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 _____	04/12/2022

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 STANDARD SURVEY: CENSUS: 41 SAMPLE: 17+1 closed The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to document bimonthly weights per the physician order and in accordance with professional standards for 1 of 17 sampled residents (Resident #29). This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care	F 658	F658 SS=D (1)Resident #29 was affected by this deficient practice. The LPN failed to document the weight into EHR (electronic health record). The order was changed in Sigma so that the nurse must record the weight before marking administered. The resident's weight on [redacted] was [redacted] which required no call to the physician. There was no harm to the resident. (2)All residents who have ordered weights more than monthly have the potential to be affected. (3)The weight policy was revised to reflect	4/14/22

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

Electronically Signed | 04/20/2022

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F 658	Continued From page 1 supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." During the initial tour of Spruce hallway on 4/1/2022 at 10:53 AM, Resident #29 was observed sitting in his/her wheelchair with NJ Exec. Order 26:4.b.1 on his/her NJ Exec. Orde Resident #29 said he/she Exec Order 26, 4b1 NJAC 8:43E-2.1 A review of the Resident Face Sheet revealed Resident #29 was admitted to the facility with diagnoses including but not limited to: Exec Order 26, 4b1 [redacted] A review of the most recent Minimum Data Set, an assessment tool dated Exec Order 26, 4b1 NJ revealed a Brief Interview for Mental Status (BIMS) score of Exec Order 26 indicating Resident #29 was Exec Order 26, 4b1 NJA A review of the Physician's Orders with a renewal date of Exec Order 26, 4b1 NJ, revealed the following physician order: "Per Exec Order 26, 4b1 NJAC 8:43E-2 Physician	F 658	the weight orders to be placed in monitoring with a show required so the nurse must document the weight before he/she signs it off as administered. All staff in-serviced to policy revision. The LPN who failed to document the weights was disciplined and counseled on ensuring that weights are documented into EHR (electronic health record software). Monthly Audits will be done by the Nurse Manager and Dietician to ensure weights are being documented and addressed per physicians orders. This audit, once completed, will then be given to the DON for review to ensure compliance is being met. This will be done monthly for one year then thereafter changed to quarterly. (4)The audit will be brought to the quarterly QAPI and QAA meetings and reviewed with the Medical Director to ensure compliance is being met.	

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F 658	Continued From page 2 check weight every 2 weeks. If weight is above baseline weight of [redacted] by [redacted] pounds, then call office for additional [redacted] A review of the Resident Medication Administration Record (RMAR) from [redacted] up to and including [redacted] revealed the physician order as indicated above. The RMAR revealed staff initials for completion of the bi-weekly weights but did not include documentation of the actual weights. A review of the documented weights for Resident #29 under the Monitoring section of the Electronic Medical Record (EMR), revealed weight results for [redacted] and [redacted] There were no negative outcomes to Resident #29. During an interview with the surveyor on 4/6/2022 at 9:42 AM, the assigned Certified Nursing Assistant (CNA) revealed that weights are done monthly at the beginning of the month, according to facility policy. "We then give the weights to the nurse." She went on to say, "The nurse notifies us if we need weekly or daily weights." During an interview with the surveyor on 4/6/2022 at 9:44 AM, the assigned Licensed Practical Nurse (LPN #1) said, "The CNA gives the nurse the weight and I record the weight on the monthly weight monitoring sheets for the hall/unit. I give the sheet to the Director of Nursing (DON) after all the weights and reweights are completed. If a resident is on weekly weights, that will come up on the RMAR and we document the weight on the	F 658		

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F 658	Continued From page 3 RMAR, and then the weight goes directly into the monitoring section of the EMR." During an interview with the surveyor on 4/6/2022 at 9:55 AM, the DON said "This resident (Resident #29) is on weights [redacted] per the physician order. The weights need to be documented in the RMAR and will carry into the monitoring section." The DON then pulled up the documentation of the weights on Resident #29's RMARS and confirmed the weights were not documented. The DON then said she will be calling the involved nurse. The DON said she will check the nurses report sheets for January thru March to see if they are documented. At 10:04 AM, the DON confirmed that the only weights under the monitoring section are the monthly weights and could not find the weights for [redacted] as ordered for this resident. During a follow up interview on 4/7/2022 at 10:18 AM, with the DON stated, "Absolutely, they (nurses) should have made sure the weight went into the medical record." She went on to say, "The Bottom line is they (nurses) took a weight and did not put it in the computer. She went on to say, "Whether prompted by the EMR or not, the order is on the RMAR." The surveyor reviewed the facility policy titled Weighing Residents with a reviewed date of 10/21. The policy did not include where specific physician ordered weights were to be documented. NJAC 8:39-27.1(a)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		4/17/22

