercation per activity staff. Resident taken for medical evaluation.

The PN did not include any physician documentation of the specific needs that could not be met at the facility for Resident #3. The PN also did not include any documentation that the safety of individuals in the facility were endangered due to the clinical or behavioral status of the resident or that the health of individuals in the facility would otherwise be endangered.

During a follow-up interview with the surveyor on 10/18/23 at 11:50 AM, the LNHA stated he could not provide documentation that Resident #3's behaviors would exclude him from coming back to the facility. The LNHA further stated he could not provide documentation that prevented Resident #3's readmission back to the facility.

During an interview with the surveyor on 10/18/23 at 12:00 PM, the MD stated Resident #3 became NJ Exec. Order 26:4.b.1 numerous times with the nursing staff. He could not provide documentation on Resident #3's behaviors

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F 626	Continued From page 8	F 626		

because he was not Resident #3's personal physician. The MD stated, he did not know if Resident #3's personal physician saw or assessed Resident #3 prior to him/her being sent out to the hospital. The MD stated he did not observe any behaviors and that he went by staff input about Resident #3's behaviors. The MD further stated the resident became disruptive and was sent out to the hospital. The facility called him and said they were reluctant to have Resident #3 readmitted back from the hospital, because the staff felt threatened by the resident. The MD stated he agreed with the facility and advised them not to take the resident back. The MD also stated there was no 30-day discharge initiated.

During an interview with the surveyor on 10/18/23 at 12:45 PM, the LPN stated she didn't know if Resident #3 had behaviors. She stated Resident #3 would help people in the dining room and would sometimes argue about playing cards. The LPN added that she never noticed Resident #3 have behaviors with anybody in the facility. The LPN further stated, "I never had a problem with Resident #3."

During an interview with the surveyor on 10/18/23 at 12:56 PM, the Activities Aide (AA) stated the MA separated Resident #3 and Resident #2 during the incident. The AA added that Resident #3 would help with the coffee social by giving snacks to other residents. She stated Resident #3 enjoyed helping out other residents and was pleasant. The AA further stated, she never felt threatened around Resident #3 and no other residents were threatened by him/her as far as she knew. The AA added that she hadn't had any problems with Resident #3.

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F 626	Continued From page 9	F 626		

During an interview with the surveyor on 10/18/23 at 1:19 PM, the DON stated the facility did not issue a 30-day notice to Resident #3. She stated she was told it was being discussed, but that she didn't know why it wasn't issued. The DON stated she observed Resident #3 being NJ Exec. Order 26:4 [redacted] with the LHNA in July and she tried to intervene. The DON added that she did not document the incident and stated, "I don't know why, but I should have." The surveyor asked the DON how were Resident #3's NJ Exec. Order 26:4.b.1 [redacted] monitored. The DON stated, "Based on observation only. And if it was not documented, it didn't happen." The DON further stated there was no documentation indicating why Resident #3 couldn't come back to the facility.

Review of the facility's "Transfer or Discharge Documentation," reviewed/revised on 1/2023, reflected under the Under the "Policy Interpretation and Implementation" section revealed "1. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless- a) The transfer or discharge is necessary for the residents' welfare and the resident's needs cannot be met in this facility; c) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; d) The health of individuals in the facility would otherwise be endangered...
5. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record by the resident's Attending Physician: a. The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility; or b. The transfer or

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F 626	Continued From page 10 discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. The policy also revealed that "6. Should the resident by transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record by a physician: a. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; or b. the health of individuals in the facility would otherwise be endangered." NJAC 8:39 4.1(a)32 NJAC 8:39 5.1(d)	F 626		

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S 000	Initial Comments Complaint#: NJ#164728 SAMPLE SIZE: 6 CENSUS: 117 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Complaint # NJ164728 Based on interview and review of pertinent facility documentation on 10/18/23, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 14 out of 14 day and 7 of 14 overnight shifts reviewed. Findings include:	S 560	All residents have the potential to be affected. Hire additional Staff to fill all open positions Job Board sponsorship increased. Staffing coordinator was immediately re in-serviced on staffing ratio requirements.	11/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/10/23

New Jersey Department of Health

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 5/28/23 to 6/3/23 and 6/4/23 to 6/10/23. 1.For the weeks of Complaint staffing from 05/28/2023 to 6/3/23 and 06/4/2023 to 6/10/23, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -05/28/23 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -05/29/23 had 12 CNAs for 119 residents on the	S 560	Job Board sponsorship increased. 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 X3 months.	

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 ______	C 10/18/2023

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) COMPLETE DATE
S 560	Continued From page 2 day shift, required at least 15 CNAs. -05/30/23 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. -05/31/23 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -06/01/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -06/02/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -06/03/23 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -06/04/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -06/04/23 had 7 total staff for 116 residents on the overnight shift, required at least 8 total staff. -06/05/23 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -06/06/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -06/07/23 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -06/08/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -06/09/23 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. -06/10/23 had 10 CNAs for 117 residents on the day shift, required at least 15 CNAs. The surveyor requested staffing for 10/1/23 to 10/7/23 and 10/8/23 to 10/14/23. 2. For the 2 weeks of staffing prior to the survey from 10/01/2023 to 10/7/2023 and 10/8/23 to 10/14/23, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 6 of 14 overnight shifts as follows: -10/01/23 had 9 CNAs for 118 residents on the	S 560		

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 ______	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 560	Continued From page 3 day shift, required at least 15 CNAs. -10/02/23 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/02/23 had 7 total staff for 118 residents on the overnight shift, required at least 8 total staff. -10/03/23 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/04/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/05/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/06/23 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/07/23 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/07/23 had 7 total staff for 118 residents on the overnight shift, required at least 8 total staff. -10/08/23 had 0 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/09/23 had 9 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/10/23 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/10/23 had 7 total staff for 118 residents on the overnight shift, required at least 8 total staff. -10/11/23 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -10/12/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -10/12/23 had 7 total staff for 115 residents on the overnight shift, required at least 8 total staff. -10/13/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -10/13/23 had 7 total staff for 115 residents on the overnight shift, required at least 8 total staff. -10/14/23 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/14/23 had 7 total staff for 113 residents on the overnight shift, required at least 8 total staff.	S 560		

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 ____	C **10/18/2023**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315305	A. Building B. Wing	11/17/2023

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 F0626 Reg. # 483.15(e)(1)(2) LSC	Correction Completed 11/10/2023	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
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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	
10/18/2023	☐ 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 A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061201		11/17/2023

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 11/10/2023	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
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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	
10/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO