STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315005	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Grove Rehabilitation and Healthcare Center	144 Gales Drive New Providence, NJ 07974

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint: 2613838 Based on interviews, record reviews, and review of facility documentation it was determined that the facility failed to a.) keep resident medical information confidential and b.) follow their Resident Rights policy. The deficient practice was identified for one of 3 residents reviewed for medical records (Resident #4). This deficient practice was evidenced by the following:According to the, admission Record, Resident #4 was admitted to the facility with diagnoses including but not limited to: muscle wasting and atrophy (loss of muscle mass and strength); type 2 diabetes (chronic condition where the body cannot keep blood sugar at a normal level); need for assistance with personal care; and chronic lymphocytic leukemia (cancer of the blood and bone marrow). Review of the Minimum Data Set (MDS), an assessment tool, revealed that Resident #4 had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. The progress notes (PN) for Resident #4 were reviewed. A PN written by the Social Worker (SW #1) on 02/03/2025 at 11:55 AM, revealed that an interdisciplinary team (IDT) meeting was conducted to update the resident's family member on Resident #4's progress. The PN further revealed that Resident #4 wanted the call to be cut short because Resident #4 no longer wanted their family member to participate. The PN revealed that the Unit Manager (UM #1) discussed medications and overall health, and SW #1 discussed the discharge plan. SW #1 was no longer employed at the facility and was not available for an interview. The surveyor attempted to reach UM #1 for a telephone interview but was not successful. A statement signed by SW #1 and dated 02/04/2025, was reviewed. The statement revealed that on 02/03/2025 SW #1 and UM #1 called Resident #4's family member in preparation for an IDT meeting. The statement revealed that UM #1 began reading Resident #4's medication information when Resident #4's family member stated that the resident who was present did not sound like their family member. It was at that time that UM #1 stopped reading Resident #4's medication information, checked the resident who was present's identification (ID) band, and determined that it was not Resident #4. The statement revealed that SW #1 then stopped the meeting and located Resident #4 in the rehabilitation department. SWW #1 later informed Resident #4 of what occurred during the earlier IDT meeting and apologized. A statement signed by UM #1 and dated 02/04/20025 was reviewed. The statement revealed that on 02/03/2025 a meeting was held to provide Resident #4's family with a progress update. The statement revealed that UM #1 began to read Resident #4's medication information at the beginning of the meeting. At the beginning of the meeting Resident #4's facility member, who attended by phone stated that the voice of the resident who was also attending the meeting did not sound like Resident #4. The statement further revealed that the meeting was stopped and the ID band of the resident in attendance was checked, and it was identified that the resident at the meeting was Resident #3, not Resident #4. A letter written by the Licensed Nursing Home Administrator (LNHA) to Resident #4 was reviewed. The letter revealed, .it is important to us that you are made fully aware of a potential privacy issue. We have learned that your personal information may have been compromised. [.] it was discovered that our Social Worker was holding a care conference on 2/3/2025 along with the Unit Manager with the incorrect resident in the room. The Social worker along with the Unit manager contacted your [family member] to review your medications when your [family member] stated that the resident in attendance didn't sound like [their family member] . An interview was conducted with the LNHA on 09/26/2025 at 2:20 PM. The LNHA stated that the expectation was for staff to verify the identity of a resident before medical information was discussed. The LNHA stated that this was important to ensure that accurate information was given and for the Health Insurance Portability and Accountability Act (federal standards protecting sensitive health information from disclosure without patient's consent). The LNHA stated that resident identification could have been done by verifying the name with the resident and by checking the resident's ID band. The LNHA confirmed that on 02/03/2025, Resident #4's family member was called to participate in a care conference, but it was Resident #4's roommate (Resident #3) who was present when the conference started. The LNHA stated that UM #1 began reading Resident #4's medications when Resident #4's family member recognized that the resident present did not sound like their family member. During ta follow up interview on 09/26/2025 at 5:00 PM, the LNHA stated that maintaining resident privacy and confidentiality was important to maintain resident rights. The LNHA further stated that reading Resident #4's medications with Resident #3 present did not maintain Resident #4's privacy and confidentiality. The facility policy, Resident Rights, with a revised date of February 2021, was reviewed. Under, Policy Interpretation and Implementation, the policy revealed, 1. Federal and state laws guarantee certain rights to