STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING _____ B. WING _____	C 08/15/2023

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SPRING HILLS POST ACUTE LIVINGSTON	348 E CEDAR STREET LIVINGSTON, NJ 07039

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F 000	INITIAL COMMENTS Complaint #: NJ00157193, NJ00155196, NJ00153898, NJ00153555, NJ00153472 Survey Date: 8/15/2023 Census: 105 Sample: 22 + 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 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries,	F 640		9/6/23

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

Electronically Signed | 09/06/2023

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 640	Continued From page 1 and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) - Entry Reporting Assessment in accordance with federal guidelines. This deficient practice was identified for 2 of 38 residents reviewed for resident assessment (Resident #90, #133). This deficient practice was evidenced by: On 8/10/23 at 10:26 AM, the surveyor reviewed	F 640	#1 There were no residents identified as being negatively affected by this deficient practice. #2 All residents have the potential to be affected by this deficient practice. #3 There are currently 2 MDS nurses overseeing the completion of	

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F 640	Continued From page 2 the facility assessment task that included the Resident's MDS Assessments. A MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. 1. Resident #90 was observed to have an Entry MDS of [redacted] and was due to be transmitted no later than [redacted]. The Entry MDS was not transmitted until [redacted]. 2. Resident #133 was observed to have an Entry MDS of [redacted] and was due to be transmitted no later than [redacted]. The Entry MDS was not transmitted until [redacted]. According to the latest version of the Center for Medicare/Medicaid Services (CMS)- Resident Assessment Instrument 3.0 Manual (updated October 2019) page 2-11 " ....MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home. The manual revealed on Page 2-18 "Entry tracking record must be completed not later than entry date +7 calendar days. The assessment must also be transmitted to the QIES ASAP system not later than entry date + 14 calendar days." On 8/15/23 at 11:44 AM, the surveyor interviewed the facility's Registered Nurse (RN) MDS Coordinator who was responsible for completing and transmitting the MDS assessments who agreed that the above MDS assessments were transmitted late. No further information was provided.	F 640	comprehensive assessments. Additional MDS PRN nurse was added in August and another RN will be added in September PRN to assist with timeliness of completion. Education/training completed by DON on 8/16/23 with MDS nurses on time frames of completion and submission for MDS's. #4 MDS coordinator pulls clinical MDS list/action summary 2x a week to ensure the MDS's that are flagged for completion according to its due date. MDS coordinator to do QAPI for September, October and November on timeliness of completion monthly to track patterns and identify which MDS to complete first. The check 1x monthly for accuracy. #5 Administrator/DON or designee to complete audit monthly x 3 months on or about the 15th of the month and pull 5 assessments to audit for timeliness. Completion Date [redacted] and audit monthly x 3 months or until QAPI committee determines substantial compliance.	

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F 640	Continued From page 3 On 8/15/23 at 12:30 PM, the surveyor discussed the above concern to the facility's RN Vice President of Clinical Services. No further information was provided. NJAC 8:39-11.2	F 640		
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 record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 3 of 22 residents (Resident # 138, #140, and #86) reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 8/10/23 at 12:13 PM the surveyor reviewed the closed medical chart for Resident #138 who was MDS coded for hospitalization. The surveyor reviewed the Progress Notes (PN) created on [redacted] by the Social Worker (SW) for Resident #138. The PN documented that Resident #138 was discharged home per their family's request. Review of the [redacted] Nursing PN documented that Resident #138 was discharged at 11:30 with the family via a wheelchair, without any distress	F 641	#1 There were no residents identified as being negatively affected by this deficient practice. #2 All residents have the potential to be affected by this deficient practice. #3 Education completed with MDS nurses on coding and accuracy done by DON on 8/16/23. MDS coordinators will be cross checking their MDS's for accuracy to ensure that correct coding is done upon discharge MDS, so that MDS is double checked prior. #4	9/6/23

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F 641	Continued From page 4 or discomfort, all discharge papers ready and signed by the resident. Review of Resident #138's Face Sheet (FS) (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted] and [redacted]. Review of the "A section" of the [redacted] MDS for Resident #138 revealed that section '[redacted] Discharge Status" documented "03. Acute hospital." There was another option "01. Community (private home/apt., board/care, assisted living, group home)" which identified the correct discharge for Resident #138. On 8/10/23 at 1:17 PM, the surveyor met with both MDS Coordinators #1 and #2. MDS Coordinator #1 explained, "the wrong button was chosen" when the MDS was completed for Resident #138. 2. On 8/7/23 at 2:05 PM, the surveyor reviewed the closed medical chart for Resident #140 who was MDS coded for being discharged home, to the "Community." a. Review of Resident #140's [redacted] Nursing PN documented, "patient admitted to SBMC with diagnosis of [redacted] as per Emergency Room (E.R.) nurse." Continued review of the Nursing PN documented: b. On [redacted] at 19:15 the documented Nursing PN read, "Nursing Note Narrative: Writer went to check on patient and administer night	F 641	Monthly QAPI x 3 months to ensure accuracy of discharge location. Usage of consulting firm Pivotal Consulting Services to review all MDS's for accuracy. Administrator/DON or designee will complete random audits on or about the 15th of the month x 5 charts a month to ensure accuracy. #5 Compliance date of 9/15/23 and monthly audits x 3 months or until QAPI commute determines substantial compliance.	

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F 641	Continued From page 5	F 641		

meds, when writer went in patient was laying on his side, unresponsive, unarousable. Writer called for help.

c. 19:15- CPR was initiated.

d. 19:17 - Code was called, 911 called.

e. 19:26 - EMS on scene, writer continued compression.

f. 19:30 - EMS took over compressions, placed patient on Lucas, patient intubated.

g. Family and MD aware

h. 20:05 - Patient regain pulse, EMT transferred to patient to hospital. Family made aware, left message for doctor, awaiting return call.

i. Nursing supervisor in room during code."

Review of Resident #140's FS reflected that the resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted].

Review of the "A section" of the [redacted] MDS for Resident #140 revealed that section '[redacted] Discharge Status" documented "01. Community (private home/apt., board/care, assisted living, group home)." Acute hospital." There was another option "03. Acute hospital." which identified the correct discharge for Resident #140.

On 8/10/23 at 1:21 PM, the surveyor met with both MDS Coordinators #1 and #2. MDS Coordinator #2 explained, "the wrong button was chosen" when the MDS was completed for Resident #140.

3. On 8/7/23 at 1:56 PM, the surveyor reviewed the medical records for Resident #86.

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F 641	Continued From page 6 A review of the Resident #86's FS revealed that the resident was admitted to the facility in [redacted] with diagnoses that included but were not limited to Chronic Ischemic Heart Disease (heart problems caused by narrowed [redacted] A review of the Quarterly MDS, dated [redacted], documented in [redacted] under nutrition that the resident had a weight of [redacted] lbs., and had no significant [redacted] A review of the weights in the electronic health record documented the following weights: 6/2/23 [redacted] lbs. [pounds] 6/8/23- [redacted] lbs. 7/4/23- [redacted] lbs. 7/6/23- [redacted] lbs. 7/7/23- [redacted] lbs. 7/8/23- [redacted] lbs. 7/9/23- [redacted] lbs. 7/11/23 [redacted] lbs. 7/12/23 [redacted] lbs. A review of the dietician's nutrition note dated [redacted], indicated the weights on [redacted] were likely not accurate, compared to the resident's weight trend. On 8/10/23 at 9:57 AM, the surveyor interviewed the MDS Coordinator #2 who completed the nutrition section of the Quarterly MDS for Resident #86. MDS coordinator #2 stated that she checked the resident's weight history in the electronic medical record for any significant [redacted] prior to completing the Quarterly MDS.	F 641		

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F 641	Continued From page 7	F 641		

The surveyor reviewed Resident #86's weights and Quarterly MDS with MDS Coordinator #2. She acknowledged that the documented weight of [redacted] lbs. was not an accurate weight in comparison with the resident's weight trends at the time. The MDS Coordinator #2 also acknowledged that the assessment should have been coded to indicate the resident had a 5% weight loss in 1 month, based on the resident's weight at the time of the assessment.

A review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, updated October 2019, indicated in Chapter 3 MDS Items [A] section A2100: OBRA Discharge Status under Coding Instructions: "Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home" and "Code 03, Acute hospital."

A review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, updated October 2019, indicated in Chapter 3 MDS Items [K] section [redacted], Weight indicates:
"1. Base weight on the most recent measure in the last 30 days.
2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the Assessment Reference Date (ARD) of this assessment.

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F 641	Continued From page 8 4. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again. 5. If the resident's weight was taken more than once during the preceding month, record the most recent weight..." Review of the CMS RAI Version 3.0 Manual Section K0300 indicates, Weight Loss, indicated the definition of 5% weight loss in 30 days as: "Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight ..." On 8/10/23 at 2:13 PM, the surveyor met with the Vice President of Clinical Services and the Acting Licensed Nursing Home Administrator who could not explain why the MDS was coded incorrectly for Resident #138, #140 and #86. No further information was provided. NJAC 8:39-11.1, 11.2(e)(1)	F 641		
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, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 658	#1	9/6/23

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F 658	Continued From page 9 review it was determined that the facility failed to properly administer a medication used to treat hypotension in accordance with the physician's order (PO) in accordance with professional standards of nursing practice, for 1 of 22 residents, Resident #97. The deficient practice is 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 and 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: 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 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." The surveyor reviewed the electronic medical record (EMR) of Resident #97 which revealed the	F 658	There was one resident (resident #97) identified as being affected by the deficient practice. #2 All residents have the potential to be negatively impacted by this deficient practice. #3 All nurses were educated by ADONs and Unit Managers regarding following hold parameter orders, includig orders for midodine by September 1st, 2023. Audit of patients in house with midodrine order was completed to ensure that parameters are being followed. #4 ADON or designee with audit all patients on midodrine weekly x 4 weeks then monthly x 2 months to ensure parameters are followed as per physicians orders. Audit results will be reviewed in quarterly QAPI meeting to determine if further monitoring is needed. #5 Compliance date of 9/15/23 and will continue to audit x 4 weeks then x 2 months.	

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following:

The Admission Record revealed that Resident #97 was admitted [redacted] with diagnoses that included but were not limited to, [redacted]

The Admission Minimum Data Set (MDS) assessment, dated [redacted], indicated that Resident #97 was rarely understood, had unclear speech. A Brief Interview for Mental Status (BIMS) could not be completed, indicating that Resident #97 was [redacted].

A PO, dated [redacted] read, [redacted] Oral Tablet [redacted] mg Give 1 tablet [redacted] every [redacted] hours for [redacted] related to S [redacted] ...Hold for [redacted]] more than [redacted]

A review of the electronic Medication Administration Record (eMAR) for [redacted] revealed the nurses signed the [redacted] mg was administered 7/1 at 0600, 7/3 at 2200, 7/4 at 0600, 7/5 at 0600 and 1400, 7/6 0600 and 2200, 7/7 at 0600, 7/13 at 2200, 7/15 at 1400, 7/18 at 2200, 7/20 at 0600, 7/27 at 0600 and 2200, 7/29 at 2200, 7/31 at 1400. All of the [redacted] listed nursing administration times had documented

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F 658	Continued From page 11 [redacted]s that exceeded [redacted] All of the documented nursing administration times with the BPs that exceeded [redacted], should not have been administered to Resident #97 as per the PO. A review of [redacted] eMAR revealed that the nurses signed for the administration of the Midodrine 5 mg on 8/2 at 1400, 8/3 at 2200, 8/4 at 0600 and 2200, 8/6 at 1400 and 2200, 8/9 at 0600. All of the August 2023 listed nursing administration times had documented [redacted] that exceeded [redacted] All of the documented nursing administration times with the [redacted] that exceeded [redacted] should not have been administered to Resident #97 as per the PO. On 8/10/23 at 10:54 AM, the surveyor interviewed a Licensed Practice Nurse (LPN) assigned to care for Resident #97. The LPN stated that the vital signs for a medication with specific [redacted] would be checked first, the PO reviewed, and followed to hold a medication based on the [redacted] ordered. On 8/10/23 at 11:00 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM). The LPN/UM stated it was expected for the nurses to follow the PO as ordered. The surveyor reviewed the August 2023 eMAR regarding the administration of [redacted] mg with the LPN/UM. The LPN/UM acknowledged that the [redacted] mg was administered many times when it should have been held according to [redacted] of the PO. On 8/10/23 at 2:05 PM, the surveyor informed the Acting Licensed Nursing Home Administrator and Regional VP of Clinical Services of the above concerns with Resident #97's [redacted]	F 658		

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F 658	Continued From page 12 medication order not being followed. The surveyor reviewed the facility provided policy titled, "Administering Medications", with a date of 4/2023. Under Policy heading it read: "Medications are administered in a safe and timely manner, as prescribed. Under Policy Interpretation and Implementation it read: "4. Medications are administered in accordance with prescriber orders, including any requires time frame ...10. The individual administering the medication checks 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 ...11. The following information is checked/verified for each resident prior to administering medications:...b. Vital signs, if necessary ..." On 8/14/23 at 2:53 PM, the surveyor informed the Director of Nursing, and the two Acting Directors of Nursing of the above concerns. No further information was provided by the facility. NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		9/6/23

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F 692	Continued From page 13 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to obtain weekly weights for a resident according to the physician's order (PO) and facility policy for 1 of 5 residents, Resident #97 reviewed for nutrition. This deficient practice was evidenced by the following: On 8/7/23 at 9:10 AM, the surveyor reviewed Resident #97's electronic medical record (EMR) which revealed the following: A review of the Resident #97's face sheet (FS) (an admission summary) revealed that they were admitted on [redacted] with diagnoses that included but were not limited to [redacted]	F 692	#1 There was one resident (resident #97) identified as being affected by the deficient practice. #2 All residents have the potential to be affected by the deficient practice. #3 All nurses and certified nurses aides will be educated on obtaining weekly weights as directed by the physician and entered into Point Click Care by Unit Manger/ADON/Designee. All residents weights were audited for compliance with weight orders. Weekly weights are being obtained by the certified nurse aide and/or the nurse, and	

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F 692	Continued From page 14 [redacted] The Admission Minimum Data Set (MDS) assessment, dated[redacted] indicated that Resident #97 was rarely understood, and a Brief Interview for Mental Status (BIMS) could not be completed, indicating that Resident #97 was [redacted]. The Admission MDS assessment further indicated that Resident #97 received nutrition via a [redacted] with no known [redacted]. A PO dated [redacted] documented, "Weight upon admission, weekly x 4 weeks, then monthly thereafter". A review of the resident's nutritional care plan (CP) included an intervention "Record weight per protocol". The start date of the CP was [redacted] and the intervention start date was [redacted]. A review of the weights documented in the EMR for Resident #97 revealed [redacted] pounds (lbs.) on [redacted] and [redacted] lbs. on [redacted]. A nutrition note written by the Registered Dietician (RD), dated [redacted], indicated that the RD was unable to assess the resident's current weight and once feasible would get an updated weight for the resident. On 8/9/23 at 10:55 AM, the surveyor interviewed the certified nursing assistant (CNA) who was assigned to care for Resident #97. The CNA	F 692	recorded into PCC by the nurse. Procurement of 2 new chair scales and a new hoyer lift scale was completed and added to the floors by 9/5/23. #4 The registered dietician will review weekly weights for all patients with a physician order and make any further recommendations based on results in collaboration with the physician. DON/ADON will review/audit weekly weights x 4 weeks, then monthly, to ensure weekly weights have been obtained as per physician order. Results of audit will be reviewed in quarterly QAPI meeting to determineif furhter follow up is needed. #5 Compliance date will be 09/15/23 and monitoring will be x 4 weeks from 8/15/23 then weekly x 2 months. QAPI team will determine if compliance is met or need for further auditing.	

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stated at the start of the shift after receiving report, the unit clerk would provide the list of residents to be weighed for the day. The CNA stated the weight results would be provided to the nurse or unit clerk to be documented on the weight list at the nurses' station. The CNA stated she was not sure of the schedule for when Resident #97 needed to be weighed.