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F 695	Continued From page 4 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to follow their own policy for storage of respiratory equipment. This deficient practice was identified for 1 of 3 (Resident #33) residents reviewed for [NJ Exec. Order 26:4.b.1] [redacted] and was evidenced by the following: During a tour of the facility on 4/1/2022 at 10:40 AM, Resident #33 was observed lying in bed. The surveyor observed the [Exec Order 26, 4b1 N] machine [redacted] on a cabinet next to the resident's bed. The surveyor observed the tubing and mouthpiece of the [Exec Order 26, 4b1 N] machine exposed to air and uncovered. At that time the surveyor observed [Exec Order 26, 4b1 NJAC 8:43E-2.1] of the mouthpiece that was attached to the tubing. On 4/4/2022 at 9:21 AM, the surveyor observed the tubing and mouthpiece of the [Exec Order 26, 4b1 N] machine exposed to air and uncovered . The surveyor observed [Exec Order 26, 4b1 NJAC 8:43E-2.1] of the	F 695	F695 SS=D (1) Resident #33 was affected by the deficient practice. The licensed staff was in-serviced on 4/6/22 to the revised policy for rinsing and drying the chamber of the [Exec Order 26, 4b1 N] [redacted] treatment and ensuring that it is stowed in a bag when not in use. There was no harm to this resident. (2) All residents with Nebulizer treatments have the potential to be affected. (3) The policy for medication administration was revised to reflect rinsing and drying of the chamber of the nebulizer and placing it into a bag for storage when not in use. The in-service of licensed staff took place on 4/6/22 and 4/11/22 to be alerted of the change in policy and procedure. Unit inspection by the NM (Nurse Manager) will be done on every resident receiving Nebulizer treatments monthly and documented on paper to ensure compliance of changes to policy regarding Nebulizer treatments. This will be done monthly for 1 year and	

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F 695	Continued From page 5 mouthpiece that was attached to the tubing. Resident #33 stated that he/she received their last [Exec Order 26, 4b1 N] treatment at [Exec Order 26, 4b1 N] On 04/05/22 at 12:09 PM, the surveyor observed the tubing and mouthpiece of the [Exec Order 26, 4b1 N] machine exposed to air and uncovered. The surveyor observed [NJ Exec. Order 26:4.b.1] of the mouthpiece that was attached to the tubing. On 04/06/22 at 10:50 AM, the surveyor observed the tubing and mouthpiece of the [Exec Order 26, 4b1 N] machine exposed to air and uncovered. The surveyor observed [Exec Order 26, 4b1 NJAC 8:43E-2.1] of the mouthpiece that was attached to the tubing. When interviewed at that time, Licensed Practical Nurse #2 stated that if a [Exec Order 26, 4b1] r machine mouthpiece and chamber is not in use, it should be in a bag and not open to air. A review of the medical record revealed Resident # 33 had diagnoses that included but were not limited; to [Exec Order 26, 4b1 NJAC 8:43E-2.1] A review of a Physician Order Sheet (POS) revealed a physician's order dated [Exec Order 26, 4b], reflected that Resident # 33 was to receive [Exec Order 26, 4b1 NJAC 8:43E-2.1] route 4 times per day. The POS also included an order dated [Exec Order 26, 4b] to change then label and date [Exec Order 26, 4b1 NJAC 8:43E-2] tubing every Friday on 11-7 shift and place in plastic bag when not in use. During an interview with the surveyor on 04/06/22	F 695	then quarterly thereafter. (4) The monthly reports that the NM provides will be monitored quarterly by the DON (Director of Nursing) for compliance and reviewed at the facilities quarterly QAPI and QAA meetings with the Medical Director.	

