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 |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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<br><br>Initial Comments:<br>Census 74<br><br>Sample size: 5<br><br>Type of Survey: Standard survey of 60 residential units<br><br>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 Residents, Comprehensive Personal Care Homes and Assisted Living Programs.<br><br>The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is impleted. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter43E, Enforcement of Licensure Regulations. | A 000 | | |
| A 269 | 8:36-3.1(a) Administration<br><br>(a) An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds, and on a half-time basis in facilities that have fewer than 60 licensed beds, in accordance with the definition of "full-time" and "half-time" at N.J.A.C. 8:36-1.3. | A 269 | | |

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 |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 269 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of facility documentation, it was determined that the person identified as the facility Administrator of this 78 bed assisted living residential facility (ALR) was also identified as fulfilling other positions within the facility in violation of N.J.A.C. 8:36-3.1(a) which requires:<br>"The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds."<br>The findings are as follows:<br><br>Form AAS 82, "Facility Staff and Basic Information" identified the same person as both the Administrator and the Director of Nursing. In the space at the bottom of AAS 82, the person identified as the Administrator of the sister memory care facility was also identified as the Executive Director and Activity Director of this ALR building. Because this is a 78 bed facility, a full time Administrator is required.<br><br>The "Staff ID List" identified the Administrator of the sister memory care facility as the Activities Director and Executive Director of the this ALR facility. The Administrator can not also be the Director of Nurses (DON) in this facility nor can the Administrator serve in this position in another facility.<br><br>On 07/26/2021 at 12 :50 PM, the surveyor interviewed an RN.who was identified as the Director of Nursing for the sister memory care building. She told the surveyor that the same person was the Executive Director for the | A 269 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING HOME AT GALLOWAY | 46 WEST JIMMIE LEEDS ROAD 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 269 | Continued From page 2<br>memory care building and this building and that her CALA (Certified Assisted Living Administrator) certificate was "used" for the memory care building. She further explained that the Director of Nurses for this ALR facility had a CALA certificate which was being "used" in this building where this person also served as the DON.<br><br>This 78 bed facility is required to have a full time Administrator whose sole responsibility is to serve as Administrator of this building. | A 269 | | |
| A 891 | 8:36-10.5(a) Dining Services<br><br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and policy review, it was determined that the facility failed to comply with the provisions of New Jersey Administrative Code (N.J.A.C.) 8:24, Retail Food Establishments and Food and Beverages Vending Machines Chapter XII of the New Jersey Sanitary Code when:<br><br>1. The facility did not use pasteurized eggs | A 891 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ____ B. WING ____ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 3 | A 891 | | |

(eggs that have gone through a process to reduce the amount of bacteria in the egg) to prepare sunny side up eggs (undercooked eggs - eggs that have not been thoroughly cooked to a safe temperature) that were served to residents. This failure had the potential for the eggs to contain bacteria that could lead to food borne illness.

2. Frozen meat was thawed in a sink without water running over the meat. This failure had the potential for the meat to grow bacteria that could lead to food borne illness.

3. Drinking glasses used to serve beverages to residents were stored wet and stacked one glass on top of another. This failure had the potential to breed bacteria that could lead to food borne illness.

Findings included:

Reference: N.J.A.C. 8:24, Retail Food Establishments and Food and Beverages Vending Machines Chapter XII of the New Jersey Sanitary Code 8:24- 3.3 (e), indicated that unpasteurized eggs should not be used in dishes that are not cooked to safe cooking temperatures.

1. On 07/13/2021 at 8:20 AM in the kitchen, the surveyor observed the Dietary Staff (DS #1) cracking eggs into a frying pan, cooking the eggs sunny-side up, and plating the eggs for a server to take to a resident in the dining room, On 07/13/2021 at 9:50 AM, DS #1 told the surveyor that eggs were served sunny-side up to residents and confirmed that sunny-side up eggs were considered to be under-cooked eggs. On 07/14/2021 at 11:00 AM, the Food Services Director (FSD) told the surveyor that meals that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ____ B. WING ____ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 4 | A 891 | | |

include undercooked eggs should not be made with unpasteurized eggs. On 07/14/2021 at 12:15 PM, the Administrator (ADM) told the surveyor that the eggs used in the facility were unpasteurized and acknowledged that the facility was not following regulations.

Reference: N.J.A.C. 8:24, Retail Food Establishments and Food and Beverages Vending Machines Chapter XII of the New Jersey Sanitary Code, regulation 3.5 (c) indicated that frozen food should be thawed in a refrigerator or completely submerged under running water.

2. On 07/13/2021 at 8:20 AM, the surveyor wrapped meat was in a dry sink in the dishwashing section of the kitchen with no water running over the meat. On 07/13/2021 at 8:47 AM, the surveyor again observed wrapped meat in a dry sink in the dishwashing section of the kitchen with no water running over the meat.

On 07/13/2021 at 9:10 AM, the surveyor observed that the wrapped meat had been removed from the sink and placed on a food preparation counter. On 07/14/2021 at 11:00 AM, the Food Service Director (FSD) told the surveyor that the facility's process for thawing meat was to thaw frozen meat in the refrigerator or in a sink under running water. The FSD further stated that meat should not be out at room temperature for 20 minutes or longer without being under running water and acknowledged that the facility was not following the policy for thawing meat.

A review of the facility policy titled, "Food Storage," undated, indicated that frozen meat was to be thawed in a refrigerator or under cold running water.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 5<br>Reference: N.J.A.C. 8:24, Retail Food Establishments and Food and Beverages Vending Machines Chapter XII of the New Jersey Sanitary Code 8:24-4.11 (a) (1), indicated that after cleaning, equipment and utensils should be air dried and code 8:24- 4.11 (a) (2), indicated that these items should not be dried with a cloth.<br><br>3. During a concurrent observation and interview conducted in the serving area off the kitchen on 07/13/2021 at 9:18 AM with Dietary Staff (DS #3), the surveyor observed wet beverage glasses stacked upside down, one on top of another on a serving cart. DS #3 confirmed that the stacked glasses were wet and stated that the serving staff dried the glasses with a cloth prior to filling the glasses and serving beverages to the residents. On 07/14/2021 at 11:00 AM, the Food Service Director (FSD) told the surveyor that wet glasses should be air dried, not stacked while wet and acknowledged that the facility was not following policy.<br><br>A review of the facility policy titled "Dry Storage," undated, indicated that glasses should be stacked one layer high, and that dishware should be stored to promote air drying. | A 891 | | |
| A 901 | 8:36-10.5(c)(4) Dining Services<br><br>(c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following:<br><br>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 | A 901 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

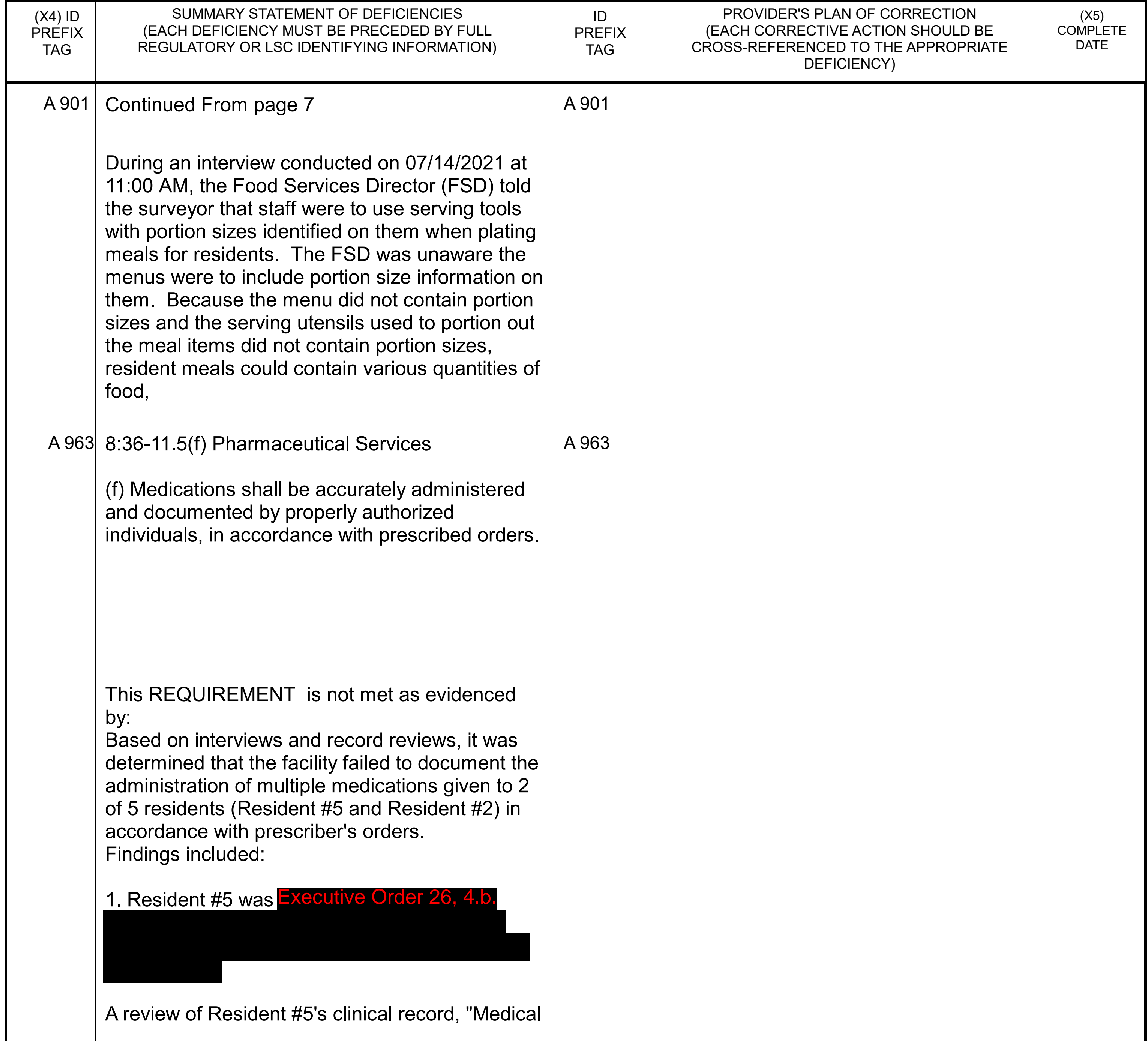
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING HOME AT GALLOWAY | 46 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205 |

| (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 6<br><br>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;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interviews, it was determined that the facility failed to include portion sizes on menus posted in the kitchen. This failure had the potential for residents to receive too little or too much food, impacting residents' nutrition and health. This had the potential to affect all residents.<br><br>Findings included:<br><br>During a concurrent observation and interview conducted in the facility kitchen on 07/13/2021 at 9:10 AM, Dietary Staff (DS #1) told the surveyor that there were no portion sizes listed on the menu plan. DS #1 further stated portion sizes were usually 6 ounces of meat and approximately 4 ounces of potatoes and vegetable. DS #1 stated he usually "eyeballs" the meat servings if they were not prepacked as individual servings. A book was observed that contained residents' names and the type of diet for each resident, but it did not include portion sizes. DS #1 confirmed the book did not contain portion sizes. On 07/13/2021 at 2:55 PM, DS #4 told they surveyor that the facility was serving Swedish meatballs for dinner that day and every resident would be served three meatballs. DS #4 stated the staff used one of the spoons for the pasta. There was no measurement scoop used for portioning out the meals. | A 901 | | |

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 |
|---|---|---|---|
| | 01a004 | A. BUILDING: ____ B. WING ____ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 7<br><br>During an interview conducted on 07/14/2021 at 11:00 AM, the Food Services Director (FSD) told the surveyor that staff were to use serving tools with portion sizes identified on them when plating meals for residents. The FSD was unaware the menus were to include portion size information on them. Because the menu did not contain portion sizes and the serving utensils used to portion out the meal items did not contain portion sizes, resident meals could contain various quantities of food, | A 901 | | |
| A 963 | 8:36-11.5(f) Pharmaceutical Services<br><br>(f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and record reviews, it was determined that the facility failed to document the administration of multiple medications given to 2 of 5 residents (Resident #5 and Resident #2) in accordance with prescriber's orders.<br>Findings included:<br><br>1. Resident #5 was Executive Order 26, 4.b.<br><br>A review of Resident #5's clinical record, "Medical | A 963 | | |

PRINTED: 09/30/2021
FORM APPROVED

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 |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 963 | Continued From page 8<br><br>Orders," indicated that Resident #5 was to receive Executive Order 26, 4.b.<br><br>A review of Resident #5's Executive Order 26, 4.b. Record Executive Order 2 dated Executive Order 26, 4 indicated that on Executive Order 26, 4.b., staff did not document if they had applied Resident 5's Executive Order 26, 4.b.<br><br>2. Resident #2 was Executive Order 26, 4.b.<br><br>A review of Resident #2's Executive Order record, "Executive Order 26 Orders," indicated that Resident #2 was to receive Executive Order 26, 4.b.<br><br>A review of Resident #2's Executive Order 26, 4.b. | A 963 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ____ B. WING ____ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 963 | Continued From page 9<br>Executive Order 26, 4.b. Record (MAR) dated Executive Order 26, indicated that on Executive Order 26, 4.b., staff failed to document the administration of Resident #2's Executive Order 26, 4.b.<br>A review of Resident #2's MAR dated Executive Order 26, indicated that on Executive Order 26, 4.b. staff failed to document the administration of Resident #2's Executive Order 26, 4.b.<br><br>During an interview conducted on 07/14/2021 at 8:53 AM, Licensed Practical Nurse (LPN #1) told the surveyor that staff were to document all medications administered and were to document whether medications were offered and refused by the residents in the residents' MARs. LPN #1 confirmed that on Executive Order 26, 4.b., staff did not document if they had applied Resident 5's Executive Order 26, 4.b. LPN #1 further confirmed that staff had not documented if they had administered Executive Order 26, 4.b. Executive Order 26, 4.b. to Resident #2 on Executive Order 26 and Executive Order.<br><br>The facility failed to provide a policy requiring the documentation of medication administration in the resident's medical records or on the Executive Order 26, 4.b. Executive Order 26, 4.b. Record Executive Order 26. | A 963 | | |
| A1041 | 8:36-14.3(a) Emergency Services and Procedures<br><br>(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 | A1041 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING HOME AT GALLOWAY | 46 WEST JIMMIE LEEDS ROAD 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 10<br>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 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and interviews, it was determined the facility failed to<br>conduct and/or provide the following services:<br><br>1. One emergency non-fire drill for all staff for the past 12 months<br>2. Monthly fire drills for the facility staff for the past 12 months<br>3. Four drills for every shift for the past 12 months<br>4. Conduct one non-fire drill emergency drill yearly.<br><br>This had the potential to affect all 74 residents who resided in the facility.<br><br>Findings included:<br><br>1. The in-service documentation contained no indication that one emergency, non-fire drill had been conducted during the past 12 months.<br><br>On 07/13/2021 at 11:20 AM, the Director of Maintenance (DM) stated that no additional emergency, non-fire drill in-service had been | A1041 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 11<br>provided to staff during the past 12 months.<br><br>2. The surveyor reviewed copies of facility in-service records for the past 12 months which revealed fire drill in-services had not been conducted in 09/2020, 12/2020, 01/2021, 02/2021, or 05/2021.<br><br>On 07/13/2021 at 10:59 AM, the surveyor provided the Director of Maintenance with copies of the fire drill in-services. The surveyor asked the DM if he had additional in-services for the missing months. The DM told the surveyor that no additional fire drill in-services had been provided to staff.<br><br>On 07/13/2021 at 11:10 AM, the Surveyor asked the DM if four fire drills had been provided to every shift for the past 12 months. The DM stated that four fire drill in-services had not been provided to each shift during the past 12 months.<br><br>3. The in-service documentation contained no indication each shift had been in-serviced four times in the past 12 months.<br><br>On 07/13/2021 at 11:10 AM, the Surveyor asked the Director of Maintenance if four fire drills had been provided to every shift for the past 12 months. The DM stated that four fire drill in-services had not been provided to each shift during the past 12 months.<br><br>4. The in-service records contained no indication an emergency (non-fire) drill had been conducted in the past 12 months.<br><br>On 07/13/2021 at 11:10 AM, the Surveyor asked the Director of Maintenance if an emergency drill, other than a fire drill, had been conducted in the | A1041 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 12<br>past 12 months. The DM stated no such emergency drill had been conducted. | A1041 | | |
| A1043 | 8:36-14.3(b) Emergency Services and Procedures<br><br>(b) The facility shall request of the local fire department that at least one joint fire drill be conducted annually. Upon scheduling a joint fire drill, the facility shall notify first aid and civil defense agencies of this drill and shall participate in community-wide disaster drills.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and interviews, it was determined the facility failed to inform and/or invite the local fire department to participate in at least one fire drill for the last 12 months. This had the potential to affect all 74 residents who resided in the facility.<br><br>Findings included:<br><br>The in-service records contained no indication that the fire department had been invited to attend and/or participate in at least one fire drill in the past 12 months.<br><br>On 07/13/2021 at 11:20 AM, the Director of Maintenance told the surveyor that the local fire department had not been invited and/or attended any of the fire drills. | A1043 | | |
| 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 |
|---|---|---|---|
| | 01a004 | A. BUILDING: ___ B. WING ___ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 13 | A1047 | | |

(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 interview, it was determined the facility failed to conduct and/or provide monthly fire extinguisher inspections for the past 12 months. This had the potential to affect all 74 residents who resided in the facility.

Findings included:

On 07/12/2021 at 2:25 PM, a tour of the interior of the building was conducted with the Director of Maintenance (DM). Fire extinguishers were examined and observed to be without the monthly certificate of inspection attached to any of the fire extinguishers.

On 07/12/2021 at 2:25 PM, the surveyor asked the DM if the fire extinguishers were inspected monthly. He stated that they were not. The surveyor added that the inspection tags attached to the fire extinguishers did not contain evidence of monthly inspections. The DM stated he did not know how many fire extinguishers were in the building, but none of them had been inspected monthly.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 |
|---|---|---|---|---|
| A1179 | 8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance<br><br>(a) The facility shall provide and maintain a sanitary and safe environment for residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, it was determined that the facility failed to maintain a safe environment for residents when the door of a room containing water heating equipment and the door of a room containing high voltage (electrical energy with the potential to cause serious injury) electrical equipment were unlocked and unattended. These failures had the potential for injury as residents were able to access the equipment in these rooms.<br><br>These failures had the potential to affect all residents.<br><br>Findings included:<br><br>During a concurrent observation and interview conducted on 07/12/2021 at 2:20 PM with the Maintenance Director (MD), the surveyor observed that the door to a room that contained the facility water heating equipment, and the door to a different room that contained high voltage electrical equipment were left unlocked, and unattended. No staff were working in or near either room at the time. The surveyor further identified that these rooms were located in a hallway accessible to residents. The MD confirmed the doors to both rooms were not locked and acknowledged the doors to both these rooms should be locked when the rooms were | A1179 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 |
|---|---|---|---|---|
| A1179 | Continued From page 15<br>not in use by staff. | A1179 | | |
| A1201 | 8:36-17.3(a)(8) Housekeeping-Sanitation-Safety-Maintenance<br><br>(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:<br><br>8. Articles in storage shall be elevated from the floor and away from walls (if moisture is present), ceilings, and air vents;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined that the facility failed to elevate storage boxes off the floor in 2 of 2 first floor record storage closets (closet used to store resident charts). This failure had the potential for the boxes to become wet and to provide a place for the development of mold or mildew.<br><br>Findings included:<br><br>1. Based on a concurrent observation and interview conducted on 07/12/2021 at 2:20 PM with the Maintenance Director (DM), several storage boxes were observed on the floor in a first-floor record storage closet and five storage boxes were observed on the floor in the other first floor record storage closet. The DM confirmed that the storage boxes were on the floor and | A1201 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 |
|---|---|---|---|---|
| A1201 | Continued From page 16<br>acknowledged that the boxes should not be stored on the floor. | A1201 | | |
| A1217 | 8:36-17.3(b)(4) Housekeeping-Sanitation-Safety-Maintenance<br><br>(b) The following safety conditions shall be met:<br><br>4. All household and cleaning products used by facility staff shall be identified, labeled, and secured. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room. The telephone number of the poison control center shall be conspicuously posted in the facility;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined that the facility failed to:<br>1. label and secure a spray bottle of disinfectant in the first-floor hallway leading to the outside of residents' rooms.<br>2. The door to a closet used to store housekeeping supplies was not locked. This failure had the potential for injury to residents as access to chemicals used for cleaning were left accessible to residents.<br><br>This failure had the potential for residents to be exposed to potentially hazardous chemicals. This deficient practice had the potential to affect all residents.<br><br>Findings included: | A1217 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ______ B. WING ______ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 |
|---|---|---|---|---|
| A1217 | Continued From page 17<br><br>1. During a concurrent observation and interview conducted on 07/12/2021 at 2:20 PM with the Maintenance Director (MD), an unlabeled spray bottle was observed on a desk area in a first-floor hallway leading to residents' rooms. Further observation indicated "COVID-19 Disinfectant" was written on the spray bottle but no other information or label was affixed the bottle. The MD confirmed the spray bottle was unlabeled and acknowledged the bottle should be labeled and stored in a secured place.<br><br>2. During a concurrent observation and interview conducted on 07/12/2021 at 2:20 PM with the MD, the surveyor observed that the door of a room on hallway B that contained cleaning solutions was unlocked and unattended. No staff were working in or near the room. The MD confirmed the room contained potential toxic cleaning materials and acknowledged the door to the room should have been locked to prevent resident access to these hazardous chemicals. | A1217 | | |
| A1225 | 8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance<br><br>(b) The following safety conditions shall be met:<br><br>8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition;<br><br>i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent | A1225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01a004 | A. BUILDING: ____ B. WING ____ | 07/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SPRING HOME AT GALLOWAY** | **46 WEST JIMMIE LEEDS ROAD 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 18<br>fixtures are in safe condition, and that all portable electrical appliances,<br>including lamps, are Underwriters Laboratories (U.L.) approved; and<br><br>ii. The written statement shall be available for review by the Department<br>during survey.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on an interview and document review, it was determined that the facility failed to ensure that a licensed electrician conducted an annual inspection of the facility to ensure the wiring in the facility remained in safe condition. This had the potential to affect all residents.<br><br>Findings included:<br><br>1. During a concurrent interview and document review conducted on 07/13/2021 at 3:26 PM, the Maintenance Director (DM) told the surveyor the facility did not have an annual electrical inspection. The DM further stated he thought the last electrical inspection was completed approximately 6 years ago. The DM was unable to produce documentation that annual electrician inspections had been conducted in accordance with state regulation. | A1225 | | |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION A. Building B. Wing (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 01a004 | | 8/25/2021 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING HOME AT GALLOWAY | 46 WEST JIMMIE LEEDS ROAD<br>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 A0269<br>Reg. # 8:36-3.1(a)<br>LSC | Correction Completed 08/24/2021 | ID Prefix A0891<br>Reg. # 8:36-10.5(a)<br>LSC | Correction Completed 07/15/2021 | ID Prefix A0901<br>Reg. # 8:36-10.5(c)(4)<br>LSC | Correction Completed 07/19/2021 |
| ID Prefix A0963<br>Reg. # 8:36-11.5(f)<br>LSC | Correction Completed 07/19/2021 | ID Prefix A1041<br>Reg. # 8:36-14.3(a)<br>LSC | Correction Completed 08/31/2021 | ID Prefix A1043<br>Reg. # 8:36-14.3(b)<br>LSC | Correction Completed 08/19/2021 |
| ID Prefix A1047<br>Reg. # 8:36-14.3(d)<br>LSC | Correction Completed 07/12/2021 | ID Prefix A1179<br>Reg. # 8:36-17.1(a)<br>LSC | Correction Completed 07/12/2021 | ID Prefix A1201<br>Reg. # 8:36-17.3(a)(8)<br>LSC | Correction Completed 07/12/2021 |
| ID Prefix A1217<br>Reg. # 8:36-17.3(b)(4)<br>LSC | Correction Completed 07/12/2021 | ID Prefix A1225<br>Reg. # 8:36-17.3(b)(8)(i-ii)<br>LSC | Correction Completed 09/03/2021 | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>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 | |
|---|---|
| 7/14/2021 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |

 EVENT ID: JWE112

# 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.