On 8/9/23 at 11:03 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) on the unit. The LPN informed the surveyor that admission and daily weights would be documented in the EMR by the nurses. Weekly and monthly weights to be obtained were on a list which was provided by the RD. The LPN explained that the list was kept in a "weight binder" on the unit. The CNA would let the unit clerk know the weight results for it to be documented on the list, which the dietician would review.

On 8/9/23 at 11:20 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM). The LPN/UM informed the surveyor that located in the EMR there would be a Physician's Order (PO) and the CNAs would be directed to obtain the resident's weight. The LPN/UM stated that the unit clerk would create a weight list for residents who would have to be weighed that would be directed by the RD. The weight list includes residents for weekly weights, monthly weights and those who needed to be re-weighed.

The LPN/UM specified that daily weights were documented by the nurses in the EMR. The LPN/UM added that weekly and monthly weight results were entered by the RD in the EMR.

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The LPN/UM informed the surveyor that the nurses were responsible for reviewing the weights of residents and ensuring weights were done. The LPN/UM added that the RD should review the resident's weights.

On 8/9/23 at 11:45 AM, the surveyor interviewed the RD in the presence of the Regional Registered Dietician (RRD). The RD stated the facility protocol was for residents to be weighed upon admission, then weekly weights for four weeks, followed by monthly weights. The RD stated she provided the list of residents to be weighed on a weekly basis to the nursing unit. The RD revealed that she would then review the results and if there were weight differences or missing weights, she would request a re-weigh. The RD further stated that she would request that the nurse, unit clerk and unit manager would re-weigh of a resident.

The RD stated that she was responsible for reviewing residents' weights, as well as nurses monitoring that resident's weights are done.

The surveyor discussed the discrepancy of Resident #97 with the RD, missing weekly weights for a total of four weeks in the months of June and July.

On 8/10/23 at 1:32 PM, the RD informed the surveyor that she reviewed the weights in the weight binder and did not find any weights for Resident #97. The RD could not provide information as to why there were no other weights obtained for the resident between [redacted] and [redacted]

On 8/10/23 at 2:05 PM, the surveyor informed the Acting Licensed Nursing Home Administrator

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(LNHA) and the Regional VP of Clinical Services of the above concerns.

On 8/14/23 at 9:47 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). The ADON acknowledged that weights should be obtained and documented according to the facility's policy and the PO.

On 8/14/23 at 9:55 AM, Resident #97 was observed lying in bed with the head of the bed elevated. The resident was [redacted] The resident was receiving a [redacted]

A review of the facility provided policy titled "Weight Policy" with a revised date of 12/2022, under Policy, it read: "It is the policy of this facility to weigh each resident on admission, then weekly for (4) four weeks, then monthly thereafter, unless otherwise ordered by physician/IDT team. The facility will utilize a consistent procedure for monitoring weights and prevent unnecessary weight loss/gain in our residents."

A review of the facility provided policy titled "Weight Assessment and Intervention" with a date of 4/3/2023, under Weight Assessment it read: "1. Residents are weighed upon admission and at intervals established by the interdisciplinary team and/or as ordered by the physician ... 2. Weights are recorded in each unit's weight record chart and in the individual's medical record ..."

On 8/14/23 at 2:53 PM, the surveyor discussed the above concerns related to Resident #97's missing weights with the Director of Nursing

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F 692	Continued From page 18 (DON), and the two ADONs. There was no further information provided by the facility. NJAC 8:39-27.2(a)	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record, it was determined that the facility failed to monitor an [redacted] administration [redacted] to assure the [redacted] administered was in accordance with physician's orders. This deficient practice was identified for 1 of 3 residents reviewed for [redacted], (Resident	F 693	#1 Based on observation, interview, and record, it was determined that the facility failed to monitor [redacted] administration [redacted] to assure the [redacted] administered was in accordance	9/6/23