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F 695	Continued From page 6 at 01:43 PM, the Unit Manager in the presence of the Director of Nursing (DON) stated the [redacted] mouthpiece should be in a bag. The Unit Manager went on to say that when not in use the [redacted] mouthpiece and chamber should not be stored with moisture in it. During an interview with the surveyor on 04/07/22 at 10:20 AM, the DON stated the [redacted] mouthpiece and chamber should be dry and, in a bag, when not in use. A review of a facility policy titled Oxygen-Changing of Tubing and Filters with a reviewed date of 10/21, reflected that [redacted] tubing is to be placed into plastic bag when not in use. The policy does not include that the chamber should be kept dry. NJAC 8:39-15.1(a)	F 695		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and review of other pertinent facility documentation, it was determined that the facility failed to 1.) include a standardized infection assessment tool or management	F 881	F881 SS=F (1) No residents were found to be affected by the deficient practice.	4/18/22

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F 881	Continued From page 7 algorithm when prescribing antibiotics, 2.) provide evidence of staff education about antibiotic stewardship and 3.) provide evidence of antibiotic monitoring during quarterly reviews. These deficient practices were identified during investigation of the Infection Control Task. The deficient practice was evidenced by the following: 1.) On 4/6/22 at 1:17 PM, during an interview with the surveyor, the Director of Nursing (DON) stated that the facility does not use any standardized criteria for determining infections. The DON further revealed they use their own clinical experience and microbial cultures (method of multiplying microbial organisms in a culture medium under laboratory conditions) to determine true infections. 2.) On 4/6/22 during the same interview with the surveyor, the DON revealed that a lot of time is spent on educating staff on the facility's antibiotic stewardship procedure. During an interview with the surveyor on 4/12/22 at 9:51 AM, the DON said that there was no documented staff education about antibiotic stewardship during the year of 2021. 3.) A review of a document titled, "Pharmacy and Therapeutics Meeting (P&T), QAA (Quality Assurance Assessment) and QAPI (Quality Assurance Performance Improvement)-COVID 19, Outbreak Response Plan, Antibiotic Stewardship Quarterly Review" dated 7/21/21 did not include any minutes or documentation of discussions about an antibiotic stewardship quarterly review.	F 881	(2) All residents have the potential to be affected. (3) The policy on Antibiotic Stewardship was revised on 4/5/22 and 4/6/22 reflecting the use of McGeers Criteria which was also added to EHR (electronic health record software) under nursing progress notes for licensed staff use. Nursing Supervisors will review completed McGeers to ensure completion. A weekly monitoring system was implemented where the team meets weekly on all antibiotics that are in use and is the antibiotic warranted for continued use with typed minutes. This is then reviewed by the Medical Director quarterly for compliance. Staff will be in-serviced annually by the Staff Educator and when any changed occur with the policy. The in-service of staff took place on 4/6/22 and 4/11/22 to be alerted of the change in policy and procedure. (4) Nursing Supervisors will review completed McGeers in EHR (electronic health record software) to ensure completion and appropriate clinical response for the residents. This information will be reviewed by the Medical Director quarterly for compliance. Staff Educator will bring her staff in-servicing quarterly to the QAPI and QAA meetings for review by the Administrator to ensure compliance. The minutes from the weekly antibiotic meeting will be typed and brought to the quarterly QAPI and QAA meeting for the	

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F 881	Continued From page 8 A review of a document titled, "P&T, QAPI and QAA, Satisfaction Surveys, Policy and Procedure for Visitation, Antibiotic Stewardship Quarterly Review" dated 1/19/22, did not include any minutes or documentation of discussion about an antibiotic stewardship quarterly review. During a review of the facility policy titled, "Antibiotic Stewardship Program" with revised date of 4/5/22, revealed under "Standard" section that the facility will "Communicate with nursing staff and prescribing clinicians the facility's expectations about use of antibiotics and the monitoring and enforcement of stewardship policies." The policy further revealed under "Policy" section that the facility will "Track the amount of antibiotic used in the home to review patterns of use and determine the impact of the new stewardship interventions during quarterly review." N.J.A.C. 8:39-19.4(a)	F 881	Pharmacist and Medical Director to review and ensure compliance. There will be no stop date for this at this time.	
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.	F 888		4/14/22

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F 888	Continued From page 9	F 888		

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary

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vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive

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F 888	Continued From page 11 and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documentation, it was determined that the facility failed to develop and implement a policy to include contingency plans that address staff who are not fully vaccinated due to an exemption or temporary delay in vaccination, to include implementing additional precautions.	F 888	F888 SS=E (1) No facility staff were found to be affected by the deficient practice as all staff are fully vaccinated. (2) All residents and facility staff have the	

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	315405	A. BUILDING _____ B. WING _____	04/12/2022

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 888	Continued From page 12 This deficient practice was evidenced by the following: During Entrance Conference with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing on 4/1/22, the surveyor requested a copy of the facility policy and procedures regarding staff vaccination for Covid-19. On 4/6/22 at 9:44 AM, the LNHA provided the Surveyor a document titled "Infection Control Employee Mantoux Testing, COVID 19 Vaccinations," that included the following vaccination related policies and procedures: COVID 19 Vaccinations are offered through CVS Clinic and Mega Center all staff must be vaccinated and must be able to show proof of CDC Vaccination card. Added booster 2/2022, all staff must be boostered by April 11, 2022, and must show proof of booster on their CDC Vaccination cards prior to April 11, 2022. Shady Lane Home will continue to offer booster clinics for all staff. There was no documentation to indicate the facility's contingency plan for staff who were unvaccinated, on temporary delay or who would qualify for an exemption. When the surveyor reiterated the request for a policy that included a vaccination contingency plan as required, the LNHA stated it was in their "Outbreak Response Plan." On review of the Outbreak Response Plan, it was found that it did not include a contingency plan for staff that declined the vaccination.	F 888	potential to be affected. (3) The policy on Infection Control - Employee COVID-19 Vaccination Program was revised to add a contingency plan on 4/7/22 using QSO-22-07-All 2/2022 and revised 4/12/22 to add Matrix Excel spreadsheet. The in-service of staff took place on 4/12/22 to be alerted of the change in policy and procedure. Staff will be in-serviced at least yearly by the Staff Educator and when any changes occur with the policy. Matrix Excel spread sheet will be maintained by the Administrator on all staff, agency staff, physicians, PA's (physician assistant), RNP's (registered nurse practitioner), contractors, vendors, visitors, volunteers who interact or come in contact with residents and as staff changes. The Administrator also contacted CMS Center for Clinical Standards and Quality/Safety Oversight Group to ensure she receives all up to date memorandum to ensure our compliance as a facility in regulatory compliance. This will be monitored quarterly for the duration of the policy. (4) Staff Educator will bring staff in-servicing quarterly to the QAPI & QAA meeting for review by the administrative team, Pharmacist and Medical Director to ensure compliance of policy. The Administrator will keep the Excel spreadsheet up to date with changes as they occur and bring to QAPI & QAA meeting for review by the Medical Director to ensure compliance. Overview of each	

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F 888	Continued From page 13 On 4/7/22 at 10:35AM, the surveyor met with the LNHA and the Director of Nursing, and they both stated that they are not familiar with the CMS New Staff Vaccination Rule other than Covid-19 administration deadlines. They further stated that they get their information and guidance from the County Department of Health; if an employee asks about exemptions, they refer them to Human Resources. N.J.A.C. 8:39-5.1(a);19.4(a)	F 888	will be typed into minutes to and placed in the QAPI and QAA Manual.	

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	060805	A. BUILDING: _____ B. WING _____	04/12/2022

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 not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to total staff ratios as mandated by the state of New Jersey. This was evident for 8 of 14 evening shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	S560 (1) No residents were found to be affected. Shady Lane Home utilizes their licensed staff and mandation policy when falling below minimum staffing requirements and also to ensure that CNA staffing is 50% greater than licensed staff to maintain required staffing levels to ensure delivery of care to our residents. (2) All residents have the potential to be affected. (3) All administrative RN's were in-serviced on capturing the licensed staff when being used as a CNA to meet	4/14/22

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

Electronically Signed | 04/20/22

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 _____	04/12/2022

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 2/1/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA to total staff ratio on 8 of 14 evening shifts as follows: -03/14/22 had 5 CNAs to 11 total staff on the evening shift, required 6 CNAs. -03/15/22 had 5 CNAs to 11 total staff on the evening shift, required 6 CNAs. -03/16/22 had 5 CNAs to 11 total staff on the evening shift, required 6 CNAs. -03/17/22 had 5 CNAs to 11 total staff on the evening shift, required 6 CNAs. -03/20/22 had 4 CNAs to 9 total staff on the evening shift, required 5 CNAs. -03/22/22 had 5 CNAs to 11 total staff on the evening shift, required 6 CNAs. -03/23/22 had 5 CNAs to 11 total staff on the evening shift, required 6 CNAs. -03/25/22 had 5 CNAs to 11 total staff on the evening shift, required 6 CNAs. During an interview with the surveyor on 4/6/2022	S 560	staffing guidelines and licensed staff when moved in a CNA role are only to work as CNA. Also to ensure the CNA staffing is 50% greater than licensed staffing for each shift. The Nursing Home Staffing Report Form is completed each shift and posted to ensure compliance with staffing guidelines and for families, residents and staff to see. Monthly audits will be done by the Administrator to ensure staffing compliance for the facility. There will be no stop date at this time for this audit. (4) Monthly audits will be brought to the quarterly QAPI & QAA meetings and will be reviewed with the Medical Director to ensure compliance is being met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 at 9:25 AM, the Director of Nursing (DON) said that she and the Nurse Manager were responsible for nursing and direct care staffing of the facility. The surveyor asked the DON if she was familiar with the nursing home staffing requirements implemented for long term care facilities on 2/1/2021. The DON replied, "The law requires on 7-3 shift 1 CNA to 8 residents, 3-11 shift is 1 CNA to 10 residents, and 11-7 shift is 1 CNA to 14 residents. We consistently meet that law." The surveyor further questioned the DON if she was familiar with the direct care staff to total staff requirement component of the staffing law. The DON responded, "Yes, we had to beef up our 11-7 shift staff Monday thru Sunday. We have 1 or 2 nurses Monday thru Sunday and 4 to 5 CNA staff on 11-7 to meet the other requirement of CNA's being at least half of our staff." The facility was unable to provide any policy or procedure addressing the minimum staffing requirements effective on 2/1/2021.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060805		5/18/2022

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 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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/14/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
4/12/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315405 Y1	A. Building B. Wing Y2	5/18/2022 Y3

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 F0658	Correction	ID Prefix F0695	Correction	ID Prefix F0881	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.80(a)(3)	Completed
LSC	04/14/2022	LSC	04/17/2022	LSC	04/18/2022
ID Prefix F0888	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(i)(1)-(3)(i)-(x)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/14/2022	LSC		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	
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	
4/12/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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 _____	**04/12/2022**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/11/22, 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 The facility is a 2-story building that was built in 2005, It is composed of Type II protected construction. The facility is divided into 8- smoke zones. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 60 certified beds. At the time of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/2022

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K 000	Continued From page 1 the survey the census was 41.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222		4/13/22

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K 222	Continued From page 2 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/11/22, it was determined that the facility failed to ensure that exit doors locked with a delayed egress device were provided with instructional signage as per the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was identified in 1 of 6 egress doors and evidenced by the following: At 9:58 AM, the surveyor observed, with the Maintenance and Operations Director, that the egress door identified as door #18, had a delayed egress device installed on the door for non-emergency egress. The door was not	K 222	K222 SS=D (1) No residents were found to be affected by the deficient practice. (2) All residents have the potential to be affected. (3) After notification from the Life Safety Inspector, the Maintenance and Operations Director were immediately instructed by the Administrator to place a readily visible sign with 1 inch lettering indicating that delayed egress door #18	

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K 222	Continued From page 3 provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button keypad and opened with the activation of the fire alarm. The Maintenance and Operations Director, confirmed the finding during the observation. The Administrator was informed of these findings during the Life Safety Code survey exit conference on 4/11/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222	can "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds". Signed placed 4/13/22 on door #18. All alarmed doors will be inspected weekly for proper signage during weekly facility rounds by maintenance team. Weekly rounds will have no stop date. (4) The Administrator will review weekly inspection reports for compliance and will incorporate inspection reports in the facilities quarterly QAPI & QAA meetings.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation on 4/11/22, in the presence of the Maintenance Director and Operations Director, it was determined that the facility failed provide a battery backup emergency light above the emergency generator's transfer switches, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: At 12:05 PM, the Surveyor, Maintenance Director and Operations Director observed an inspection of the outside 750 KW generator transfer switch. The surveyor observed the area was not	K 291	K291 SS=F (1) No residents were found to be affected by the deficient practice. (2) All residents have the potential to be affected. (3) After notification from the Life Safety Inspector, the Maintenance and Operations Director were immediately instructed by the Administrator to contact an electrical service vendor to schedule the installation of a 90 minute emergency	4/26/22

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SHADY LANE GLOUCESTER CO HOME	**256 COUNTY HOUSE ROAD** **CLARKSBORO, NJ 08020**

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K 291	Continued From page 4 equipped with battery back-up emergency lighting, independent of the building's electrical system and emergency generator. The Maintenance and Operations Director both confirmed the finding during the observations. The Administrator was notified of the finding at the Life Safety Code exit conference on 4/11/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	backup light above the emergency generator's transfer switches that would run independently from the buildings electrical system. Installation of emergency backup light was scheduled for 4/26/22 and has been completed. Weekly inspection of the backup lighting will be conducted during facility rounds by the Maintenance team and Administrator. Weekly Inspections will have no end date. (4) The Administrator will review weekly inspection reports for compliance. Inspection reports will be incorporated into the facilities quarterly QAPI & QAA meetings.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/11/22, in the presence of the Maintenance and Operations Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 13 of 23 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A,	K 521	K521 SS=F (1) Thirteen residents were found to be affected by the deficient practice. (2) All residents have the potential to be affected.	4/13/22

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 _____	**04/12/2022**

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 521	Continued From page 5 B. This deficient practice was evidenced by the following: The Surveyor and Maintenance and Operations Director observed that the ventilation in the following resident room bathrooms did not function: # 101, 102, 103, 104, 105, 211, 212, 213, 214, 215, 216, 217 and 218. The surveyor requested that the Maintenance Director confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Maintenance and Operations Director, who confirmed that the exhaust vents in the above resident room bathrooms were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	(3) After notification from the Life Safety Inspector, the Maintenance and Operations Director were immediately instructed by the Administrator to contact an HVAC service vendor to schedule a ventilation system check for all 23 resident bathroom ventilation systems. On 4/13/22 a HVAC company inspected all ventilation units and found the motors on unit #5 an unit #7 were not in working order. Both unit motors were replaced and remaining units were serviced. A confirmation test of each resident bathroom ventilation system was then done using "single ply toilet tissue across ceiling grills" to confirm proper ventilation. All ventilations systems were in working order. Weekly inspection of all resident bathroom ventilation systems will be done using the "toilet tissue test". Weekly inspections will have no stop date. (4) Administrator will review weekly inspection reports for compliance and will incorporate reports into the facilities quarterly QAPI & QAA meetings.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		4/21/22

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 _____	**04/12/2022**

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 918	Continued From page 6 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/11/22, the facility did not ensure a remote manual stop station for 1 of 1 generators that was provided in	K 918	K918 SS=F (1) No residents were found to be affected	

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	315405	A. BUILDING **03** B. WING _____	**04/12/2022**

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K 918	Continued From page 7 accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents. On 4/11/22, the Surveyor, Maintenance Director and Operations Director observed that the 750 KW diesel generator was outside and encased. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. An interview was conducted during the observation with the Maintenance Director and Operations Director, where he stated that at the time of observation, the area was observed not to have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	by the deficient practice. (2) All residents have the potential to be affected. (3) After notification from the Life Safety Inspector, the Maintenance and Operations Director were immediately instructed by the Administrator to contact a generator service company to schedule installation of a remote manual stop station for the facilities generator in order to prevent inadvertent or unintentional operation. On 4/20/22 a generator service company proposed the installation of an "E-Stop ATS Switch". Notice to proceed with work was given by the Administrator on 4/20/22. Installation scheduled for 4/21/22 and completed. Weekly inspections of the remote stop station will be done by maintenance team. There is no end date to weekly inspections. (4) Administrator will review weekly inspection reports for compliance and will incorporate reports into the facilities quarterly QAPI & QAA meetings.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315405 Y1	A. Building 03 - SHADY LANE B. Wing Y2	5/18/2022 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	04/13/2022	LSC K0291	04/26/2022	LSC K0521	04/13/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	04/21/2022	LSC		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	
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	
4/12/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO