STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315005	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING GROVE REHABILITATION AND HEALTHCARE CENTER	**144 GALES DRIVE NEW PROVIDENCE, NJ 07974**

(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 #: NJ00179501 Census: 102 Sample Size: 3 THE FACILITY IS 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/20/2024

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
	062008	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING GROVE REHABILITATION AND HEALT	144 GALES DRIVE NEW PROVIDENCE, NJ 07974

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S 000	Initial Comments The facility was 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review on 11/13/2024, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 4 of 14 day shifts. This deficient practice was evidenced by the following: 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,	S 560	1. No Residents were identified. 2. All residents have the potential to be affected by this deficient practice. 3. The Administrator/designee will conduct staffing meetings with the Staffing Coordinator/Human Resources Director and the Director of Nursing to review turnover, open positions, recruitment job postings, candidate interviews, and new hire start dates 5 days per week for 4 weeks. Recruitment and retention initiatives	12/3/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062008	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING GROVE REHABILITATION AND HEALT	144 GALES DRIVE NEW PROVIDENCE, NJ 07974

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S 560	Continued From page 1 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 certified nurse aide 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 10/27/2024 to 11/02/2024 and 11/03/2024 to 11/09/2024. The facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -10/27/24 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs. -11/02/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -11/04/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -11/06/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs.	S 560	include but are not limited to sign-on bonuses, referral bonuses, pick up shift bonuses, rate adjustments, benefit adjustments and text message campaigns. Job fairs and a partnership with a CNA school. The facility has developed a Culture Committee focused on recruitment and retention of staff by enhancing the employee experience. Two employees of the month are chosen. The facility has seasonal holiday parties, and gives all employees presents during each holiday season. The facility celebrates all employee's birthday's once a month. The facility has implemented the Care Champion program to mentor new employees where the champions/mentors receive a bonus if the new employee stays for a certain period of time. The facility participates in a weekly interdisciplinary Quality Care Resource call with consultants to review open positions, recruitment tactics, and changes to improve outcome. The facility conducts an exit interview with any employee who resigns to better improve the employee experience and help with retention. The facility has implemented processes to increase communication with employees through monthly town hall meetings. 4. The Administrator/designee will review the minutes from monthly resident council	

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S 560	Continued From page 2	S 560	meetings for 3 months to determine whether there are any concerns regarding care and services. The Human Resource Director/designee will report recruitment and retention data trends to QAPI committee monthly x 3 months. The results of the audits will be reviewed during QAPI Committee. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062008 (Y1)	A. Building B. Wing (Y2)	11/27/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING GROVE REHABILITATION AND HEALTHCARE CENTER	144 GALES DRIVE NEW PROVIDENCE, NJ 07974

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 12/03/2024	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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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 11/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			