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 11/04/2022

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#: NJ00159057 CENSUS: 110 SAMPLE SIZE: 4 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		12/23/22

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

Electronically Signed — 12/16/2022

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 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: C# 00159057 Based on observation, interview, record review, and review of pertinent facility documents on 11/3/22 an 11/4/2022, it was determined that the nursing staff failed to notify the Physician about the resident's changes in condition and follow the facility policy for 2 of 2 residents (Resident #2 and #3) reviewed for Physician notification. This deficient practice is evidenced by the following:	F 580	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Cannot retroactively correct the deficient practice as it pertains to Resident #2 since (s)he no longer resides at the facility. Physician was notified on [redacted] about Resident #3’s change in condition. 2. How you will identify other residents having potential to be affected by the	

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F 580	See below	F 580	See below	

F 580

Continued From page 2

Review of the Electronic Medical Records (EMRs) were as follows:

1. According to the Admission Record (AR), Resident #2 was admitted to the facility on [NJAC 8 43E-2.1] and readmitted on [NJAC 8 43E-2.1 an].

The Minimum Data Set (MDS), an assessment tool, dated 8/13/22, revealed a Brief Interview for Mental Status (BIMS) score of [NJAC 8] which indicated that the Resident's cognitive status was [NJAC 8 43E-2.1]. The MDS also indicated that the Resident was ambulatory and independent with Activities of Daily Living (ADL).

The Medical Doctor (MD) Progress Notes (MDPN) dated [NJAC 8 43E-2.1 and Exe] indicated diagnoses that included but were not limited to: [NJAC 8 43E-2.1 and Exec Ord], NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [NJAC 8 43E-2.1 and Exe]

The MDPN History and Physical dated [NJAC 8 43E-2.1 and E] at 1:22 PM, by the Attending Physician (AP) showed [redacted]] responded to [redacted] call, patient was [redacted] in his/her room, [NJAC 8 43E-2.1 and] given with good results, patient transported to the ED [Emergency Department] where [NJAC 8 43E-2.1 a] was found by Detectives in the patients clothing. He/she is now in his room, awake and alert in [NJAC 8 43E-2.1 and Exec Order 26, 4] [NJAC 8 43E-2.1 and Exec]

Review of the nurse's Progress Notes (PN) dated 10/20/22 at 4:15 AM, indicated that Resident #2 became [NJAC 8 43E-2.1 and Exec Order 2] while the nurse was attending to the roommate (Resident #3), [redacted] was activated and upon arrival, the [redacted] responder administered [NJAC 8 43E-2.1 an] ([NJAC ... 1 and Exec O]

F 580 – Plan of Correction (continued)

same practice and what corrective actions will be taken:
All residents have the potential to be affected by this deficient practice.
3.What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:
All nursing staff will be reeducated on facility policy tilted “Change in Condition or Status” specifically regarding notification of changes of residents to their physician
Newly hired staff will be educated on these components during orientation.
4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:
A QA audit tool will be completed by the DON/designee on all residents with a change in condition weekly for 8 weeks to ensure any change in a resident’s condition has been communicated to the physician promptly and documented in the progress notes
Findings of review will be presented by LNHA at quarterly QAPI meeting.

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F 580	Continued From page 3 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.) to Resident #2 who subsequently . Resident #2 was transported to the afterwards. Review of the Licensed Practical Nurse/Shift Supervisor (LPN/SS) statement dated 10/23/33 at 12:45 PM, indicated that at 9:00 PM (no date) Resident #2 was found sitting outside on the bench and ' . The LPN/SS further indicated "both patients [Resident #2 and #3] but ." The Licensed Nursing Home Administrator (LNHA) was made aware and instructed the LPN/SS to place both residents in room NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. (both Residents lived on another floor). There was no documented evidence in the nurse's PN that reflected the LPN/SS statement as well as Resident #2's assessment. Additionally, there was no documented evidence that AP was notified about the changes in Resident's condition. 2. According to the AR, Resident #3 was admitted to the facility on with diagnoses that included but were not limited to: NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. The MDS dated 8/14/22, revealed a BIMS score of NJAC 8 which indicated that the Resident's was NJAC 8:43E-2.1 The MDS also indicated that the Resident was ambulatory and independent with ADLs. Review of the nurse's PN dated 10/19/22 at 3:10	F 580		

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F 580	Continued From page 4 PM, revealed that LPN #1 was called to the hallway for Resident #3 and upon her arrival, she observed 2 staff holding the Resident to prevent [redacted]. The Resident was transferred to a wheelchair and assisted to the room. LPN #1 took the Resident's Vital Sign (VS) but only documented the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] (level for a healthy person range between NJAC 8:43E-2.1 and Exec Order 26, 4. b. [redacted] The LPN administered [redacted] of NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. which increased the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. The LPN administered the [redacted] without a Physician's Oder (PO), which she confirmed during her interview on 11/4/22 at 9:49AM. Despite diagnosis of [redacted] Resident #3's recorded NJAC 8:43E-2.1 and E [redacted] from [redacted] 22 ranged between [redacted] in room air ([redacted]) and the Order Summary Report (OSR) did not reveal an order for [redacted] The PN notes indicated that the Resident was out and ambulatory. Further review of the nurse's PN dated 10/19/22 at 10:30 PM, revealed that at 9:40 PM, LPN #1 was called to the [redacted] patio because Resident #3 and another resident (Resident #2) needed assistance. When LPN#1 and LPN/SS responded, Resident #3 was [redacted], was noted with [redacted], and [redacted]. Resident #3 was assisted and transported back to his/her unit [redacted] floor) in a wheelchair. At 11:00 PM, the LPN/SS moved Resident #3 to the [redacted] floor in the same room with Resident #2 for [redacted] At 3:45 AM, Resident #3 was [redacted] and when the [redacted], his/her [redacted]. While the LPN/SS was conducting her assessment, Resident #3 started making [redacted]", which prompted the	F 580		

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F 580	Continued From page 5 LPN/SS to . Resident #3 then . The LPN/SS initiated) until the arrived. Resident #3 was at Review of Resident #3's recorded from revealed that the Resident had that ranged between in room air (.) There was no documented evidence in the nurse's PN that the Attending Physician (AP) was notified when Resident #3's to on , which was and and when Resident #3 had a change in condition, an episode of and . On 11/3/22 at 2:07 PM, the surveyor conducted a phone interview with the AP who stated that he is the AP for both Residents. The AP stated that he expects the nurses to call him for any changes in patient's status or condition so he can order an intervention based on the nurse's report. He explained that the staff did not notify him until the next day, on , about the changes in clinical condition of both Residents, Resident #2's , and the Resident #3. On 11/4/22 at 9:49AM, the surveyor interviewed the LPN #1 who stated that she did not notify the AP when Resident #3's on or the episode of	F 580		

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F 580	Continued From page 6 [redacted] on [redacted]. She explained that the Assistant Director of Nursing (ADON) came and assessed the Resident during the first event at [redacted]. LPN #1 could not explain her reason for not notifying the Physician about the changes in Resident's [redacted] even after she administered the [redacted] without a Physician's order or when the Resident was noted with an episode of [redacted]. However, she acknowledged that she should have called and notified the AP when she noticed the changes in the Resident's status. The surveyor reviewed the ADON's statement dated [redacted]. The statement indicated that on [redacted] at around [redacted], LPN #1 called her to assess Resident #3. The ADON took the Resident's VS and conducted a [redacted] assessment and found no [redacted]. On 11/4/22 at 10:26 AM, the surveyor interviewed the ADON who confirmed what she wrote in her statement was accurate. The surveyor asked if she notified the AP about Resident #3's condition and she answered no. She explained that her assessments were normal and that she was not aware that the Resident's [redacted] [redacted] prior to her assessment and LPN #1 administered the Oxygen without calling the AP. Furthermore, the ADON could not answer when the surveyor asked why there was no documentation of her assessment in the EMR, however, she acknowledged that she should have documented her assessment and called the AP. The surveyor interviewed the LPN/SS on 11/4/22 at 10:37 AM who confirmed that what was written on her statement was accurate. The surveyor	F 580		

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F 580	Continued From page 7 asked what she meant when she wrote " " and "both patients [Resident #2 and #3] but ." The LPN/SS stated, " " and she felt suspicious that both residents . Furthermore, the surveyor asked, why there was no documentation about the Resident's assessment in the PN as well as AP notification when her observation indicated that both residents were not acting like their and could . She explained that she did not notify the AP and assumed that LPN #1 had notified the AP about Resident #3's changes in condition. Furthermore, the LPN/SS could not explain why she did not notify the AP about Resident #2's changes in condition but acknowledged that she should have called the AP and notified him herself. On 11/4/22 at 11:30 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she expects the nurses to notify her and the AP when there's changes in resident's condition. She explained that she was not informed about the changes in status of both Residents and the events that took place on until the next morning. She acknowledged that LPN #1 and LPN/SS are responsible for notifying the AP for any changes in a Resident condition and On 11/4/22 at 11:35 AM, the surveyor interviewed the LNHA who stated that the LPN/SS called him on 10/19/22 and informed him that both Residents (Resident #2 and #3) " ." He instructed the LPN/SS to move both residents on the floor to monitor. The	F 580		

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F 580	Continued From page 8 surveyor asked the LNHA if he instructed that LPN/SS to call the AP, or the DON and the LNHA stated that it was a clinical judgment, and the LPN/SS should have notified the AP and DON based on her clinical judgment. Review of facility's policy titled "Change in Condition or Status" revised 1/2022, under "Policy Statement" indicated "Our facility should promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/ or status" under "Policy Interpretation" indicated 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an) d. significant change in resident's physical/emotional/mental condition. NJAC 8:39-27.1	F 580		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		12/23/22

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F 842	Continued From page 9 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 10 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C# 00159057 Based on interviews, record review, and review of pertinent facility documents on 11/3/22 and 11/4/22, it was determined that the nursing staff failed to accurately document the resident's status and assessments in the Resident's Progress Notes in accordance with accepted professional standards of practice and facility policy for 2 of 2 residents (Resident #2 and #3) reviewed for documentation. This deficient practice is evidenced by the following: Review of the Electronic Medical Records (EMRs) were as follows: 1. According to the Admission Record (AR), Resident #2 was admitted to the facility on NJAC 8 43E-2.1 and readmitted on NJAC 8 43E-2.1 and The Minimum Data Set (MDS), an assessment tool, dated NJAC 8 43E-2.1 and, revealed a Brief Interview for Mental Status (BIMS) score of NJAC 8 which indicated that the Resident's NJAC 8 43E-2.1 and 8 status was	F 842	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Late Entry Progress Note was written by the nurse for Resident 2. Late entry progress note was written by the nurse for Resident 3. 2. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: All residents have the potential to be affected by this deficient practice. 3.What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: All nursing staff will be reeducated on facility policy tilted Charting and Documentation. Newly hired staff will be educated on these components during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not	

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F 842	Continued From page 11 The MDS also indicated that the Resident was ambulatory and independent with Activities of Daily Living (ADL). Review of the nurse's Progress Notes (PN) dated 10/19/22 at 1:11 PM, indicated that Resident #2 was [redacted], [redacted] the unit, and had [redacted]. The succeeding documentation was written at [redacted], when Resident #2 became [redacted] and [redacted]. The [redacted] administered [redacted] to Resident #2 who [redacted]. Resident #2 was transported to the [redacted] afterwards. Review of the Licensed Practical Nurse/Shift Supervisor (LPN/SS) statement dated 10/23/33 at 12:45 PM, 3 days after the incident, indicated on 10/19/22 at around 9:00 PM, Resident #2 was [redacted] and [redacted]." The LPN/SS further indicated "both patients (Resident #2 and #3) were [redacted]." The Licensed Nursing Home Administrator was made aware and instructed the LPN/SS to place both residents in room [redacted] on the [redacted] floor [redacted]). There was no documented evidence in the nurse's PN that Resident #2 was assessed, or vital signs (VS) was taken on [redacted] or after the event. 2. According to the AR, Resident #3 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted]	F 842	recur, i.e., what quality assurance program will be put into place: The Director of Nursing/designee will audit 5 random charts weekly for 4 weeks and then monthly for 3 months to ensure nursing documentation is completed as required by facility policy. Findings will be presented by LNHA at quarterly QAPI meeting.	

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 11/04/2022

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

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F 842	Continued From page 12 . The MDS dated 8/14/22, revealed a BIMS score of which indicated that the Resident's was . The MDS also indicated that the Resident was ambulatory and independent with ADLs. Review of the nurse's PN dated 10/19/22 at 3:10 PM, revealed that LPN #1 was called to the hallway for Resident #3 and upon her arrival, she observed 2 staff holding the Resident to . The Resident was transferred to a wheelchair and assisted to the room. LPN #1 took the Resident's VS but only documented the level for a healthy person range between 95% and 100%). Afterwards, the LPN administered Despite diagnosis of Resident #3's recorded ranged between in room air) and the Order Summary Report (OSR) did not reveal an order for . There was no further documentation of the Resident's status in the progress notes until 9:40 PM on 10/19/22. The surveyor reviewed the ADON's statement dated . The statement indicated that on at around 3:20 PM, LPN #1 called her to assess Resident #3. The ADON took the Resident's VS and conducted a assessment and found . On 11/4/22 at 10:26 AM, the surveyor interviewed the ADON who confirmed what she wrote in her statement was accurate. However, the ADON could not answer when the surveyor asked why there was no documentation of her assessment	F 842		

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 11/04/2022

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

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F 842	Continued From page 13 in the EMR and acknowledged that she should have documented her findings in the Resident's PN. The surveyor interviewed the LPN/SS on 11/4/22 at 10:37 AM who confirmed that what was written on her statement was accurate. The surveyor asked what she meant when she wrote " " and "both patients (Resident #2 and #3) were " The LPN/SS stated, " and she fel that both residents The surveyor asked why there was no documentation in Resident #2's PN about what she wrote in her statement and her observations or assessment of Resident #2. The LPN/SS could not answer and stated that she should have documented her observation in the PN. On 11/4/22 at 11:30 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she expects the nurses to notify her and the AP when there are changes in resident's clinical condition. She explained that she was not informed about the changes in status of both Residents and the events that took place on until the next morning, on 10/20/22. She acknowledged that LPN #1 and LPN/SS were responsible for notifying the AP for any changes in Resident's . Additionally, the DON stated that she expects the nurses to write or enter accurate documentation in the Resident's progress notes to reflect their assessments and the Resident's status. Review of facility's policy titled "Charting and	F 842		

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	315305	A. BUILDING ______ B. WING ______	C 11/04/2022

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F 842	Continued From page 14 Documentation" revised 7/2022, under "Policy Statement" indicated "All services provided to the residents, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, and psychosocial condition, shall be documented in the resident's medical record." Under "Policy Interpretation and Implementation" indicated that 2. The following information is to be documented in the resident medical record: a. Objective observations ...d. Changes in resident's condition, e. Events, incidents or accidents involving the resident. 3. Documentation in the medical record will be objective, complete, and accurate. 5. Documentation ...will include care-specific details, including: a. date and time ...c. the assessment data and/ or unusual findings ... NJAC 8:39-35.2 (d) 5, 6	F 842		

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 11/04/2022

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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H3450	8:43E-10.11(b)(1)(i), (2-3) Other Rprtng Rqrmnts Unrltd to Pt Sfty Act A facility licensed in accordance with N.J.S.A. 26:2H-1 et seq. shall notify the Department immediately of the types of reportable events described in N.J.A.C. 8:43E-10.11(c) and 8:43E-10.11(d). 1. The Department anticipates the development of an Internet web-based electronic reporting system but shall, in the interim, require facilities to submit the notice required pursuant to N.J.A.C. 8:43E-10.11(a) by means of telephone, facsimile, or e-mail, or a combination thereof. i. The Department shall provide notice to facilities on the reporting medium to be used, including telephone and facsimile numbers, e-mail addresses and/or web addresses. 2.In the case of acute care facilities, "immediately" means no later than three hours after discovery of the event 3. In the case of long-term care facilities, "immediately" means telephonic notification to the Department at (609) 392-2020 followed by written notification within 72 hours. This REQUIREMENT is not met as evidenced by:	H3450		12/23/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/16/22

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 11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H3450	Continued From page 1 C# 00159057 Based on observation, interview, record review, and review of pertinent facility documents on 11/3/22 and 11/4/2022, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) facility reportable events for residents that sustained serious injury, for 2 of 2 residents (Resident #2 and #3) reviewed for reportable events. This deficient practice is evidenced by the following: On 11/3/22 at 10:00 AM, the surveyor interviewed Resident #2, who stated that on he/she was . He/she explained that the nurse called the ambulance because he/she had Then, the police arrived and asked questions. The Resident further explained that a Resident from the floor, who no longer lived at the facility gave him/her the and then the Resident said, ." Resident #2 further stated to the surveyor that he/she now participates to a weekly at the Review of the Electronic Medical Records (EMRs) were as follows: 1. According to the Admission Record (AR), Resident #2 was admitted to the facility on and readmitted on The Minimum Data Set (MDS), an assessment tool, dated 8/13/22, revealed a Brief Interview for Mental Status (BIMS) score of which indicated that the Resident's . The MDS also indicated that the Resident was ambulatory and independent with Activities of	H3450	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 12/15/2022 Administrator reported a for residents #2 and #3 that occurred on On 12/15/2022 Administrator reported a for residents #2 and #3 that occurred on 2. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: All residents have the potential to be affected by this deficient practice. 3.What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Administrator and Director of nursing will be reeducated on reporting policy by Regional Administrator. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Regional Administrator/DON will review all reportable events monthly for three months. Findings of review will be presented by LNHA at quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 11/04/2022

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H3450	Continued From page 2 Daily Living (ADL). The Medical Doctor (MD) Progress Notes (MDPN) dated indicated diagnoses that included but were not limited to: The MDPN also showed the following: , patient was in room, with , patient transported to the ED [Emergency Department] where was found by in the patients . is now in room, awake and alert in " Review of the nurse's Progress Notes (PN) revealed that Resident #2 was transferred to the) on , returned on with discharged diagnosis ." The Resident was again transferred to the ER on and readmitted back same day with the same discharged diagnosis. Further review of a PN dated 10/20/22 at 4:15 AM, revealed that Resident #2 became while the nurse was attending to the roommate (Resident #3), and upon arrival, the to Resident #2 who . Resident #2 was transported to the afterwards. Review of Resident #2's hospital records indicated that the Resident received and had a diagnosis of for the and . It	H3450		

New Jersey Department of Health

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	061201	A. BUILDING: ____ B. WING ____	C 11/04/2022

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H3450	Continued From page 3 further revealed that the Resident acknowledged that he snorted heroin on both incidents. 2. According to the AR, Resident #3 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted]. The MDS dated 8/14/22, revealed a BIMS score of [redacted] which indicated that the Resident's [redacted]. The MDS also indicated that the Resident was ambulatory and independent with ADL. Review of the nurse's PN showed that Resident #3 was transferred to the ER on [redacted] and returned on [redacted] (the same date Resident #2 was sent out to the ER). The PN further revealed that the Resident [redacted] for [redacted]. Review of the hospital records indicated that Resident #3 received [redacted] when transferred to the hospital on [redacted] and MDPN revealed a diagnosis of "[redacted]." Further review of the nurse's PN dated 10/19/22 at 10:30 PM, revealed that at 9:40 PM Licensed Practical Nurse #1 (LPN #1) was called to the [redacted] because Resident #3 and another resident (Resident #2) [redacted] When LPN#1 and LPN/Shift Supervisor (LPN/SS) responded, Resident #3 was [redacted], was noted with [redacted], and [redacted]. Resident #3 was assisted and transported back to his unit ([redacted]) in a wheelchair. At 11:00 PM, the LPN/SS moved Resident #3 to the [redacted] floor in the same room	H3450		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 11/04/2022

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H3450	Continued From page 4 with Resident #2 for . At 3:45 AM, Resident #3 was and when the , (level for a healthy person range between 95% and 100%). While the LPN/SS was conducting her assessment, Resident #3 started making '", which prompted the LPN/SS to call . The Resident then stopped LPN/SS initiated) until the . Resident #3 was . There was no documentation in the PN where Resident #3's was , but during interview with the Licensed Nursing Home Administrator (LNHA) on 11/4/22 at 11:35 AM, he confirmed that the was picked up by the and had not received any report at the time of survey. On 11/4/22 at 11:35 AM, the surveyor interviewed the LNHA who stated that the LPN/SS called him on 10/19/22 and reported that both Residents (Resident #2 and #3) . He instructed the LNP/SS to move both residents in the same room to the floor for He was later made aware that Resident #3 had and Resident #2 was to the hospital. The surveyor asked the LNHA if he notified the NJDOH about Resident #3's on and incidents of on and for both residents. The LNHA stated that he did not report the incidents to the NJDOH but completed an investigation. He further stated that he was unsure if the incidents were reportable. The LNHA could not provide a policy for other	H3450		

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H3450	Continued From page 5 reportable incidents to the surveyor.	H3450		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315305 (Y1)	A. Building B. Wing (Y2)	1/3/2023 (Y3)

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 12/23/2022	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 12/23/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
11/4/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO