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 _____	12/04/2019

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 000	INITIAL COMMENTS STANDARD SURVEY 12/4/19 CENSUS: 57 SAMPLE SIZE: 15	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide adequate supervision to a resident who had a history of falls. This deficient practice was identified for 1 of 3 residents reviewed for falls (Resident #25) and was evidenced by the following. During the initial tour of the facility on 12/1/19 at 10:50 AM, the surveyor observed Resident #25 sitting in the dayroom with a fall deterrent alarm (a pad alarm the resident was sitting on) that was attached to the resident's wheelchair. The resident's head was down, and he/she did not engage in a conversation when attempted by the surveyor. On 12/2/19 at 8:36 AM, the surveyor observed	F 689	1. Resident #25 on October 11, 2019 at 12:50pm was left unattended in the bathroom by agency CNA. When this deficient act occurred CNA was removed from the care area and re-educated on following the resident's plan of care and being left unattended in the bathroom by the RN Nursing Supervisor and this CNA signed off on the Verbal/Education form and was subsequently made a Do Not Return (DNR). The District Nurse LPN and CNA gave a verbal and written detailed report to CNA prior to care of resident. The LPN did rounds every 30 minutes after the incident to ensure her plan of care was followed and not left unattended in the bathroom. There were no further findings of deficient practice with this CNA.	12/16/19

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

Electronically Signed | 12/18/2019

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F 689	Continued From page 1 Resident #25 sitting at a table near the nursing station eating breakfast. The surveyor observed the pad alarm in place. The surveyor reviewed the resident's medical record, which reflected that the resident had diagnoses that included [redacted]. The [redacted] Minimum Data Set, an assessment tool used to facilitate the management of care, identified the resident as [redacted]. The surveyor reviewed the nursing care plan and observed a "Focus" area of "at risk for fall and actual fall" dated 8/7/19. Interventions included "resident to be in staff supervised areas." During a further review of the resident's medical record, the surveyor observed that Resident #25 sustained falls at the facility on 6/3/19, 6/24/19, and 8/7/19. The resident was not injured in any of those falls. The surveyor observed that on 10/12/19, the resident again sustained a fall while in the bathroom. The surveyor reviewed the 10/12/19 "Accident" investigative report, which was provided to the surveyor by the facility. According to the "Accident" report, Resident #25 "ambulated out of bathroom on own and fell." The "Accident" report noted under "Contributing Factors" that "Resident was left on toilet unattended" and noted under "Accident Reason" that "Not following care plan." The "Accident" report included "Noted [redacted]. Also noted [redacted] to the [redacted]." When interviewed on 12/2/19 at 11:35 AM, the	F 689	2. All residents have the potential to be affected by the deficient practice. 3. All agency staff will be oriented to their group assignment and be given nurse instructions prior to direct care, emphasizing on residents with poor safety awareness by the District Nurse. Rounds will be conducted every hour by the District Nurse when an agency CNA is working on an assignment in their care area. The nurse instructions will be signed and collected for the file at the end of the shift and given to the Staff Educator / Designee for monthly audit. The monthly audit will be completed by the 5th of the month. All District Nurses and RN's were in-serviced on December 4, 2019 regarding changes to the orientation policy and procedure. Administration will ensure that in-servicing and competencies are completed prior to scheduling and/or caring for a resident in the direct care area by the Staff Educator/Designee. 4. During our quarterly QAPI meeting the Staff Educator will present to the Medical Director a monthly audit of the files of the agency staff that was used during the quarter to ensure all orientation, competencies, nurse instructions are complete for each agency staff member.	

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F 689	Continued From page 2	F 689		

Certified Nursing Assistant (CNA #1), who cared for Resident #25, stated that Resident #25 was confused and dependent on staff for care. CNA #1 said Resident #25 was a fall risk and "should be supervised at all times." CNA #1 further stated that she did not have Resident #25 on 10/12/19, but she had reported to the agency CNA (CNA #2) who cared for Resident #25 that day. CNA #1 said she had informed CNA #2 that Resident #25 should not be left unattended in the bathroom.

When interviewed on 12/2/19 at 11:45 AM, the Director of Nursing (DON) confirmed that the CNA who cared for Resident #25 on 10/12/19 was an "agency" CNA and that she had been informed that Resident #25 was not to be left unattended in the bathroom.

On 12/3/19 at 9:55 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who cared for Resident #25 on 10/12/19. The LPN stated she recalled that Resident #25 was getting restless after lunch. The LPN said CNA #2 took the resident to the bathroom and left the resident in the bathroom. The resident attempted to ambulate and fell. The LPN further stated that CNA #2 was informed during morning report that day that Resident #25 should not be left unattended in the bathroom. The LPN also said that she interviewed CNA #2 after the fall, and CNA #2 told her that she thought she could leave the resident alone on the toilet. The LPN said CNA #2 said that she left the resident in the bathroom to answer a call light.

The surveyor reviewed an "Employee Statement" that had been written by the LPN after interviewing CNA #2. The LPN wrote, "CNA stated, 'I took the resident to the bathroom

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F 689	Continued From page 3 because [redacted] was restless in [redacted] wheelchair after lunch. I took [redacted] into the bathroom and put [redacted] on the toilet. I came out of the bathroom, leaving the resident on the toilet. I thought I could leave [redacted] on the toilet. When I came back, resident had walked out of the bathroom and fell.'" (The surveyor attempted to call the agency CNA for an interview. The phone number provided by the facility was incorrect.) During a follow-up meeting with the survey team on 12/4/19 at 9:35 AM, the DON stated: "On 10/12/19, the resident should not have been left alone in the bathroom." When asked how long that intervention had been in place, the DON replied, "for a while, (the LPN) would know." When interviewed on 12/4/19 at 10:25 AM, the LPN stated the intervention of not leaving the resident alone in the bathroom had been in place "since at least September." The facility was unable to provide a policy that was pertinent to supervising a resident. NJAC 8:39-27.1 (a)	F 689		