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F 693	Continued From page 19 #391), and was evidenced by the following: On 8/2/23 at 10:24 AM, the surveyor observed Resident #391 in bed [redacted] board on table at bed side. observed with an [redacted] administering [redacted]) at a [redacted] an [redacted] r. On 8/3/23 at 9:13 AM, the surveyor observed the resident in bed on [redacted] awake, [redacted] and responded appropriately to surveyor. The surveyor observed [redacted] being administered at a [redacted]. The surveyor reviewed the Electronic Medical Record for Resident #391. Review of the Face Sheet (FS) (a one-page summary of information about a resident that documents pertinent information), which included but was not limited to [redacted] A review of the Brief Interview for Mental Status (BIMS) dated [redacted] expressed a score of [redacted] out of [redacted], indicating that Resident #391 had [redacted] A review of the [redacted] Physician Orders (PO), which revealed an order initiated on [redacted] for [redacted] r every shift for [redacted]	F 693	with the physician order. There was 1 resident (resident #391) that was identified as being affected by this deficient practice. #2 All residents on continuous or intermittent enteral feeds have the potential to be affected by this deficient practice. #3 All [redacted] orders were audited to ensure that all residents in house are receiving adequate caloric intake. Education will be provided by the ADON/Unit manager to all nurses and the registered dietician by 9/8/23 to review total volume is in accordance with physician orders. #4 All [redacted] orders will be reviewed upon admission by both the nurse, physician, and registered dietician to ensure adequate caloric intake. Nurse will ensure that [redacted] is [redacted] with correct [redacted] infused at [redacted] as per physician order prior to [redacted] Prior to taking down [redacted], nurse will review [redacted] infused to ensure total amount received as per physician order. Nurse will document [redacted]	

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F 693	Continued From page 20 at [redacted]), [redacted] mL, which was discontinued on [redacted]. The surveyor reviewed the July and August 2023 Electronic Administration Medication Administration Record (eMAR) which documented a physician order for Resident #391, [redacted] for [redacted]. Review of the [redacted] in [redacted] documented for the 7 to 3 shift on the July and August 2023 eMAR included, 7/25/23 [redacted], 7/26/23 [redacted] 7/27/23 eMAR documented a [redacted] indicating to see progress notes, which documented, every shift for [redacted] support [redacted] still [redacted] and [redacted] documented [redacted]. The [redacted] documentation did not consider any pauses for resident care throughout the day. The directions for the [redacted] at [redacted] would have to be [redacted] without any pausing to completely [redacted] in a [redacted]. On 8/3/23 at 9:48 AM, the surveyor interviewed the Registered Nurse (RN) assigned to Resident #391. The RN stated that Resident #391 was fed with [redacted]. The RN further stated that if facility staff are providing care for Resident #391, the [redacted] would be held, once care is completed the [redacted]	F 693	[redacted] on Medication Administration Record at the completion of the [redacted] Registered dietician will conduct audit of all patients receiving [redacted] to ensure that all [redacted] has been met, weekly x 4 weeks and then monthly x 3 months. Audit results will be reviewed in QAPI meeting to determine if further monitoring is needed. #5 Compliance date will be 9/15/23 with audits weekly x 4 weeks and then monthly x 3 months.	

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would be resumed. The RN added that there is no [redacted] ordered that needs to be [redacted]

On 8/3/23 at 9:57 AM, the surveyor interviewed the RN/Unit Manager (UM), who verified that there was a previous order for [redacted] The [redacted] is held when Resident #391 is receiving physical therapy that requires the resident to lay flat on a bed. The RN/UM verified that the resident's [redacted] is also held during care. The RN/UM stated that there was no [redacted] ordered with the [redacted]

On 8/3/23 at 10:49 AM, the surveyor reviewed the [redacted] eMAR with the RN/UM. The RN/UM agreed that the [redacted] PO dictated the feed for [redacted] was ordered at [redacted] The RN/UM admitted that she was not aware of a [redacted] ordered by the physician. The RN/UM added that she was only aware of a [redacted] ordered by the Physician.

On 8/7/23 at 12:23 PM, the surveyor interviewed the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), who could not explain the accountability for the difference between the [redacted] ordered by the physician for the day and the amount that was actually [redacted] when the [redacted] was held during daily care and rehabilitation. The DON and ADON could not verify the exact amount of [redacted] received by Resident #391 daily.

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F 693	Continued From page 22 A review of the facility's policy titled [redacted] under Policy Interpretation and Implementation number 10 presents, "[redacted]al [redacted] are scheduled to try and optimize resident independence whenever possible ..." Further review of the policy numbered section 11 establishes, "The nurse confirms that the orders for enteral nutrition are complete. Complete orders include e. volume and rate administration." On 8/10/23 at 2:07 PM, the surveyor met with the covering Licensed Nursing Home Administrator (LNHA) and Vice President of Clinical Services to discuss the discrepancy with Resident #391's [redacted] The Vice President of Clinical Services acknowledged that there was a discrepancy, and that Resident #391 was not receiving the [redacted] ordered. No further information was provided. NJAC 8:39-27.1(a)	F 693		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		9/6/23

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F 756	Continued From page 23 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to act upon recommendations reported to the facility by the Pharmacy Consultant (PC) within an acceptable timeframe. This deficient practice was observed for 1 of 38 residents (Resident #105) reviewed. On 8/7/23 at 12:24 PM, the surveyor observed Resident #105 lying in bed, [redacted]. The resident was placed under contact isolation due to diagnosis of [redacted] caused by the [redacted]	F 756	#1 Based on observation, interview, and record review, it was determnied that the facility failed to act upon recommendations reported to the faciity by the phamracy consultant. This deficient practice was observed for 1 resident (resident #105). #2 All residents have the potential to be	

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F 756	Continued From page 24 [redacted]. A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care Brief Interview for Mental Status (BIMS) section, dated [redacted] reflected that Resident #105 was [redacted]. A review of the resident's face sheet (FS) (an admission summary) indicated that Resident #105 was admitted to the facility on [redacted] and had diagnosis which included but not limited to, [redacted]. On 8/8/23 at 10:22 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) on the unit who provided forms dated [redacted] and [redacted] titled, "Nursing Summary Report" (NSR). The NSR documented the recommendations by the PC. The surveyor did not find any recommendations made for Resident #105. The RN/UM confirmed that she could not locate any NSR for Resident #105 from [redacted] through [redacted]. A review of the progress notes dated [redacted] and documented by the pharmacist indicating, "IMRR (independent medical record review) complete". On 8/10/23 at 9:30 AM, the Registered Nurse/Vice President of Clinical Services (RN/VP CS) provided a copy of Resident #105's Nursing Summary Report (NSR) which documented the PC review from [redacted] and [redacted] The surveyor reviewed the NSR with the RN/UM who confirmed to the surveyor that the NSR had not been reviewed, as the form was not initialed	F 756	affected by this deficient practice. #3 Educated provided to the unit managers and ADONs by the Director of Nursing on 9/1/23. Monthly Medication Reviews reviewed by nursing management to ensure all recommendations are being followed. #4 Pharmacy consultant will review all patient records during the monthly review and submit recommendations within 48 hours to the facility. Monthly medication recommendations will be reviewed by the MD and signed off accordingl, with a copy placed in the patient chart and competed reports kept in the pharmacy consultant binder on each floor. DON or designee will audit of monthly MMR will be conducted monthly x 3 months and results reviewed in QAPI to determine if further monitoring is needed. #5 Compliance date of 9/15/23 with monthly audits x 3 months until compliance is met, or longer if QAPI team feels appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE LIVINGSTON	348 E CEDAR STREET LIVINGSTON, NJ 07039

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F 756	Continued From page 25	F 756		

nor dated as completed. There was no documentation on the form to indicate that the PC's recommendations were reviewed or addressed. The RN/UM further stated that she was responsible to review all the recommendations from the PC and to discuss the recommendations with the Physician.

A review of the NSR form dated [redacted], included PC recommendations, 1.) "[redacted]) should be mixed in [redacted] prior to administration. Include the volume needed for mixing in the order." ; 2.) "[redacted] should be administered on an [redacted], at least [redacted] minutes [redacted]. Evaluate 1800 (6:00 PM) dose."

A review of the NSR form dated [redacted], included PC recommendations, 1.) [redacted]) should be mixed in [redacted] prior to administration. Include the volume needed for mixing in the order." ; 2.) "[redacted] should be administered on an [redacted], at least [redacted] minutes [redacted]. Evaluate 1800 (6:00 PM) dose."

A review of the electronic Medication Administration Record (eMAR) from [redacted] through [redacted] did not reflect that the above PC recommendations were handled based on the PC's recommendation.

On 8/10/23 at 2:45 PM, the surveyor requested the facility's policy for the Pharmacy Consultant. A review of the facility's policy titled; "Medication Regimen Reviews" revealed the following: "#14. The consultant pharmacist provides the director of nursing services and medical director with a written, signed and dated copy of all medication

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	315526	A. BUILDING _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE LIVINGSTON	348 E CEDAR STREET LIVINGSTON, NJ 07039

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F 756	Continued From page 26 regimen reports. Follow up will be completed within 30 days." On 8/15/23 at 10:54 AM, the RN/VP CS confirmed that the 6/15/23 and 7/26/23 NSR which was provided by the PC were never reviewed or handled. NJAC 8:39-29.3 (a)	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE LIVINGSTON	348 E CEDAR STREET LIVINGSTON, NJ 07039

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S 000	Initial Comments 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: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.	S 560	#1 No residents were identified as having been affected. #2 All residents have the potential to be affected. #3 Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. Trends identified from these meeting will be presented during	9/6/23

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

Electronically Signed | 09/06/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 08/15/2023

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S 560	Continued From page 1 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins.	S 560	monthly QAPI meeting. The facility has implemented a multifaceted approach for recruitment and retention of employees, which includes increased utilization of PRN/Per diem staff (Staff hired without any set hours, usually staff who have another job and pickup extra shifts when the need arises), Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, and Text message campaigns. The facility has hired a recruitment company to do paid campaigns with Indeed, and other social media platforms to recruit nursing staff. Daily update emails and weekly meetings help to identify trends in hiring and review all new hires and where candidates stand in the hiring process. Employee engagement is led by management team/department heads to facilitate seasonal holiday parties, monthly staff appreciation, and birthday celebrations. Administrator/designee will review the minutes from monthly resident council meetings for 3 months to determine whether there are any concerns regarding care and services. Administrator/designee will review the minutes from the daily staffing meeting to determine whether all efforts are resulting in staffing levels meeting the requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 08/15/2023

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S 560	Continued From page 2 d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 7/16/23 to 7/22/23 and ending 7/23/23 to 7/29/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 6 of 14 day shifts as follows: For the 2 weeks of staffing 7/16/2023 to 7/22/2023 and 7/23/2023 to 7/29/2023 the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -07/16/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -07/23/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -07/24/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -07/26/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -07/27/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -07/29/23 had 13 CNAs for 113 residents on the day shift, required at least 14 CNAs. The facility's Director of Nursing was informed of their deficient practice on 8/14/23 at 11:00 AM. No further information was provided.	S 560	The results of staffing audits will be reported to the facility QAPI Committee for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit. #5 Facillity will be in compliance by September 30, 2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NH07001 Y1	A. Building B. Wing Y2	10/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE LIVINGSTON	348 E CEDAR STREET LIVINGSTON, NJ 07039

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/06/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315526 Y1	A. Building B. Wing Y2	10/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE LIVINGSTON	348 E CEDAR STREET LIVINGSTON, NJ 07039

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 F0640	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	09/06/2023	LSC	09/06/2023	LSC	09/06/2023
ID Prefix F0692	Correction	ID Prefix F0693	Correction	ID Prefix F0756	Correction
Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(g)(4)(5)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed
LSC	09/06/2023	LSC	09/06/2023	LSC	09/06/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/15/2023	☐ YES ☐ NO

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
315526 Y1	A. Building 01 - ATRIUM POST ACUTE CARE LIVINGSTON B. Wing Y2	10/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE LIVINGSTON	348 E CEDAR STREET LIVINGSTON, NJ 07039

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0311	09/08/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO