STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING ______ B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD CLARKSBORO, NJ 08020**

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F 000	INITIAL COMMENTS Survey Date: 04/18/24 Census: 35 Sample: 17 + 0 = 17 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		5/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/09/2024

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 609	Continued From page 1 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) and the State Ombudsman, an unwitnessed NJ Exec which resulted in NJ Exec Order 26.4b1 This deficient practice was identified for 1 of 3 residents (Resident #22) reviewed for accidents and was evidenced by the following: A review of the facility provided policy and procedure, "Incident and Accident Report/Falls" reviewed 03/2024, which included but was not limited to; "to accurately record any incident or accident when it occurs in accordance with legal liabilities and state and federal regulations." Procedure 1. Incidents or accidents include but are not limited to ... any happening or experience which may be traumatic or inflict bodily injury ... witnessed or un-witnessed. 4. Incidents and Accidents are ... investigated to see if it is a reportable event. 12. Accidents or incidents that endanger the mental or physical health or safety of the resident in cases of abuse must be reported to ... the Ombudsman Office and the NJDOH. Points of Emphasis 1. "cases of abuse must be reported to the NJ State Ombudsman's Office and NJDOH ..." On 04/01/24 at 10:14 AM, the surveyor observed Resident #22 in his/her bed and observed there was a NJ Exec Order 26.4b1 .	F 609	(1) Resident #22 was affected by the deficient practice. Administration has revised the policy and procedure on Accidents & Incidents to give more detailed investigation that includes all staff involved statements, resident statement, RN on duty statement. RN will write a conclusion summary stating what the investigation brought forth. The team going over the Accident and Incident and determining whether or not this is a reportable event and reporting to NJDOH, LTCO and the local (East Greenwich) police department. (2) All residents have the potential to be affected by the deficient practice. (3) Revised policy for Accidents and Incidents. A detailed investigation which includes all staff involved statements with resident's statement as well as the RN on duty writing a conclusion summary stating what the investigation brought forth. Report to NJDOH, LTCO, Local Police Department. The Director of Nursing will review all accident and incidents reports for completeness and review with IDT team weekly at Utilization Review. Intervention to prevent reoccurrence, care plans before and after event and orders obtained during event. Completed in servicing of staff on all updates to	

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F 609	Continued From page 2 A review of the facility provided, NJ Exec Order 26.4b" report regarding Resident #22's incident dated NJ Exec Order 26.4b1 included but was not limited to; Severity: NJ Exec Order 26. Type: NJ Exec Order 26.4b1. NJ Exec Order 26.4b Reason: Not following Care Plan. Contributing Factors: resident sat [her/himself] on the side of the bed when CNA (Certified Nursing Assistant) went to get [name redacted] mechanical lift. When CNA returned, resident was NJ Exec Order 26.4b1 Resident stated [he/she] NJ Exec Order 26.4b1 On 04/02/24 at 11:42 AM, in the presence of two surveyors, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were interviewed. The DON was asked what would a reportable event be considered. The DON gave an example that if staff used a [name redacted] mechanical lift without two staff members, and there was a NJ Exec Order 26.4b1, it would be a reportable because the staff failed to follow the policy. The LNHA stated that the facility would do an investigation and "if we determine what happened, that would not be reported". The DON further stated that if staff left a resident room and returned to find the resident NJ Exec Order 26.4b1, that would be considered an "NJ Exec Order 26.4b1 The LNHA and DON both confirmed that the NJ Exec Order 26.4b1 which resulted in NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b for Resident #22, was not reported to the NJDOH or Ombudsman. When asked if the facility had a policy specific for the staff to follow regarding reportable events, the LNHA stated "no" and that the only area regarding reporting an event was in the policy and procedure for Incident and Accident Report/Falls that had been provided.	F 609	changes in policy and procedure including when and how to report and completion of report (attached). When reporting "soft" file will be kept for NJDOH and LTCO investigation. All accident and incidents with paperwork will be kept in binder in Director of Nursing's office. (4) During quarterly QAPI meetings, team will review and go over all accident and incident reports with Medical Director and team. Ensuring compliance with policy and procedure.	

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F 609	Continued From page 3 NJAC 8:39-9.4(e), 27.1(a)	F 609		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to ensure medications were dated upon opening and all medications were secured inside the medication cart. This deficient practice was identified in 1 of 2 medication carts	F 761	(1) Resident #26 was not affected by the deficient practice. District Nurse was educated immediately on the policy and procedure of Medication Pass which includes proper placement of narcotics and [NJ Ex.Order 26.] must be dated when opened.	5/9/24

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F 761	Continued From page 4 observed and was evidenced by the following: 1. On 04/03/24 at 7:35 am, the surveyor observed the Licensed Practical Nurse (LPN) in an adjacent hallway. The surveyor approached the LPN and informed her that she would be observed for medication administration. The LPN had a Bingo card of medication in their hands. The LPN placed the Bingo card on top of the medication cart and wheeled the medication cart to the next hallway. On 04/03/24 at 7:57 AM, the LPN entered Resident #29's room and left the Bingo card on top of the medication cart. The LPN informed the resident that she would be coming with their medications. The LPN went to the bathroom and washed their hands. The Bingo card was left unattended on top of the medication cart. The LPN did not have a line of sight to visualize the medication cart while inside the bathroom. The surveyor remained at the door and observed ancillary staff in the hallway while the Bingo card was on top of the medication cart. The LPN returned to the medication cart, prepared medications for Resident #29, went back to the room and administered the medications. On 04/03/24 at 08:11 AM, the LPN returned to the medication cart to sign for the medications administered and proceeded with the NJ Exec Order 26 count at the surveyor's request. The nurse opened the NJ Exec Order 26 book and the first page indicated NJ Exec Order 26.4b1 tablet NJ Exec Order 26.4b1 a specific type of NJ Exec Order 26 medicine for Resident #26. The Bingo card was not in the NJ Exec Order 26.4 drawer. The LPN then attempted to pull the Bingo card from underneath the NJ Exec Order 26 book on top of the	F 761	The policy and procedure was revised to add sticker label to NJ Ex.Order 26.4 with open date as well as expiration date. (2) All residents have the potential to be affected by the deficient practice. (3) During our Pharmacy & Therapeutics meeting on 4/17/24, it was discussed with O. Elwir (PharmaCare pharmacy consultant) that during his medication pass inspections with our District Nurses, proper placement of Narcotic bingo cards as well as insulin dating with stickered labels noting open date and expiration date must be part of his review. All licensed nursing staff were in serviced and educated (attached) on the revision to Medication policy & procedures. RN staff educator was informed to include during competencies to pay close attention to storage of narcotic bingo cards and insulin's being stickered and dated. The pharmacy consultant as well as the staff educator will provide written documentation of med passes to the Director of Nursing for review of any deficient practice. (4) During our quarterly QAPI & QAA meeting the documentation for med passes will be reviewed by the team for and deficiencies.	

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F 761	Continued From page 5	F 761		

medication cart. The surveyor asked to see the label on the Bingo card. The Bingo card was the missing the [NJ Exec Order 26.4b] that was not locked with the other [NJ Exec Order 26] and had belonged to Resident #26.

On 04/03/24 at 8:25 AM, during an interview with the LPN, she stated that the [NJ Exec Order 26.4b1] was discontinued and she wanted to remove the medication from the [NJ Exec Order 26.4] drawer. The surveyor then inquired regarding the process for the storage of controlled substances. The LPN indicated that all controlled substances should be double locked.

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A review of the Physician Order Sheet (POS) for Resident #26, revealed that the [NJ Exec Order 26.4b] was reordered on [NJ Exec Order 26.4b] at 06:15 AM. The order was still active.

2. On 04/03/24 at 7:40 AM, in the presence of the Licensed Practical Nurse (LPN) the surveyor inspected the low hall medication cart on the Long Term Care unit. The surveyor observed an open Flexpen of Humalog insulin (a medication used to treat high blood sugar) which was delivered from the pharmacy on 03/30/24. The Humalog Flexpen was opened and not dated. Also noted was a Lantus Flexpen Insulin which was open and not dated, three other insulin Flexpens were noted with a date on the bag only not the Flexpen.

On 04/03/24 at 7:50 AM, the surveyor interviewed the LPN responsible for the medication cart and asked about the facility's process for dating multidose vial medication. The LPN stated that the Humalog Flexpen and the Lantus Flexpen Insulin should have been dated when opening.

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F 761	Continued From page 6 According to the manufacturer's recommendations, Humalog and Lantus Insulin should be discarded 28 days after first use. On 04/04/24 at 12:30 PM, the surveyor reviewed the facility's Administering Oral/ IV Medications/ Insulin's/ Storage of Medications and Treatment Carts with a revision date of 1/2019, revealed that all stock medications are to be dated upon opening. A review of the facility's Medication Management: Skills Evaluation revealed under "Medication Administration Technique" Medication should be locked when staff are not on the cart. Medications are not left on top of medication cart or residents bedside. Maintains security of scheduled medication under double lock system. On 04/08/24 at 9:00 AM, the Director of Nursing (DON) provided a revised policy which included that insulin's should be dated with an open and expired date. The DON added that staff were in-serviced. On 04/08/24 at 09:39 AM, during an interview with the Nurse Educator regarding the insulin, she stated that the staff were to place the date directly on the Insulin Pen not on the bag that contained the insulin. NJAC 8:39-29.4	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/9/24

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F 880	Continued From page 7	F 880		

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation,

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F 880	Continued From page 8 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent documents, it was determined that the facility failed to ensure that all staff used appropriate hand hygiene and proper disinfection while providing [NJ Exec Order] care to a resident, and were adhered to infection control practices in accordance with facility policy regarding medication administration. This deficient practice was observed for 1 of 1 resident (Resident #15) investigated for [NJ Exec Order 26.4b] [redacted] and during the medication administration observation as evidenced by the	F 880	(1) Resident #15 was not affected by the deficient practice but had the potential to be affected. District Nurse was educated immediately on Hand Washing and cleansing of scissors during treatment removal and administration of treatment. The policy & procedure "Dressing Change" (attached) was revised to prevent reoccurrance. The District Nurse for [NJ Ex.Order 26.4(b)] administration was educated immediately. The [NJ Ex.Order 26.4(b)] was replaced with a new bottle in the medication cart.	

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F 880	Continued From page 9 following: On 04/01/2024 at 9:38 AM, the surveyor observed Resident #15 lying in bed NJ Exec Order 26.4b1 Resident #15 is noted to be on NJ Exec Order 26.4b1. Resident #15 stated that he/she had a NJ Exec Order 26.4b1 that resulted in a NJ Exec Order 26.4b1. Resident #15 also stated that he/she gets NJ Exec Order 26.4 changes done daily and goes to the NJ Exec Order 2 doctor every other week. Resident #15 was observed NJ Exec Order 26 A review of Resident #15's Electronic Medical Record (EMR) revealed that Resident #15 was admitted to the facility with the following diagnoses including but not limited to: NJ Exec Order 26.4b1. A review of Resident #15's Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1 revealed that Resident #15 had a Brief Interview for Mental Status score of NJ /15, indicating NJ Exec Order 26.4b1. Section M of the MDS was reviewed and revealed that Resident #15 has a NJ Exec Order 26.4b1 and was at risk for NJ Exec Order 26.4b1 A review of Resident #15's EMR revealed that he/she had the following physician's order "NJ Exec Order 26.4b1. Wash your hands with soap and water. Remove old NJ Exec Order 26.4, discard into practice bag and place into trash. Cleanse the NJ Exec Order with NJ Exec Order 26.4b1 prior	F 880	The policy and procedure for medication was revised. (2) All residents have the potential to be affected by the deficient practice. (3) All licensed nursing staff was in serviced on the policy and procedure of dressing change. Staff educator during competencies will ensure policy and procedure is being followed paying close attention to hand hygiene and cleansing of scissors. Regarding Flonase, medication policy and procedure was revised and all licensed nursing staff were in serviced. Pharmacy consultant has added nasal sprays to his competencies for medication pass observations. Any competencies that a District Nurse has not adhered to the policy & procedure will be directed to the Director of Nursing for further education and discipline. (4) During our quarterly QAPI & QAA meeting the staff educator will present competencies of District Nurses treatments to the team to ensure compliance is being met as well as pharmacy consultant's medication pass observations to further ensure compliance is being met.	

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F 880	Continued From page 10	F 880		

to applying a clean NJ Exec Order 26.4b using NJ Exec Order , not tissues or cotton balls. Do not scrub or use excessive force. Pat dry using NJ Exec Order , not tissue or cotton balls (or NJ Exec Order , if available). Protect NJ Exec Order 26.4b1 . Apply a NJ Exec Order only, then cover with NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 - apply to NJ Exec Order 26.4b1 followed by NJ Exec Order 26.4b1 and lay over NJ Exec Order 26.4b1 after NJ Exec Order 2 and NJ Exec Order 26.4b1 . Change NJ Exec Order 26.4 every day or as needed for NJ Exec Order 26.4b1.

A review of Resident #15's care plan revealed that he/she had a comprehensive care plan initiated on NJ Exec Order 26.4b1 for: "NJ Exec Order 26.4b1 ". Interventions included: "NJ Exec Order 2 as ordered. NJ Exec Order 26.4b1 measurement with documentation. Assess for NJ Exec O and medicate before NJ Exec Order 2 treatment. NJ Exec Order 26.4b1 assessment and documentation NJ Exec Order 26.4b1 in chair and mattress on bed. NJ Ex.Order 26.4(b)(1) as needed. Protect and off load NJ Exec Or . Prevent NJ Exec Order 26.4b1 by using pillows and padding. Monitor for symptoms of NJ Exec Order 26.4b1 . Use NJ Exec Order 26.4b1 e.g., pillow or wedges to maintain proper body alignment. Enhanced NJ Exec Order 26.4b1 as ordered."

On 04/03/2024 at 9:44 AM the surveyor obtained verbal permission from Resident #15 to observe his/her NJ Exec Order care.

On the same date at 10:12 AM, the surveyor observed the Licensed Practical Nurse (LPN)

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F 880	Continued From page 11	F 880		

begin to perform NJ Exec Order care to the NJ Exec Order 26.4. The LPN performed hand hygiene prior to donning (putting on) gloves at the start of the NJ Exec Order 2 care. The surveyor then observed the LPN doffing (removing) gloves from both hands after removing the NJ Exec Order 26.4b1 and placing it in the trash. At that time, the LPN did not perform hand hygiene. The LPN then donned (applied) a new pair of gloves, cleansed the NJ Exec Order with NJ Exec Order 26.4b1, removed both gloves without performing hand hygiene. The LPN then donned a new pair of gloves and applied skin prep to the NJ Exec Order 2 edges. The surveyor then observed the LPN remove the gloves, then donned a new pair of gloves to perform the rest of the NJ Exec Order 2 care treatment without performing hand hygiene. The LPN removed both gloves once the NJ Exec Order 2 care treatment was completed and performed hand hygiene.

During the NJ Exec Order 2 care treatment this surveyor observed the LPN cut the prescribed NJ Exec Order with scissors located directly on top of the treatment cart. Prior to the use of the scissors, the LPN did not disinfect the scissors.

On the same date at 10:25 AM during an interview with the LPN, the surveyor asked when should you perform hand hygiene during NJ Exec Order 2 care, the LPN said, "I would perform hand hygiene before starting the treatment and once I am done with the treatment." The surveyor asked the LPN if hand hygiene should be performed between glove changes. The LPN stated, "yes, it should be done but I didn't do it every time."
The surveyor asked when providing NJ Exec Order care should the scissors be cleaned prior to using them, the LPN stated, "yes, but I did not wipe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING ______ B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	256 COUNTY HOUSE ROAD CLARKSBORO, NJ 08020

(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 880	Continued From page 12	F 880		

them before cutting the [name redacted], but I should have."

On 04/04/2024 at 9:55 AM, the surveyor asked the Director of Nursing (DON) what were the expectations for staff regarding hand hygiene while performing [NJ Exec Order] care. The DON said, "They should wash their hands before and after the procedure, if they are visibly soiled and in between glove changes. If they remove their gloves, they need to also do hand hygiene with either hand sanitizer or by washing them." The surveyor asked the DON should hand hygiene be done in between glove changes. The DON stated, "Yes, they should be cleaned with either hand sanitizer or hand washing." This surveyor then asked the DON, when providing [NJ Exec Order] care should instruments such as scissors be cleaned prior to use. The DON said, "Yes, they must wipe the instruments prior to using them with wipes."

On 04/04/2024 at 12:40 PM, a review of the facility policy and procedure for Dressing Change, reviewed on 03/2024, revealed the following under the Policy section: To ensure proper application of treatments. To prevent cross contamination and infection.
Under the Procedure section it included the steps of the procedure as follows,
1) Wash hands prior to patient contact or use of ABHS (alcohol-based hand sanitizer)
3) Apply gloves
4) Remove soiled dressing and dispose of it in a plastic bag on treatment cart.
5) Either: a) wash hands, or b) use ABHS
6) Don new gloves after hand washing or use of ABHS
7) Assess wounds for exudates (drainage) before applying treatment. If necessary, clean wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING ______ B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD CLARKSBORO, NJ 08020**

(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 880	Continued From page 13	F 880		

with 4 x 4 dressing and normal saline solution or wound solution. Dispose of dressings in plastic bag.
8) Remove gloves, wash hands or use of ABHS, and apply new gloves.
9) Apply ordered medication ....
13) All tools ie: bandage scissors that are reusable must be cleaned with antimicrobial wipes prior to placing back in treatment cart and moving to next resident.

b. On 4/3/24 at 7:57 AM, the surveyor observed the Licensed Practical Nurse (LPN) administered NJ Exec Order 26.4b1 which was delivered from the pharmacy on NJ Exec Order 26.4b. The NJ Exec Order 26.4b1 was observed in a bag and not protected with a cap. The LPN did not wipe the NJ Exec Order 26.4b1 prior to administering the NJ Exec Order 26.4b1. After use, the LPN returned the NJ Exec Order 26.4b1 in the bag without cleansing the NJ Exec Order 26.4b1, and then stored the NJ Exec Order 26.4b1 in the medication cart along with other medications.

On 04/03/24 at 8:05 AM, the surveyor inquired regarding the missing cap that was not observed when the LPN removed the bottle from the the bag. The LPN stated that the cap had been missing and would not elaborate further.
The surveyor asked the LPN if she had received in-service on how to administer NJ Exec Order 26.4b1. The LPN stated that she had not received any in-service regarding how to administer NJ Exec Ord but she would read the recommendations on the product box. The surveyor then inquired regarding infection control protocol. The nurse then stated that she should have used a tissue to wipe the NJ Exec Order 26.4b1 before and after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING ______ B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD CLARKSBORO, NJ 08020**

(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 880	Continued From page 14	F 880		

administration to prevent the spread of "germs". The manufacturer recommendations revealed the NJ Exec Order 26.4b1 should be wiped with a clean tissue after being used and the NJ Exec Order 26.4b1 should be protected with a translucent cap.

On 04/08/24 at 9:39 AM, the surveyor interviewed the Registered Nurse Educator regarding the infection control concerns observed during the medication administration. The RN stated that if the cap from the NJ Ex.Order 26.4(b)(1) had been missing, the LPN should have called the pharmacy and requested another NJ Ex.Order 26.4(b)(1) to prevent the spread of infection. The RN confirmed that she had not provided in-service to the staff on how to administer NJ Ex.Order 26.4(b)(1).
A review of the facility's policy titled, " Infection Control-Standards Precautions provided by the DON on 04/04/24, indicated that employees will be in-serviced annually on infection control issues, including hand washing and gloves use, standards precautions and epidemiological significant pathogens.

N.J.A.C 8:39-19.4(a)

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
	060805	A. BUILDING: ______ B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD CLARKSBORO, NJ 08020**

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S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/24

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315405	A. Building B. Wing	5/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	256 COUNTY HOUSE ROAD CLARKSBORO, NJ 08020

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 05/09/2024	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 05/09/2024	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 05/09/2024
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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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
4/18/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING 03 B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	256 COUNTY HOUSE ROAD CLARKSBORO, NJ 08020

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 04/18/2024. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/18/24 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Shady Lane Gloucester County Home is a two-story building built in 2006, it is composed of Type II protected construction. The facility is divided into four - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 34 of 60.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited	K 324		5/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/09/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING **03** B. WING ____________	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD** **CLARKSBORO, NJ 08020**

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K 324	Continued From page 1 cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		
	This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the kitchen's fire-extinguishing system was inspected, tested, and maintained at least every six months in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 edition) section 11.2.1. This deficient practice had the potential to affect all 34 residents who resided at the facility. Findings include: A review of the facility's "Kitchen System Report," provided by the facility, revealed the fire-extinguishing system was inspected on 06/06/23. No other documentation was presented to show any other inspection of the fire-extinguishing system.		(1) No residents were found to be affected by the deficient practice. (2) All residents have the potential to be affected. (3) On 4/18/24 after notification from the Life Safety Inspector, the Maintenance and Facility Operations Directors were immediately instructed by the Administrator to contact Atlantic Fire (contracted fire inspection vendor) to add an additional "inspection, test and maintenance" for the fire-extinguishing system in the facilities kitchen. Annual testing and inspections are being done every June. Second inspection of the kitchen fire-extinguishing was added to the contract. Inspection & Testing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING **03** B. WING ______	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD** **CLARKSBORO, NJ 08020**

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K 324	Continued From page 2 An observation on 04/18/24 at 12:54 PM of the automatic extinguishing system revealed the inspection tag that was placed on the pull station near the automatic extinguishing system was dated 06/23. At the time of observation, the Maintenance Director confirmed the kitchen's automatic fire-extinguishing system had not occurred at least every six months. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	schedule is now two (2) times per year in June (6/11/24) and December (12/18/24) and work order confirmations are attached. All fire-extinguishing systems throughout the facility will be inspected for proper and compliant inspection tags weekly by the facility maintenance team. Administrator will review weekly inspection reports for compliance. Weekly inspections have no stop date. (4) Administrator will bring weekly inspection reports to the quarterly QAPI & QAA meeting team to review for compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.1.6. This deficient practice had the potential to affect all 34 residents who resided at the	K 712	(1) No residents were found to be affected by the deficient practice. (2) All residents have the potential to be affected.	5/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING **03** B. WING	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD** **CLARKSBORO, NJ 08020**

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K 712	Continued From page 3 facility. Findings include: A review of the facility's "Fire Drill," logs for 2023 and 2024, provided by the facility, revealed no documented evidence of fire drills were conducted during the second or third shifts. During an interview on 04/18/24 at 2:50 PM, the Maintenance Director confirmed the fire drills were not conducted for the second or third shifts. NJAC 8:39-31.2(e)	K 712	(3) On 4/18/24 after notification from the Life Safety Inspector, the Maintenance and Facility Operations Directors were immediately instructed by the Administrator to conduct fire drills monthly on every shift (7-3, 3-11 & 11-7) and complete a fire drill log for each instance on each shift. Second shift testing done on 4/22/24 at 4pm. Third shift testing done on 4/25/24 at 11:45pm (fire drill log attached). Fire Drill logs will be reviewed by the Administrator monthly. Monthly review of logs will have no stop date. (4) The QAPI team will review fire drill logs for compliance at the quarterly QAPI & QAA meetings.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 761	(1) No residents were found to be	5/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315405	A. BUILDING **03** B. WING ______	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD** **CLARKSBORO, NJ 08020**

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K 761	Continued From page 4 failed to ensure fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 34 residents who resided at the facility. Findings include: A review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence that the facility's fire doors were inspected. An observation of the facility's fire doors on 04/18/24 from 11:39 AM to 01:55 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of each observation, the Maintenance Director confirmed the fire doors had not been inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	affected by the deficient practice. (2) All residents have the potential to be affected. (3) On 4/18/24 after notification from the Life Safety Inspector, the Maintenance and Facility Operations Directors were immediately instructed by the Administrator to contact the Gloucester County Fire Marshall regarding fire door inspection and testing. As per the Fire Marshall (S. Layton) the Annual Inspection for the facilities "Certificate Of Inspection" includes inspection and test of all fire doors. Inspection for the year 2024 was completed on 1/23/24 and the Certificate of Inspection was issue for compliance (certificate of compliance attached). (4) Administrator will review safety binders for compliance and will bring to the quarterly QAPI & QAA meetings for review of compliance.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315405	A. Building 03 - SHADY LANE B. Wing	5/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LANE GLOUCESTER CO HOME	256 COUNTY HOUSE ROAD CLARKSBORO, NJ 08020

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 05/09/2024	ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 05/09/2024	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 05/09/2024
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	
4/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO