STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Census: 52 Sample Size: 5 TYPE OF SURVEY: Standard Survey of 44 residential units The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.	A 891		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of manufacturer's specifications, it was determined that the facility failed to ensure that meals served to residents were prepared and served in a sanitary condition for 1 of 1 kitchen staff observed in order to prevent food borne illness. The facility failed to ensure the high-temp dishwasher did not record a temperature lower than the manufacturer's recommended wash and rinse cycled temperatures for 1 of 1 dishwashers. Findings included: 1, On 07/13/2021 at 9:27 AM, Dietary Aide (DA) #10 operated the high-temp dishwasher on five continuous cycles. The temperature gauges on the machine failed to rise to the manufacturer's recommended range. The manufacturer's specifications for wash and rinse temperatures reported 160 and 180 degree Fahrenheit (F) respectively. However, the dishwasher recorded temperatures of 158 and 120 degrees F respectively for the wash and rinse temperatures after five continuous cycles. On 07/13/2021 at 2:09 PM, Cook #9 and the Certified Assisted Living Administrator (CALA) were interviewed. Cook #9 acknowledged the kitchen had cooked and served meals with utensils and dishes which came out of the dishwasher. He said that by failing to rise to the manufacturer's recommended wash and rinse temperatures, the dishwasher's current operating condition failed to ensure that food preparation and serving utensils were properly sanitized, and thus failed to ensure residents' meals were prepared under sanitary conditions. This was a high temperature dish machine and did not have	A 891		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 891	Continued From page 2 a chemical sanitzer for back up. The CALA added that the kitchen was central to the facility. She said when food from the kitchen was not prepared under sanitary conditions, it had the potential to result in food-borne illness which affected the entire population of the residents, as they all ate meals which came from the kitchen. The CALA said she would follow through with ensuring adequate training with the dietary staff and ask the maintenance crew to investigate the drop in the wash and rinse temperatures of the dishwasher and offer a solution.	A 891		
A 901	8:36-10.5(c)(4) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes, shall be kept on file in the facility for at least 30 days; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, it was determined that the facility failed to ensure that the posted meal menus and the menus available to the residents identified the portion sizes. This had the potential to affect all	A 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 3 residents. Findings included: 1. On 07/12/2021 through 07/14/2021, a review of the facility's meal menus posted across the facility and the menus available to the residents revealed that the facility failed to identify the portion sizes of each food item on the menu. On 07/14/2021 at 11:00 AM, the Food Services Director (FSD) said his duties included overseeing the kitchen, making schedules, ordering inventory, and creating meal plans. The FSD stated he developed all meal plans and substitutions in house. He stated a dietician reviewed and signed off on all meal plans. He stated staff were to use spoodles and ladles for portioning out food when plating meals. He added that the facility used 4 oz. of animal/fish protein as a standard portion, unless a different portion size was indicated in the diet folder. The FSD stated he was unaware that menus posted in the kitchen or given to residents should identify the portion sizes of the food contained in the meals.	A 901		
A1041	8:36-14.3(a) Emergency Services and Procedures (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for	A1041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1041	Continued From page 4 emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, it was determined that the facility failed to: - Perform the required monthly fire drills; and - Ensure staff recognized and responded to appropriately to a false smoke detection alarm. The foregoing failures could lead to delayed response/evacuation time and had the potential to affect all residents. Findings included: 1. On 07/12/2021 at approximately 1:38 PM, the Maintenance Director (MD) told the surveyor that the smoke detector alarms were set to blink a red light. He said that when the smoke detector indicated a solid red light, it was a sign that staff needed to check into the affected resident's room and plan an evacuation. The MD said that when staff approached a room which had a solid red light, they needed to feel the doorknob with the back of their hand for temperature suggestive of ongoing fire/smoke in the room. He said if it was hot, staff did not go into the room but waited for the fire department to come. The MD's attention was called to a solid red light on a smoke detector located in front of Room [redacted]. He went into the room and acknowledged there was no smoke from the room. He said it was a false alarm. The MD acknowledged none of the staff	A1041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1041	Continued From page 5 had brought this false alarm to his attention. He was unable to establish a timeline as to when the false alarm had begun. On 07/12/2021 at 3:33 PM, Housekeeper (HSK) #12 told the surveyor that she had no understanding of what she needed to do when she saw a solid red-light indicator on the smoke indicator. On 07/13/2021 at 10:03 AM, Certified Medication Aide (CMA) #13 told the surveyor that she could not tell when the solid red light in Room [redacted] came on. She said she had no understanding of what she needed to do when she saw a solid red-light indicator on the smoke indicator. 2. A review of the record of fire drills conducted since the last standard survey at the facility revealed the facility conducted a fire drill on all shifts on 08/27/2020, 10/22/2020, and 06/16/2021. There was documentation of fire drills on a single shift on 11/10/2020, 03/18/2021, and 04/19/2021. There were no documented fire drills for September and December 2020. There were no documented fire drills for January 2021, February 2021, and May of 2021. On 07/12/2021 at 8:22 AM, the MD said fire drills were not done because the facility was overwhelmed with COVID-19. On 07/13/2021 at 12:03 PM, the Administrator said the facility had an evacuation drill scheduled but because of the COVID-19 pandemic, the drill had not taken place.	A1041		
A1047	8:36-14.3(d) Emergency Services and Procedures	A1047		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1047	Continued From page 6 (d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements and N.J.A.C. 5:70. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to visually examine fire extinguishers monthly and record the examination on the tags attached to the fire extinguishers for 6 of 6 extinguishers on halls A, B, C, D, E, and F. This had the potential to affect 52 residents. Findings included: During an observation on 07/12/2021 at 11:35 AM, the fire extinguisher on hall A did not have a record of the monthly examination attached to the fire extinguisher. During an observation on 07/12/2021 at 11:50 AM, the fire extinguisher on hall B did not have a record of the monthly examination attached to the fire extinguisher. During an observation on 07/12/2021 at 12:05 PM, the fire extinguisher on hall C did not have a record of the monthly examination attached to the fire extinguisher.	A1047		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1047	Continued From page 7 During an observation on 07/12/2021 at 2:00 PM, the fire extinguisher on hall F did not have a record of the monthly examination attached to the fire extinguisher. During an observation on 07/12/2021 at 2:04 PM, the fire extinguisher on hall E did not have a record of the monthly examination attached to the fire extinguisher. During an observation on 07/12/2021 at 2:11 PM, the fire extinguisher on hall D did not have a record of monthly examination attached to the fire extinguisher. On 07/12/2021 at 1:27 PM, the MD told the surveyor that the facility had not been doing monthly inspections of the fire extinguishers. On 07/13/2021 at 2:18 PM, the Administrator told the surveyor that the fire extinguishers should be on a schedule to be inspected monthly.	A1047		
A1189	8:36-17.3(a)(2) Housekeeping-Sanitation-Safety-Maintenance (a) The housekeeping and sanitation conditions in paragraphs 1 through 12 below shall be met. Application of this requirement with respect to the individual living environment shall take into consideration residents' personal preferences for style of living: 2. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors;	A1189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1189	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure that all resident rooms and living areas were properly ventilated. This had the potential to effect 52 residents. Findings included: 1. On 07/12/2021 at 1:22 PM, the ventilation system in the bathroom of Resident Room A6 was observed not working. The Maintenance Director (MD) told the surveyor that the ventilation system, "did not appear to be working." He left the room to check the breaker and returned stating that the breaker was not the problem. The MD stated the ventilation system in the hallway of wing A was not working either. On 07/12/2021 at 1:44 PM, the ventilation system in the bathroom of Resident Room C4 was observed not working. The MD acknowledged the problem and stated the ventilation system in hallway C "was not pulling" either. The MD stated the ventilation system needed to be fixed. On 07/13/2021 at 12:03 PM, the Executive Director was made aware of the ventilation system findings.	A1189		
A1225	8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and	A1225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1225	Continued From page 9 provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition; i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, it was determined the facility failed to ensure an annual inspection by a licensed electrician was conducted. This had the potential to affect 52 residents. Findings included: 1. On 07/13/2021 at 3:25 PM, the "Affidavit of Compliance" form was reviewed with the Maintenance Director (MD) who had completed the form. The Surveyor asked the MD why there was no date entered on the line provided for "Electrical Inspection." The MD stated there had been no annual electrical inspections conducted since he had been at the facility.	A1225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1225	Continued From page 10 On 07/14/2021 at 8:15 AM, the Executive Director was informed of the situation. By the end of the survey, no supporting documentation of an electrical inspection for the last year had been provided to the survey team.	A1225		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure the building was kept free of fire hazards. This was evidenced by exit and fire doors failing to self-close and latch within its frame allowing for the passage of smoke. This had the potential to affect 52 residents. Findings included: 1. On 07/12/2021 at 1:35 PM, the surveyor observed that the self-closing fire door of the laundry room on hall A did not completely close when exiting the room. The Maintenance Director	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1249	Continued From page 11 acknowledged the concern and stated the door would be fixed. 2. On 07/12/2021 at 2:04 PM, the surveyor observed that the self-closing fire door did not completely self-close when exiting the spa room near Resident Room E3. The Maintenance Director acknowledged the concern and stated the door would be fixed. 3. On 07/13/2021 at 3:00 PM, the surveyor observed that the exit door across from Resident Room [redacted] did not completely self-close. The Maintenance Director acknowledged the concern and stated the door would be fixed. On 07/14/2021 at 12:03 PM, the Executive Director was made aware of the three fire doors that did not self-close and latch securely in its frame.	A1249		
A1275	8:36-18.2(a)(1) Infection Prevention and Control Services (a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications and OSHA standards, incorporated herein by reference, as amended and supplemented: 1. Guidelines for Hand Hygiene in Health Care Settings, MMWR/51 (RR-16), October 25, 2002;	A1275		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1275	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of Centers for Disease Control (CDC) guidelines, it was determined that dietary staff failed ensure Cook #9 (sole cook in the [redacted]) performed appropriate hand hygiene in between tasks so meals served to residents were prepared and served in a sanitary condition. Reference: The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance, retrieved from: https://www.cdc.gov/handhygiene/providers/guideline.html (updated 01/30/2020, retrieved on 07/15/2021), reads in part, "Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores." On 07/13/2021 8:35 AM, an observation was conducted in the facility's kitchen during the morning meal service. Cook #9 intermittently adjusted his face mask and wiped sweat off his forehead while wearing gloves. Cook #9 repeatedly left the food preparation area and	A1275		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01a003	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1275	Continued From page 13 threw plastic bags and containers which held food material into the trash. While still wearing the same pair of gloves, Cook #9 returned to the food preparation area and continued to prepare the morning meal. The observation revealed Cook #9 reached into the oven and brought out two trays which contained strips of bacon. Cook #9 collected the strips of bacon onto a flat plate with tongs. Cook #9 commenced serving the meal and in the process, Cook #9 reached into the plate which had the strips of bacon, picked up two strips of bacon with his/her gloved hands and put them on a plate which was to be served to the residents. The surveyor interrupted the meal service and reminded Cook #9 that he had contacted different surfaces as described above without changing his gloves or attempting hand hygiene. Cook #9 stated he had been trained on hand hygiene and phases of food preparation which required glove changes. He said he did not change out his gloves or perform hand hygiene as described above because it was difficult to put a fresh glove back on after his hands were wet from performing hand hygiene.	A1275		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
01a003 Y1	A. Building B. Wing Y2	8/25/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HOME AT GALLOWAY	42 WEST JIMMIE LEEDS GALLOWAY TOWNSHIP, NJ 08205

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 A0891	Correction	ID Prefix A0901	Correction	ID Prefix A1041	Correction
Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-10.5(c)(4)	Completed	Reg. # 8:36-14.3(a)	Completed
LSC	07/20/2021	LSC	07/19/2021	LSC	07/20/2021
ID Prefix A1047	Correction	ID Prefix A1189	Correction	ID Prefix A1225	Correction
Reg. # 8:36-14.3(d)	Completed	Reg. # 8:36-17.3(a)(2)	Completed	Reg. # 8:36-17.3(b)(8)(i-ii)	Completed
LSC	07/14/2021	LSC	08/06/2021	LSC	09/03/2021
ID Prefix A1249	Correction	ID Prefix A1275	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. # 8:36-18.2(a)(1)	Completed	Reg. #	Completed
LSC	08/14/2021	LSC	07/19/2021	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	
7/14/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

springhome
AT GALLOWAY

Statement of Deficiencies and Plan of Correction

42 West Jimmie Leeds Road

Galloway, NJ 08205

ID PREFIX TAG A0891: Dining Services

All residents had the potential of being affected by the deficient practice from food borne illness. On 7/20/21 the temperature gauge was replaced. The Dining Service Director will conduct weekly temperature checks and sign off.

ID PREFIX TAG A901: Dining Services

All residents had the potential of being affected as they could have been served the improper serving size. On 7/19/2021 the Dining Service Director changed all menus to include serving portions. The Executive Director will check menus weekly to ensure all portions sizes continue to be noted on every menu.

ID PREFIX A1041: Emergency Service and Procedure

All residents could have been affected by the deficient practice in the event of a true emergency due to the lack of staff training. The Maintenance Director held a fire drill on 7/20/21 and will continue to hold monthly drills for all shifts as mandated by the state regulations.

ID PREFIX TAG A1047: Emergency Services and Procedures

All residents had the potential of being affected by the deficient practice. The fire extinguishers could have malfunctioned. The Maintenance Director inspected all the fire extinguisher on 7/14/2021. He will continue to inspect monthly.

ID PREFIX TAG A1189: Housekeeping-Sanitation-Safety-Maintenance

All residents had the potential to have been affected by the deficient practice. The repairs were completed on 8/6/2021.

ID PREFIX TAG A1225: Housekeeping-Sanitation-Maintenance

All residents had the potential to have been affected by the deficient practice. The electrical inspection began on 8/19/2021 and will be completed on 9/3/2021.

ID PREFIX TAG A1249: Housekeeping-Sanitation-Safety-Maintenance

All residents had the potential to be affected by the deficient practice. The Maintenance Director fixed all three self-closing doors on 8/14/2021. He also inspected all other self-closing doors in the community to ensure they were all in proper working conditions.

ID PREFIX TAG A1275: Infection Prevention and Control Services

All residents had the potential to have been affected by the deficient practice. The Dining Service Director, the Administrator on Duty and the Executive Director will monitor by walking through and spending time in the kitchen throughout the day every day.

springhome
AT GALLOWAY

Statement of Deficiencies and Plan of Correction

46 West Jimmie Leeds Road

Galloway, NJ 08205

ID PREFIX TAG A0269: Administration

The Executive Director will request a waiver from the licensing board. Christy A Musey (Registration No. AL200012708 Expiration date 1/13/2023) will spend 20 hours weekly in the Memory Care community until the waiver has been approved and processed. Leslie Carter will become the Memory Care 7

ID PREFIX TAG A0891: Dining Services (Nesting of wet glasses)

All residents had the potential to be affected by the deficient practice. On 7/15/2021 crates were supplied for the air drying of all glasses. The Dining Service Director in-serviced the dishwashers and other kitchen staff on air drying glasses. He and the Administrator on Duty will monitor through the day every day.

ID PREFIX TAG A901: Dining Services (Portion sizes)

All residents had the potential of being affected as they could have been served the improper serving size. On 7/19/2021 the Dining Service Director changed all menus to include serving portions. The Executive Director will check menus weekly to ensure all portions sizes continue to be noted on every menu.

ID PREFIX A963: Pharmaceutical Services (Documentation)

All residents had the potential to have been affected by the deficient practice. On 7/19/21 the Certified Medication Aids and nurses were in-serviced on the documenting properly. All were able to demonstrate the proper way to sign out medications, refusals and out of the community. The CMA's will check and document immediately after each medication administration. Nursing will check Chart Meds and sign off daily, the DON will check and sign off weekly. Pharma Care will review quarterly.

ID PREFIX TAG A1041: Emergency Services and Procedures (non-fire drills)

All residents had the potential of being affected by the deficient practice. In the event of a true emergency the residents and staff would not have the training required. On Tuesday 8/31/21 the community will have a non-fire drill for staff and residents. The maintenance Director will have a yearly non-fire drill for all staff and residents. The Executive Director will participate in these drills and sign off.

ID PREFIX TAG A1043: Emergency Services and Procedures (Joint fire drill with Fire Department)

All residents had the potential of being affected by the deficient practice. On 7/19/21 the Maintenance Director sent an email to Chief Uhl of the Galloway Township Fire Department requesting assistance in a joint fire drill. Yearly in July the Maintenance Director will request in writing a joint fire drill from the Galloway Township Fire Department. The Executive Director will follow up on the request participate in this drill and sign off.

ID PREFIX TAG A1047: Emergency Services and Procedures (Fire extinguishers)

All residents had the potential of being affected by the deficient practice. In the event of a true emergency the fire extinguisher could have malfunctioned. On 7/14/21 the Maintenance Director checked and signed off on all fire extinguishers. He will continue to check and sign off monthly.

ID Prefix TAG A1179: Housekeeping-Sanitation-Safety-Maintenance (Doors to electrical equipment/high voltage)

All residents had the potential of being affected by the deficient practice. On 7/12/21 the Maintenance Director after meeting with the surveyor the placed locks on all doors containing electrical and heating equipment.

ID PREFIX TAG A1201: Housekeeping-Sanitation-Safety-Maintenance (Articles of Storage)

On 7/12 after meeting with the surveyor, the Maintenance Director removed all storage away from the ceiling and elevated from the floor.

ID PREFIX TAG A1217: Housekeeping-Sanitation-Maintenance (Labeling and storage of cleaning products)

All residents had the potential of being affected by the deficient practice. On 7/12/21 after meeting with the surveyor, the maintenance Director labeled the spray bottle. All other spray bottles and cleaning containers were checked for the appropriate labels and the closet storing cleaning supplies was locked.

ID PREFIX TAG A1225: Housekeeping-Sanitation-Safety-Maintenance (Electrical Inspection)

All residents had the potential of being affected by the deficient practice. The electrician has been contracted and the inspection will be completed on 9/3/21.