STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9 OCEAN VIEW, NJ 08230**

(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 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		
F 000	INITIAL COMMENTS Standard Survey Census: 96 Sample Size: 24 + 3 closed records 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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		2/14/24

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

Electronically Signed | 01/21/2024

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
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to maintain services necessary to maintain a sanitary, orderly, and comfortable interior. The deficient practice was identified for 3 of 3 shower rooms and 1 out of 5 residents investigated (Resident #9) under the Environmental Task. The deficient practice was evidenced by the following: On 01/04/2024 at 10:09 AM, Surveyor # 1 observed Resident # 9 in his/her room. At that time, Resident # 9 said housekeeping doesn't clean his/her room every day, and that there was	F 584	1. The paper towel in residents #9 room was immediately cleaned. The floor base was repaired. The trash can was cleaned and a trash liner was placed. The black substance was immediately cleaned. Paper towels were immediately cleaned up. The yellow stain was cleaned behind the sink immediately. The [redacted] stain was cleaned of the toilet immediately. The plunger in a bucket was removed, geriatric recliner chair, a pillow, a detached wooden door, a picture frame and a mechanical lift were removed. At that time, Surveyor #1 observed the whirlpool tub. Inside the whirlpool tub there were discolored stains, a beige	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 584	Continued From page 2 mold around the bottom of the toilet. At that time, Surveyor # 1 observed a crumbled paper towel on Resident # 9's floor next to the bed. Surveyor # 1 observed a detached floor baseboard exposing drywall. At that time, Surveyor # 1 then observed Resident # 9's bathroom. Surveyor # 1 observed the trash can. The trash can did not have a trash bag in it. Lastly, Surveyor #1 observed a black substance around the caulk on the bottom of the toilet. On 01/08/2024 at 09:41 AM, Surveyor # 1 observed Resident # 9's bathroom. At that time, the bathroom was observed with paper towels on the floor, a yellow stain on the wall behind the sink, and NJ Exec Order stains on the toilet and seat. On 01/05/2024 at 12:14 PM, Surveyor # 1 observed the shower room on B wing. At that time, Surveyor # 1 observed bath towels on the floor. Surveyor # 1 then observed the shower stalls. At that time, Surveyor # 1 observed a plunger in a bucket, geriatric recliner chair, a pillow, a detached wooden door, a picture frame and a mechanical lift. At that time, Surveyor #1 observed the whirlpool tube. Inside the whirlpool tub, Surveyor # 1 observed discolored stains, a beige strap, and a blue tube. On the same date and time outside the shower stall, Surveyor # 1 observed what appeared to be a wrapper from a feminine product on the top of a table. In another shower stall, Surveyor # 1 observed the top pump of a soap dispenser along with a bag of liquid soap on the top of a storage bin. Surveyor # 1 also observed water stains on two ceiling tiles. Lastly, Surveyor # 1 observed a broken electrical outlet plate on the wall.	F 584	strap, and a blue tube that were removed and cleaned immediately. The female product on top of the table outside the shower stall was cleaned and removed immediately. The soap bag and soap pump were removed and cleaned off the top of a storage bin. The electric plate was repaired immediately by maintenance. The clear bag with the clothing and the bag of briefs were removed and cleaned from the shower room on the sub-acute unit. The recliner chair, paper towels and briefs were removed immediately. The water fountain outside the therapy gym was cleaned immediately. The towel in the common bathroom and shower utilities located by the activity room was removed and cleaned immediately. The toilet was cleaned immediately and the wrappers, paper towels and face mask were removed. The base board behind the toilet was repaired. 2. All residents have the potential to be affected by this. 3.The US FOIA (b)(6) was educated on the importance of maintaining a clean homelike environment. The US FOIA (b)(6) was educated on following the cleaning protocols as well the maintaining the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 584	Continued From page 3 On 01/05/2024 at 12:24 PM, Surveyor # 1 observed the shower room on the subacute unit. At that time, Surveyor # 1 observed a tied, clear plastic bag that revealed what appeared to be clothing inside. Surveyor # 1 also observed an unpackaged incontinence brief on top of a storage bin in the shower stall. On 01/08/2024 at 9:44 AM, Surveyor # 1 again observed the B wing shower room. At that time, Surveyor # 1 observed the top pump of a soap dispenser on a table outside the shower. Surveyor # 1 observed paper towels on the floor in the bathroom area of the shower room. Lastly, Surveyor # 1 observed a geriatric recliner chair, a pillow, and several unpackaged incontinence briefs. On 01/08/2024 at 12:33 PM, Surveyor # 1 observed the water fountain near the physical therapy gym. At that time, Surveyor # 1 observed a discolored stain and unidentified residual matter from spout to drain. On 01/08/2024 at 11:38 AM, during interview with Surveyor # 1, Housekeeper (HK) # 1 said the resident rooms were cleaned once a day and as needed. At that time, HK # 1 replied, "sweeping, dusting, changing toilet papers and soaps, wipe down tables, AC [air conditioning] vents ..." when asked by Surveyor # 1 what room cleaning entails. He also mentioned bathrooms are done last. Secondly, HK # 1 said the shower rooms were cleaned daily at the beginning of the day. Lastly, HK # 1 replied, "Cleaning floors, picking everything off the floor, cleaning door knobs, sanitizing walls, changing soaps, bagging and removing linens ..." when asked by Surveyor # 1 what shower room cleaning entails.	F 584	cleaning schedules to ensure a homelike environment. The US FOIA (b)(6) was educated on the importance of ensuring their are no exposed areas of sheet rock and to ensure electric boxes are not exposed or cracked. 4.The housekeeping director, maintenance director and department will be responsible for conducting monthly audits x3 months in all areas that have the potential to have these deficient practices. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 584	Continued From page 4 On 01/08/2024 at 12:16 PM, during interview with Surveyor # 1, the [redacted] said the resident rooms were cleaned daily on day shift daily. He replied cleaning the bathrooms, surfaces, and walls when asked by Surveyor # 1 what cleaning a resident's room entailed. He concluded by saying that dust mop and wet mop were used on floors. On the same date and time during the same interview with Surveyor # 1, the [redacted] confirmed shower rooms are cleaned daily. At that time, The [redacted] stated "It should not look like that" when Surveyor # 1 made him aware of their observations. A review of an undated facility policy titled "SHOWER ROOM CLEANING POLICY" revealed under subsection titled, "PROCDURES" that, "B. Follow 7-Step Method: 1. Pull trash. Wipe can and if necessary, replace liner. 2. Fill Dispensers. Soap, paper, and etc. 3. Dust Mop. Pick up trash, use a dust mop before using water in the room." A review of an undated facility policy titled, "Environmental Services Guidelines" revealed under section, "Routine cleaning of horizontal surfaces" that "All horizontal surfaces such as tabletops, window ledges, bedside stands, counter, sinks, tubs, shower floors, etc. will be cleaned daily with an acceptable hospital-grade disinfectant/germicide ..." Also, the policy revealed under section "Trash" that " All trash collection containers will be lined with plastic bags to prevent leakage into the primary container and for the protection of the housekeeping staff during collection and transfer."	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 584	Continued From page 5 2. On 01/03/2024 at 09:47 AM, during initial tour of the Serenity Unit, Surveyor #2 observed a common bathroom and shower utilities located by the Activity Room. Surveyor #2 then observed a towel on top of the toilet. The towel had a [NJ Exec Order] stain on it. The toilet had [NJ Exec Order] stains inside. Surveyor #2 observed paper towels and toilet paper wrappers on the floor. A vinyl baseboard near the toilet was partially detached from the wall exposing the dry wall. On 01/08/2024 at 09:03 AM, Surveyor #2 observed the same common bathroom and shower area. Surveyor #2 then observed a towel on top of the toilet. The towel had a [NJ Exec Order] stain on it. The toilet had [NJ Exec Order] stains inside. Surveyor #2 observed paper towels, toilet paper wrappers, and surgical mask on the floor. A vinyl baseboard near the toilet was partially detached from the wall exposing the dry wall. At that time, the US FOIA (b)(6) followed Surveyor #2 to the common bathroom and shower area and stated that the area was actively utilized by residents, and that he/she would call someone to clean it.	F 584		
F 656 SS=E	N.J.A.C. 8:39-31.4(a) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 6 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, 1). it was determined	F 656	CORRECTIVE ACTION: On 1/5/2024, resident #46 medical record was reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 7 that the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical and nursing needs specifically by failing to include focuses and interventions for a NJ Exec Order 26.4b1 and 2). failing to implement Care Plan interventions for NJ Exec Order 26.4b1. The deficient practice was identified for 2 of 3 residents (Resident # 20 and # 90) investigated for NJ Exec Order 26.4b1 and 1 of 2 residents (Resident # 46) investigated for NJ Exec Orde The deficient practice is evidenced as follows: 1a). On 01/03/2024 at 10:36 AM during the initial tour of the facility, Surveyor # 1 observed Resident # 20 in his/her room. At that time, Surveyor # 1 observed a NJ Exec Order 26.4b1 [redacted] adjacent to the resident's bed. On 01/05/2024 at 09:22 AM, Surveyor # 1 observed Resident # 20 in his/her room. At that time, Surveyor # 1 observed the NJ Exec Order 26.4b1 set on top of a cardboard box adjacent to the resident's bed. At that time, Resident # 20 said he/she does receive NJ Exec Order 26.4b1 treatments and that the last time was the night before. Further, he/she said that he/she had NJ Exec Order 26.4b1 [redacted] A review of Resident # 20's Quarterly Minimum Data Set (MDS; and assessment tool) dated NJ Exec Order 26.4b1, revealed under section "I" that Resident # 20 had a diagnosis of but not limited to NJ Exec Order 26.4b1 [redacted]). A review of the list of facility residents who NJ Exec Order 26	F 656	by the DON for deficient practice. The NJ Exec Order 26.4b1 on the NJ Exec Orde was immediately applied. The resident did not have any NJ Exec Order 26.4b1 from the deficient practice. The computerized NJ Exec Order 26 was also reviewed and audited to ensure it matches the care plan for the NJ Exec Order 26.4b1 A 100% audit of NJ Exec Order 26 [redacted] was done by the DON on 1/5/2024 for the deficient practice with no further issues found. On 1/9/2024, residents #20, and #90 medical records were reviewed for the deficient practice. An immediate review of both residents care plans were completed and updated appropriately by the Director of Nursing (DON) with the deficient practice. IDENTIFICATION OF AT RISK RESIDENTS: All residents are potentially at risk for the deficient practice. This can be identified by reviewing the residents medical records and EMAR/ TAR. SYSTEMIC CHANGE: On 1/16/2024, the DON started an in-service for all nursing staff on the facility policy and the importance of following the residents plan of care as well as identifying and reporting discrepancies in a resident□s current plan of care to include, checking audible alarms at the start of every shift. Also, unit managers are being in serviced to initiate and/or update the residents care plan with medical diagnosis and interventions in a timely manner. The IDT will ensure that the care plans are completed in a timely manner, reviewed, and updated as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 8 NJ Exec Order 26.4b1 revealed that Resident # 20 was a NJ Exec Order 26.4b1 A review of the Electronic Medical Record (EMR) revealed that Resident # 20 had a diagnosis of but not limited to NJ Exec Order 26.4b1 A review of Resident # 20's Order Summary located in the EMR revealed a physician's order for NJ Exec Order 26.4b1 . According to the order, the NJ Exec Order 26.4b1 was to be administered through NJ Exec Order 26.4b1 every four hours as needed. The order became active in the EMR on NJ Exec Order 26.4b1. A review of Resident # 20's Care Plan located in the EMR revealed a focus that he/she is a NJ Exec Order 26.4 that was revised on NJ Exec Order 26.4b1 The interventions did not include any information regarding Resident # 20's NJ Exec Order 26.4b1, respiratory medications and/or diagnoses. In it's entirety at that time, the Care Plan did not include any focuses or interventions regarding Resident # 20's NJ Exec Order 26.4b1 status, NJ Exec Order 26.4b1 medications and/or diagnoses. A review of Resident # 20's progress notes located in the EMR revealed that on NJ Exec Order 26.4b1, he/she had a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . At that time, the US FOIA (b)(6) started Resident # 20 on NJ Exec Order 26.4b1 . A NJ Exec Order 26.4b1 was also ordered at that time that later revealed a, 'NJ Exec Order 26.4b1	F 656	necessary. All In services will be completed on 1/23/2024. QUALITY ASSURANCE: An audit tool was implemented, it includes checking the resident□s care plan and Kardex to match each other and contain all pertinent information needed to provide and meet the residents care goals and outcomes. The DON or designee will conduct these audits at random of 10 residents weekly x8 weeks, then bi-weekly x4 weeks, and then monthly x3 months. All findings of concern will be immediately addressed and reported to the Administrator as well as the Quality Assurance (QA)/QAPI committee quarterly for six months or until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 9 NJ Exec Order 26.4b1). On 01/09/2024 at 12:37 PM during an interview with the surveyor, the US FOIA (b)(6) stated, "If they have a diagnosis of NJ Exec Order 26.4b1] and NJ Exec Order 26.4 they should have a focus." During the same interview, the US FOIA (b)(6) replied, "In a timely manner. We review them quarterly." when the surveyor asked when a care plan should be implemented. A review of the undated facility policy titled, "Care Plans, Comprehensive Person-Centered" revealed under number, "7. The comprehensive, person-centered care plan:", "b. described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." § 8:39-11.2 (e)2 1b). During the initial tour of the facility on 1/3/2023 at 11:30 AM, Surveyor #2 observed Resident #90 in his/her room sitting on the bed. Surveyor #2 observed a NJ Exec Order 26.4b1 an with attached NJ Exec Order 26.4b1 and NJ Exec Order on Resident #90's nightstand. The NJ Exec Order 26.4b1 and NJ Exec O were not in use and exposed to air and contamination. On 1/4/2024 at 10:22 AM, Surveyor #2 observed Resident #90 sitting on his/her bed reading a magazine. The NJ Exec Order 26.4b1 were not in use and exposed to air and contamination. Resident #90 stated, "I am on NJ Exec Order 26.4b1 because my roommate NJ Exec Order 26.4b1 for NJ Exec Order 2 I have NJ Exec Order 26.4b1	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 10 once but will be tested again today." According to the Admission Record, Resident #90 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted]. According to the NJ Exec Order 26.4b1 Comprehensive Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, Resident #90 had a Brief Interview for Mental Status Score of NJ Exec indicating they were NJ Exec Order 26.4b1. Section I of the MDS revealed Resident #90 had an active diagnosis of NJ Exec Order 26.4b1 [redacted] According to section NJ of the MDS Resident #90 had NJ Exec Order 26.4b1 or NJ Exec Order 26 [redacted] A review of the Physician Order Summary Report (POS) located in the electronic medical record (EMR) revealed a physician's order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 [redacted] orally every 8 hours as needed for NJ Exec Order 26.4b1 [redacted] A review of Resident #90's NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed NJ Exec Order 26.4b1 was administered on the following dates: NJ Exec Order 26.4b1 [redacted]	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 11 A review of Resident #90's NJ Exec Order 26.4b1 MAR revealed that the NJ Exec Order 26.4b1 was administered on NJ Exec Order 26.4b1 A review of Resident #90's Care Plan date initiated NJ Exec Order 26.4b1 revised on NJ Exec Order 26.4b1, revealed that there were not any focus, goals or interventions for NJ Exec Order 26.4b1 diagnoses or NJ Exec Order 26.4b1 medications. A review of Resident #90's Care Plan located in the EMR, initiated on NJ Exec Order 26.4b1, revised on NJ Exec Order 26.4b1, revealed a focus on NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1. Interventions included NJ Exec Order 26.4b1, infection will resolve with no complications, wear a mask during care, monitor for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 assessment, and vital signs (temp) every shift. Surveyor #2 reviewed the progress notes (PN) located in the electronic medical record (EMR). According to a PN dated NJ Exec Order 26.4b1, Resident #90 complained of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The physician orders reveled that Resident #90 was started on NJ Exec Order 26.4b1 for 5 days for an NJ Exec Order 26.4b1 On 1/8/2024 at 11:10 AM, Surveyor #2 interviewed Licensed Practical Nurse Unit Manager (LPN/UM #2). The surveyor asked LPN/UM #2 what is the facility care plan process. LPN/UM#2 stated, "The baseline care plan is completed by the unit manager within 48hrs of admission. The comprehensive care plan is done by US FOIA (b)(6). Some areas that should be included are NJ Exec Order 26.4b1,	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 12	F 656		

certain medications, and [NJ Exec Order 26.4b1]." The surveyor then asked should there be a care plan for [NJ Exec Order 26.4b1] diagnoses. LPN/UM #2 stated, "Yes, if the resident has [NJ Exec Order 26] or [NJ Exec Order 26.4b1] treatments there should be a care plan for it." The surveyor then asked if Resident #90 had any [NJ Exec Order 26.4b1] issues/diagnoses. LPN/UM #2 stated, "Resident #90 was admitted with a diagnosis of NJ Exec Order 26.4b1 but isn't on [NJ Exec Order 26.4] I do see an order for a NJ Exec Order 26.4b1 every 8 hours as needed. They should have a care plan for the NJ Exec Order 26.4b1. It should have been added to the care plan by either the US FOIA (b)(6) [redacted]."

On 1/8/2024 at 11:33 AM, Surveyor #2 conducted an interview with the US FOIA (b)(6). The [US FOIA (b)] [redacted] stated, "The baseline care plan is completed by the US FOIA (b)(6) upon admission. I complete all the initial care plans for the [NJ Exec Order 26.4b1] unit. If a resident is admitted with a [NJ Exec Order 26.4b1] diagnosis, then I will add a care plan for [NJ Exec Order 26.4b1] such as [NJ Exec Order 26.4] The MDS coordinator further explained, "If a [NJ Exec Order 26.4b1] treatment or [NJ Exec Order 26] is ordered after the initial care plan is created by me then the US FOIA (b)(6) is responsible for adding it to the care plan." The surveyor then asked if [NJ Exec Order 26.4b1] treatments should be included in the resident's care plan. The US FOIA (b)(6) stated, "Yes, they should be."

On 1/9/2024 at 12:37 PM during an interview with the surveyors, the US FOIA (b)(6) [redacted] stated, "If they have a diagnosis of [NJ Exec Order 2] and or [NJ Exec Order 26.4b] they should have a focus on the care plan. There is not a specific care plan for the use of a [NJ Exec Order 26.4b1] If we do a review of the care plan, we can add it." The surveyor then asked when a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 13	F 656		

care plan should be implemented. The [US FOIA (b)(6)] replied, "In a timely manner. We don't have a specific date or time frame. We review them quarterly."

The surveyor reviewed the facility policy titled Care Planning - Interdisciplinary Team, undated. The following was revealed under the heading, Policy Interpretation and Implementation:

1. "Resident care plans are developed according to the timeframes and criteria established by 483.21."

The surveyor reviewed the facility policy titled Care Plans, Comprehensive Person-Centered, undated. The following was revealed under the heading, Policy Interpretation and Implementation:

12. "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change."

N.J.A.C. 8:39-11.2 (e)2

3. On 01/04/2024 at 12:39 PM, Surveyor #3 observed Resident #46 in the [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b] Unit. Resident #46 was in his/her chair. Surveyor #3 did not observe an [NJ Exec Order 26.4b1] being used for this resident.

On 01/05/2024 at 09:15 AM, Surveyor #3 observed Resident #46 in the [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b] Unit. Resident #46 was sitting in his/her chair. Surveyor #3 did not observe an [NJ Exec Order 26] being used for this resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 14 On 01/05/2024 at 09:28 AM, Surveyor # 3, in the presence of the US FOIA (b)(6), checked Resident # 46's chair and did not observe any NJ Exec Order 26.4b1. At that time, the US FOIA (b)(6) stated, "Oh yeah, there should be NJ Exec Order 26.4b1. It's usually right here [pointing at the back of the chair]. Let me double check." The US FOIA (b)(6) checked the chair one more time and stated, "It's not there, but it should." A review of Admission Record found in the Electronic Medical Record (EMR) revealed that Resident #46 had diagnoses, including but not limited to NJ Exec Order 26.4b NJ Exec Order 26.4b of NJ Exec Order 26.4b1 [redacted]. A review of Resident #46's Quarterly Minimum Data Set (MDS; an assessment tool) dated NJ Exec Order 26.4b1 revealed that the resident had a Brief Interview for Mental Status (BIMS; a screening tool) score of NJ Ex /15 indicating NJ Exec Order 26.4b1 Further, the MDS revealed that Resident #46 had a previous NJ Exec Order 26.4b1 and used NJ Exec and NJ Exec Order 26.4b1 on daily basis. A review of Physician's Orders found in the EMR revealed an order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 and function every shift for NJ Exec Order 26.4b1." A review of Resident #46's Care Plan (CP) initiated on NJ Exec Order 26.4b1 and revised on NJ Exec Order 26.4b1 revealed "Focus: [Resident's name] is	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 15 at risk for [redacted] r/t [related to] [redacted] and [redacted]." Furthermore, the same CP revealed an intervention of 'NJ Exec Order 26.4b1 check placement and function" initiated on NJ Exec Order 26.4b1. A review of the Treatment Administration Record (TAR) found in the EMR for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 indicated that the [redacted] was being checked for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every shift. A review of Quarterly NJ Exec Order 26.4b1 Risk Evaluation" dated NJ Exec Order 26.4b1 revealed that Resident #46 scored [redacted] which indicated [redacted] On 01/08/2024 at 09:20 AM, during an interview with surveyor #3, a Certified Nurse Aide (CNA #1) stated, "Yes, [he/she] has both" when asked if Resident #46 was using NJ Exec Order 26.4b1. Furthermore, CNA #1 stated, "Yes, if [he/she] is in bed, we put the NJ Exec Order 26.4b1 for [him/her]; and when he/she is out of bed, he/she should have the [redacted] when asked by Surveyor #3 if Resident #46 should use the [redacted] at all times. During the same interview, CNA #1 also said that it was important to use NJ Exec Order 26.4b1 for Resident #46 because it prevented him/her from [redacted] and related [redacted] On 01/08/2024 at 10:45 AM, during an interview with Surveyor #3, a Licensed Practical Nurse/Unit Manager (LPN/UM #1) said that interventions such as an NJ Exec Order 26.4b1 required a physician's order and had to be added to the CP. Furthermore, LPN/UM #1 said that it was expected of nurses and CNAs to apply [redacted]	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 16 NJ Exec Order 26.4b LPN/UM #1 stated, "So they don't NJ Exec It gives us a chance to get to them before they NJ Exec when asked by Surveyor #3 why it was important to apply NJ Exec Order 26.4b1 as per physician's order and care plan. On 01/09/2024 at 12:37 PM, during an interview with Surveyor #3, the US FOIA (b)(6) stated, "Yes" when asked if care planned interventions such as an NJ Exec Order 26.4b1 should be implemented in practice by appropriate staff. Furthermore, the US FOIA (b) said that nurses and CNAs were responsible for application of NJ Exec Order 26.4b1 and that Resident #46 should have had the NJ Exec Order2 applied while out of NJ Exec in his/her NJ Exec Orde Lastly, the US FOIA (b) stated, "It was intervention because of his/her history of NJ Exec Or to prevent him/her from any NJ Exec and NJ Exec Order 26 related to a potential NJ Exec It allows us to respond to the resident before they NJ Exec when asked by Surveyor #3 about the importance of NJ Exec Order 26.4b1 application for Resident #46. A review of facility provided undated policy titled, "Care Plans, Comprehensive Person-Centered" revealed under number four that "Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including right to ... receive the services and/or items included in the plan of care." A review of facility provided undated policy titled, "Resident Alarms" revealed under the subsection titled, "Monitoring and modification" that "b. When alarms are utilized, additional monitoring shall be provided, including but not limited to i) verifying	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 656	Continued From page 17 alarms are used in accordance with the resident's care plan." N.J.A.C. 8:39-27.1(a)	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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 pertinent facility documents it was discovered that the facility failed to a.) follow professional standards of practice specifically by not changing [redacted] weekly and as needed, and b).failed to maintain [redacted] equipment in a sanitary manner and follow their policy and procedure for [redacted] equipment care. The deficient practice was identified for 2 of 3 residents (Resident #20 and #90) investigated for [redacted] Care. The deficient practice was evidenced by the following: a.) On 01/03/2024 at 10:36 AM during the initial tour, Surveyor # 1 observed Resident # 20 in his/her room. At that time, Surveyor # 1 observed	F 695	CORRECTIVE ACTION: On 1/5/2024, residents #20 and # 90 medical records were reviewed by the Director of Nursing (DON) for the deficient practice. The [redacted] for the identified residents were replaced, dated, and stored in a [redacted] dated bag. Both residents did not have any [redacted] deficient practice. On 1/5/2024, The DON and Unit Managers conducted a [redacted] audit on all residents receiving respiratory treatments to ensure that supplies are labeled, dated and properly stored. No issues were found from the audit. IDENTIFICATION OF AT RISK RESIDENTS: All resident receiving respiratory treatments are potentially at risk for the deficient practice. This can be	2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 695	Continued From page 18 a [NJ Exec Order 26.4b1] set on top of a cardboard box adjacent to the resident's bed. The [NJ Exec Order 26.4b1] had a [NJ Exec O] connected to it and at the other end was a [NJ Exec Order 26.4b1]. The [NJ Exec O] had tape attached to it that revealed the hand written date of "[NJ Exec Order 26.4b1] On 01/05/2024 at 09:22 AM, Surveyor # 1 observed Resident # 20 in his/her room. At that time, Surveyor # 1 observed the [NJ Exec Order 26.4b1] set on top of a cardboard box adjacent to the resident's bed. The [NJ Exec Order 26.4b1] had a [NJ Exec Order 26.4b1] to it and at the other end was a [NJ Exec Order 26.4b1]. Again, the [NJ Exec O] had tape attached to it that revealed the hand written date of [NJ Exec Order 26.4b1]" At that time, Resident # 20 said he/she does receive [NJ Exec Order 26.4b1] treatments and that the last time was the night before. A review of Resident # 20's Quarterly Minimum Data Set (MDS; and assessment tool) dated [NJ Exec Order 26.4b1], revealed under section "[NJ E]" that Resident # 20 had a diagnosis of but not limited to [NJ Exec Order 26.4b1 [redacted]]. A review of Resident # 20's Order Summary located in the EMR revealed a physician's order for [NJ Exec Order 26.4b1 [redacted]]. According to the order, the [NJ Exec Order 26.4b1] was to be administered through [NJ Exec Order 26.4b1] every four hours as needed. The order became active in the EMR on [NJ Exec Order 26.4b1] A review of Resident # 20's [NJ Exec Order 26.4b1] Medication Administration Record (MAR) located in the EMR	F 695	identified by reviewing the residents electronic medical records (EMAR). SYSTEMIC CHANGE: On 1/12/2024, the DON/designee initiated in-services for all licensed nurses on the following (1) the oxygen tubing facility policy/procedures and expectation to date and change respiratory supplies weekly and record on the Electronic Treatment administration Record (ETAR) upon admission or re-admission into the facility; (2) requiring a Physician order for respiratory supply change weekly, and PRN and transcribed to the ETAR; (3) moreover, making sure that respiratory supplies, to include respiratory bag changes are completed weekly and PRN and documented on the ETAR. In-services will be completed on 1/22/2024. QUALITY ASSURANCE: Unit Managers/Supervisors or designee will audit all residents who require respiratory care daily for 4 weeks, then weekly for 4 weeks, and then bi-weekly for 16 weeks, to ensure weekly respiratory supply changes are documented on the ETAR with the specific day of the week according to the physician order. The labeling of respiratory supplies will include the date of change, resident□s room number, and a change of the storage bag. Also, a review of completed admission/re-admission charts for residents requiring respiratory care ensuring the order has been documented for respiratory supply changes weekly and PRN to the physician order and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 695	Continued From page 19 revealed that the NJ Exec Order 26.4b1 was administered at least four times since NJ Exec Order 26.4b1 [redacted] On 01/05/2024 at 11:35 AM, during an interview with Surveyor # 1, Licensed Practical Nurse (LPN) #1 said NJ Exec Order 26.4b1 is changed once a week, every Sunday during the 11 PM-7 AM shift. On 01/09/2024 at 12:37 PM during an interview with Surveyor # 1, the US FOIA (b)(6) [redacted]) replied, "Weekly" when asked how often NJ Exec Order 26.4b1 [redacted] is changed. The US FOIA (b) replied, "No" when asked should NJ Exec Order [redacted] remain on the NJ Exec Order 26.4b1 past seven days. A review of the undated facility policy titled, "Nebulizer Therapy" revealed under subsection, "Care of Equipment" to, "8. Change nebulizer tubing weekly and as needed." b.) During the initial tour of the facility on 1/3/2023 at 11:30 AM, Surveyor #2 observed Resident #90 in his/her room sitting on the bed. Surveyor #2 observed the nebulizer machine with attached face mask and tubing on Resident #90's nightstand. The nebulizer tubing and face mask were not in use and exposed to air and contamination. On 1/4/2024 at 10:22 AM, Surveyor #2 observed Resident #90 sitting on his/her bed NJ Exec Order 26.4b1 [redacted] The NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were not in use and exposed to the air and contamination. According to the Admission Record, Resident #90 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted]),	F 695	transcribed to the ETAR. Any issues from the audit will be addressed immediately and reported to the administrator as well as the QA/QAPI committee quarterly for 6 months or until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 695	Continued From page 20	F 695		

NJ Exec Order 26.4b1).

According to the NJ Exec Order 26.4b1 Comprehensive Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, Resident #90 had a Brief Interview for Mental Status Score of NJ Exec indicating they were NJ Exec Order 26.4b1. Section NJ of the MDS revealed Resident #90 had an active diagnosis of NJ Exec Order 26.4b1 According to section NJ of the MDS Resident #90 had NJ Exec Order 26.4b1 or NJ Exec Order 26 NJ Exec Order 26.4b1

A review of Resident #90's Physician Order Summary Report (POS) located in the electronic medical record (EMR) revealed a physician's order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 every 8 hours as needed for NJ Exec Or).''

A review of Resident #90's NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed NJ Exec Order 26.4b1 was administered on the following dates: NJ Exec Order 26.4b1

A review of Resident #90's NJ Exec Order 26.4b1 MAR revealed that the NJ Exec Order 26.4b1 was administered on NJ Exec Order 26.4b1

On 1/8/2024 at 9:48 AM, Resident #90 was in the bedroom sitting on the bed. Resident #90's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9 OCEAN VIEW, NJ 08230**

(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 695	Continued From page 21 NJ Exec Order 26.4b1 was located on the nightstand and the NJ Exec Order 26.4b1 was observed in a plastic zip lock type bag. The NJ Exec Order 2 was dated NJ Exec Or" Resident #90 told the surveyor, "I have been using my NJ Exec Order 26.4b1 for treatments twice a day." Surveyor #2 reviewed a physician's order located in the EMR dated NJ Exec Order 26.4b1 to "change NJ Exec Order 26.4b1 NJ Exec Order 2 weekly on Sundays, 11-7 shift." On 1/8/2024 at 11:03 AM Surveyor #2 interviewed Licensed Practical Nurse (LPN #2). LPN #2 stated, 'NJ Exec Order 26.4b1 is NJ Exec Order 26.4b1 and labeled every Sunday. It gets placed in a bag and is labeled as well. It gets NJ Exec Order 26.4b every 7 days." The surveyor then asked LPN#2 what happens when the NJ Exec Order 26.4b1 is not in use. LPN #2 replied, "When the NJ Exec Order 26.4b1 is not in use, the NJ Exec Orde should be stored in the bag." On 1/9/2024 at 12:38 PM the surveyor conducted an interview with the facility US FOIA (b)(6) . The surveyor asked what the policy and procedure is for storing the NJ Exec Order 26.4b1 when not in use. The US FOIA (b) stated, "The NJ Exec Orde should be protected when not in use. It should be placed in a bag." The surveyor reviewed an undated facility policy titled, "Nebulizer Therapy". The following was revealed under the heading, "Care of Equipment": "7. Once completely dry, store the nebulizer cup and mouthpiece in a secure bag." "8. Change nebulizer tubing weekly and as needed." N.J.A.C 8:39-27.1 (a)	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility records, it was determined that the facility failed to accurately implement a physician prescribed [redacted] order for 1 of 1 resident (Resident #91) on 1 of 3 units ([redacted] reviewed for [redacted] This deficient practice was evidenced by the following: On 01/04/2024 at 09:40 AM the surveyor observed Resident #91 observed in their room after completion of their [redacted]. Resident #91 was lying in bed. When asked by the surveyor how their [redacted] was Resident #91 responded, [redacted]." Resident #91 suspected he/she had [redacted]. According to the admission record, Resident #91 was admitted to the facility with the following but not limited to diagnoses: [redacted] According to the Resident Assessment Instrument/Minimum Data Set (MDS), an assessment tool, dated [redacted], Resident #91	F 698	CORRECTIVE ACTION: Resident #91 medical record was reviewed and corrected for deficient practice. The resident did not have [redacted] from the deficient practice. 0n 1/9/24 a 100% audit was done by the Director of Nursing (DON) for the deficient practice, no issues were found from the audit. [redacted] was immediately updated with [redacted] to reflect [redacted] order. IDENTIFICATION OF AT RISK RESIDENTS: All residents receiving dialysis treatment on fluid restrictions are at risk for this deficient practice. This can be identified by reviewing the resident medical records or medication administration records. SYSTEMIC CHANGES: On Januuary12, 2024 an in-service began by the Director of Nursing for all nursing staff to review dietary slips upon serving meal trays to ensure accurate documentation of diet orders. Secondly, the facility implemented	2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 698	Continued From page 23 had a Brief Interview for Mental Status score of [redacted] out of 15, indicating [redacted] Section GG of the MDS revealed that Resident #91 was an [redacted] and required [redacted] or [redacted] with most other activities of daily living. Section [redacted] indicated an active diagnosis of [redacted]. In addition, Section [redacted] revealed Resident #91 received a [redacted] and Section [redacted] of the MDS revealed Resident #91 received [redacted] on admission and while a resident at the facility. Review of the Order Summary Report with active orders as of: [redacted], revealed Resident #91 had the following physician order: '[redacted], every shift for [redacted]. Order Date: [redacted]" Review of the [redacted] Medication Administration Record (MAR) revealed that Resident #91 had documentation of receiving nursing [redacted] shift of [redacted] from [redacted] evening shift up to and including [redacted] day shift. A review of Resident #91's comprehensive care plan revealed a care plan focus of '[redacted] r/t (related to) [redacted] Date Initiated: [redacted] and Revision Date: [redacted]." The following Intervention(s) were observed: [redacted], [redacted]). Date	F 698	a process of communication documentation to the dietary department to include a signature of the nurse delivering the diet slip to the kitchen and the dietary staff receiving the diet slip to ensure compliance and regulatory requirements. All in-services and education will be completed on 1/22/2024. QUALITY ASSURANCE: The DON or designee will do an audit of a random 10 residents diet slips weekly for 8 weeks, then bi weekly for 4 weeks, and then monthly for 3 months. Any findings from the audit will be addressed immediately and will be reported to the Administrator and to the QA/QAPI committee quarterly for six months or until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 698	Continued From page 24 Initiated [redacted]." On 01/04/2024 at 12:56 PM the surveyor observed Resident #91 at the [redacted] served in their room. After gaining permission, the surveyor reviewed Resident #91's [redacted] ticket. The [redacted] ticket indicated that Resident #91 was to receive a [redacted] for the [redacted] Resident #91 received [redacted] Resident #81 consumed [redacted]) Resident #91 stated, "I ate [redacted] because I got [redacted] today." Further review of Resident #91's [redacted] did not reflect any [redacted] for the [redacted] or that Resident #91 in fact had a [redacted]. On 01/05/2024 at 12:45 PM the surveyor reviewed the week 2 Friday lunch menu. The menu revealed the following: Lemon dill tilapia filet or rotisserie chicken thigh, broccoli florets or green peas, roasted red skin potatoes or seasoned rice, dinner roll/bread/margarine, and pineapple tidbits. The surveyor then observed Resident #91's lunch tray. The tray consisted of [redacted] Resident #91 received [redacted] and [redacted]. Review of Resident #91's [redacted] ticket on the tray did not indicate that Resident #91 was on a [redacted] On 01/09/2024 at 11:22 AM during a review of the electronic medical record (EMR) the surveyor observed that Resident #91 had the following	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 698	Continued From page 25	F 698		

progress note:

'[NJ Exec Order 26.4b1redacted] 14:22 General Nurse Note Note Text: New orders received from [redacted] to discontinue [NJ Exec Order 26.4b1redacted] as resident gets [redacted]. Continue taking [redacted] in the morning on Tues, Thurs, Sat. Resident to start [redacted]. and to take 2 tablets of [redacted], with the NJ Exec Order 26.4b1, 7 days a week. [redacted] aware"

On 01/09/2024 at 11:34 AM the surveyor conducted an interview with the facility [redacted] The surveyor asked the [redacted] how she is notified when a resident is placed on a [redacted]. The [redacted] responded, "Nursing brings a [redacted] to me alerting that a resident is on a [redacted]." The surveyor asked the [redacted] if she currently had any residents in the facility on a [redacted]. The [redacted] said, "I don't think I do have anybody on a [redacted] at this time." The [redacted] replied, "According to [redacted] (a computer system used to keep track of resident [redacted] prescriptions and generate meal plan tickets) I do not have any resident on a [redacted] at this time." The surveyor then asked the [redacted] if she currently had Resident #91 on a [redacted]. The FSD stated, "I do not have that Resident #91 is on a [redacted]. I will have to pull my requisitions from the month of [redacted] The [redacted] then told the surveyor, "I checked my requisitions from the month of [redacted] and I have no requisition form to indicate that Resident #91 was on a [redacted]"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 698	Continued From page 26 On 01/09/2024 at 12:30 PM the [US FOM] provided the surveyor with copies of Resident #91's [NJ Exec Orde] plan [NJ Exec Order 2] for the NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1. The [NJ Exec Order 26.4b1] did not indicate that Resident #91 was on a [NJ Exec Order 26.4b1] of [NJ Exec Order 2] from [NJ Exec Order 26.] On 01/09/2024 at11:46 AM the surveyor conducted an interview with Licensed Practical Nurse (LPN #3) and LPN (#4) who were assigned to Resident #91's unit. The surveyor asked the LPN's the process for implementing the physician ordered [NJ Exec Order 26.4b1] for Resident #91. The LPN's replied, "We have a certain amount of [NJ Exec O] from nursing and from [NJ Exec Order 26] which is [NJ Exec Order 26.] from NJ Exec Order 26.4b1 per shift from nursing. [NJ Exec Order 26] gets notified via a [NJ Exec O] form from nursing that is sent to the kitchen. Nursing is responsible for notifying [NJ Exec Order 2] of any changes in [NJ Exec O] and [NJ Exec Order 26.4b1] via the use of the [NJ Exec Order 26.4b1] form." LPN #4 then stated that [NJ Exec Order 26] recommended the [NJ Exec O] be implemented for Resident #91. LPN #4 then provided the surveyor with a copy of Resident #91's [NJ Exec Order 26.4b1] Form, dated [NJ Exec Order 26.4b1]. The form indicated that Resident #91 was on a [NJ Exec Order 26.4b1] with a [NJ Exec Order 26.4b1] and a nursing total of [NJ Exec O]. LPN #4 then told the surveyor, "The only way [NJ Exec Order 2] would be aware of a resident being on a [NJ Exec Order 26.4b1] is if nursing issues the kitchen a requisition to notify [NJ Exec Order 26.4b1] of a [NJ Exec Order 26.4b1]." The surveyor reviewed the facility provided policy titled Fluid Restriction, reviewed, and updated - May 2021. The following was revealed under the heading Policy Statement: " It is the policy of this	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 698	Continued From page 27 facility to provide fluid restriction as ordered by the physician." In addition, the policy revealed the following under the heading Policy Interpretation and Implementation: "The Nursing Department will notify the Dietary Department of the fluid restriction order." "The fluids will be distributed over breakfast, lunch and dinner meals and documented on the tray card." "Supervision at tray line will assure accuracy of fluid restriction by the dietary department." N.J.A.C. 8:39-27.1 (a)	F 698		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 812	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 01/03/2024 from 9:34 to 10:12 AM, the surveyors, accompanied by the US FOIA (b)(6) observed the following in the kitchen: 1. The meat slicer on a stainless steel counter was observed to be cleaned/sanitized and covered while not in use. The US FOIA (b) confirmed that the meat slicer was cleaned, sanitized, and not in use. Further observation of the underside of the slicing wheel/ blade revealed brown unidentified food debris on the bottom of the blade guard. The US FOIA (b) stated, "The meat slicer needs to be re-cleaned." US FOIA (b) then directed a staff member to clean the meat slicer. 2. In the walk-in freezer a container of breakfast gravy was observed on a middle shelf. The label read, "Prepared 11/22. Use by date 12/22." The US FOIA (b) stated, "It was dated incorrectly, and it should be good for 90 days." 3. On an upper shelf a previously opened package of frozen bacon was wrapped in clear plastic wrap had no dates. The US FOIA (b) stated, "We are throwing it away because there is no date." 4. The outside walk-in freezer had unidentified debris littered on the floor. There was a plastic curtain from the door entrance lying on the floor.	F 812	. During the walkthrough of the kitchen on 01/02/24 multiple items were found out of compliance. a. Meat slicer underside was found to have debris, which the account manager cleaned and covered immediately. b. A pan of sausage gravy found with out of date, the product was labeled for 30 days incorrectly, Manager disposed of immediately. c. Open bacon strips found with no label or date, Manager disposed of product immediately d. Outside walk-in freezer had debris, manager cleaned immediately e. Wall and floor adjacent to the handwashing sink found to be dirty and have debris, Manager cleaned walls and floors immediately. f. Serenity floor pantry refrigerator was found to have multiple items not properly labeled and dated, Manager discarded all products immediately 2. All residents have the potential to be affected 3. Center dining will be educated by the dining services management team on the process for a. Dating, labeling, adherence to cleaning assignments.. b. Center Registered Dietician and Dining Services Management will review and complete	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 812	Continued From page 29 The [US FOIA (b)] stated, "I cleaned the floors [NJ Exec Order 26.4b1] ago. We have a cleaning schedule for it, but I ran out of the cleaner." On 01/05/2024 from 10:35 to 10:53 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN #5) observed the following in the Serenity pantry: 1. On the second shelf of the refrigerator a red cup with pudding inside had no dates. 2. An unidentified '[NJ Exec Order 26] paper wrapped item was on the bottom shelf of the pantry refrigerator. The item had no name or date on it to identify who it belonged to and when it was placed in the refrigerator. LPN #5 stated, "Residents leftovers should be labeled with their name and the date. I will toss the items that do not have a name or date on them." On 01/05/2024 from10:38 to10:50 AM the surveyor, accompanied by LPN #6, made the following observations on the B-Wing Pantry: 1. A '[NJ Exec Order 26.4b1] Bacon, Egg, & Cheddar" sandwich in the freezer had a manufacturer's "Best By: 10/04/2023". On the inside door of the refrigerator a quart container of Vanilla Spice Flavored Egg Nog had a manufacturer's "Best By date of Dec 28 23." In the unlocked bottom drawer of the refrigerator, a take-out style container with a clear plastic lid contained unidentified food. The container had no name and no date. On interview LPN#5 told the surveyor, "Everybody is responsible for monitoring the refrigerator. I'm going to throw these in the trash bin."	F 812	100% audit of dating and labeling of food in the kitchen and in the pantry room fridges/freezers. c. Dining services Management will review and complete 100% audit of the walk in floor to ensure the cleaning assignments are followed weekly and the floor is clean. 4. The dining management team will complete 5 random audits for dating, labeling, and cleaning assignment adherence for x4 weeks to begin 1/22/24, then bi-weekly x2 weeks, then monthly x1 month. 5. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee that meets Quarterly for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Food service director/District manager will be responsible for implementation of the plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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 812	Continued From page 30 On 01/09/24 from 10:04 AM to 10:38 AM the surveyors accompanied by the [redacted] observed the following in the kitchen: 1. The wall adjacent to the designated handwashing sink in the break down room/area, which is located next to the ice machines external scoop holder had an unidentified yellow substance/splash stain down the wall. There was unidentifiable black debris, an old mouse trap, and butter and creamer containers littering the floor near a floor drain. The [redacted] agreed that the break down area needed to be cleaned. The [redacted] stated, "This area is on the current cleaning schedule, and it should be deep cleaned once a week. It should be wiped down daily and any visible debris should be swept up." The [redacted] swept and mopped the area and scrubbed the wall area in the presence of the surveyors. According to the cleaning schedule provided to the surveyors from the [redacted] the "PM Cook 2" is responsible to sweep and mop the walk-in cooler and freezers on Tuesdays. A review of the kitchen cleaning schedule for the week ending "12/23/23" provided to the surveyors from the [redacted] revealed that they cleaned the "break down area" from the hand sink to the cooler was completed on 12/23/23 and initialed off by staff. The surveyor reviewed the facility policy titled Food Storage: Cold Foods, HCSG Policy 019, revised 2/2023. The following was revealed under the heading Procedures: 5. "All foods will be stored wrapped or in covered	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9 OCEAN VIEW, NJ 08230**

(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 812	Continued From page 31 containers, labeled and dated, and arranged in a manner to prevent cross contamination." The surveyor reviewed the facility policy titled Equipment, HCSG Policy 027, revised 9/2017. The following was revealed under the heading Procedures: 1. "All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials." 3. "All food contact equipment will be cleaned and sanitized after every use." The surveyor reviewed the facility policy titled Foods Brought in by Family/Visitors, undated. The following was revealed under the heading Policy Interpretation and Implementation: "Perishable foods must be stored in re-usable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date." "The nursing staff will discard perishable foods on or before the "use by" date." N.J.A.C. 18:39-17.2(g)	F 812		

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
	060505	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 interview and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 8 of 14-day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "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	S 560	S560 CORRECTIVE ACTION: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, facility will utilize staffing agencies to fill any open spots in the schedule. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents have the potential to be at risk for deficient practice. SYSTEMIC CHANGE: The facility has contracted with a new portal online to hire more facility staff. Hiring and recruitment	2/14/24

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

Electronically Signed | 01/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060505	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: 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. As per the "Nursing Staffing Report" completed by the facility for the weeks of 12/17/2023 to 12/30/2023 and other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 8 of 14 day shifts as follows: -12/17/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/19/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/21/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/23/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -12/24/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs.	S 560	efforts including wage analysis and adjustments, pay for experience, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. Open shifts are posted in advance for facility staff and agency staff to pick up to help comply with staffing ratios. Bonuses are offered to facility staff and agency staff to incentivize working open shifts. Ongoing job fairs held to continue the effort to find and retain staff. Most recent job was scheduled on February 12th 2024 in addition to meeting with a nursing school and their students. Facility has teamed up with multiple new agencies in an effort to meet staffing ratios appropriately. In addition, the Director of Nursing will meet daily with the staffing coordinator to ensure appropriate staffing. QUALITY ASSURANCE: The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. Findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly until compliance is met. The QA/QAPI Committee meets quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060505	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -12/25/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/26/23 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/28/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. During an interview with the surveyor on 01/08/2024 at 12:15 PM, the Staffing Coordinator (SC) stated she was aware of the staffing mandates for CNA's as followed: 1 CNA to 8 residents on day shift, 1 CNA to 10 residents on evening shift, and 1 CNA to 14 residents on night shift. The SC further stated that at the end of each day, on paper, every day, our ratios are met. It all falls apart when we get call outs, that's the problem. Just today, I received 4 call outs. It's an ongoing challenge. During an interview with the surveyor on 01/10/2024 at 11:20 AM, the Director of Nursing (DON) stated that she knows the staffing ratio requirements for CNA's: on days 1:8, evenings 1:10, and on nights 1:14. We do everything we can to staff our facility; we use nurses to cover CNA's assignments, we use agencies, we offer bonuses, shift differentials, and we recruit from CNA schools. A review of an undated facility policy titled, "Staffing," included, "Licensed nurses and certified nursing assistance are available 24 hours a day to provide direct resident care services. -One CNA to every eight residents for the day shift. -One direct care staff member (RN, LPN, or CNA) to every 10 residents for the evening shift; and -One direct care staff member (RN, LPN, or CNA) to every 14 residents for the night shift.	S 560		

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
	060505	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

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
315179 Y1	A. Building B. Wing Y2	2/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

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 F0584	Correction	ID Prefix F0656	Correction	ID Prefix F0695	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(i)	Completed
LSC	02/14/2024	LSC	02/14/2024	LSC	02/14/2024
ID Prefix F0698	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	02/14/2024	LSC	02/14/2024	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
1/10/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060505 Y1	A. Building B. Wing Y2	2/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/14/2024	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	
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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/10/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
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 01/04/24, 01/05/24 and 01/08/24, Autumn Lake Healthcare at Oceanview 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 Occupancies. Autumn Lake Healthcare at Oceanview is a one-story building with (4) four lower level boiler rooms. The facility has an attached assisted living wing and a (staff-only) 2 story house, both areas were observed to have 2-hour seperations with 90 minute doors. The facility is about 83,000 square feet in size. There are 4-generators: 2 of 4 generators were fueled by "natural gas" and 2 of 4 by diesel. The generators do approximately 60% of the facility as per the (new) US FOIA (b)(6) . Generator #1 (annex) located: outside in front lot next to the Parsonage. (old yellow house) Emergency Power to "A" unit nursing Generator #2 (administration) located: boiler room #3/mechanical room, next to dietary office. Emergency power to residential and administration (including dietary, accounting and halls) Generator #3 (B-wing) located: boiler room #4	K 000		

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

Electronically Signed | 01/21/2024

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
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 000	Continued From page 1 Mechanical room under Laundry "B". Emergency power to "B" unit nursing (starting at the end of West Hall, "A" unit, at the top of the ramp). Generator #4 located outside door #2, "B" unit, in the back field behind the fence. Emergency power to the septic system only. The facility provided a document from BOCA: indicating the facility is 5-A and NFPA converts that to: Type V (111) protected combustible construction. The facility was constructed in the 80"s and is divided into 8 smoke zones. The facility has 120 licensed beds and currently is occupying 96. The fire sprinkler system water is supplied by an exterior above ground water tank.	K 000		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8.	K 131		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 131	Continued From page 2 o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/04/24, in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.3.3* between the AL and the LTC facility. The deficient practice could affect all residents. This deficient practice was evidenced by the following: At 12:39 PM, the Surveyor, US FOIA (b)(6), observed the set of doors from the long term care facility to the assisted living section of the building. The doors were labeled each on top of each door with a 90 minute protection rating. The ceiling tiles were removed to inspect if the building had a 2-hour fire resistance rating above the doors. The observation indicated the opening from LTC to AL was missing fire rated wall board, exposing untreated wood beams from LTC to AL leaving the section with less then the required 2-hour seperation. The findings were verified by the US FOIA (b)(6) [redacted]	K 131	1. The 2-hour fire resistant rated element was repaired with the correct 2-hour fire rated material between the Assisted Living and Nursing Home. 2. All residents and staff personnel have the potential to be affected by this 3. The Maintenance department and US FOIA (b)(6) were educated by the Regional Administrator on the importance of not having any areas of less than the two-hour fire rated requirement for potential penetration. 4. the maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 131	Continued From page 3 US FOIA (b)(6) at the time of the observation. It was noted that the US FOIA (b)(6) was cutting wall board to install above the doors as he was aware the 2-hour fire seperation was not met. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 01/08/24. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.1.3.4.	K 131	assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)	K 161		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 161	Continued From page 4 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 01/04/24, in the presence of the US FOIA (b)(6) [redacted], a). it was determined that the facility failed to provide an acceptable construction type and wall-ceiling assembly in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1. b). it was determined that the facility failed to provide acceptable construction standards in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6. This deficient practice was evidenced by the following: a). An interview was conducted at 09:45 AM, during the entrance conference with the [redacted] who provided floor plans of the facility main floor. The floor plans were observed, but did not include 3 of 3 partial basement boiler/mechanical rooms that were identified during the building tour on 01/05/24.	K 161	1. The 3 of 3 partial basements were added to the floor plan (boiler and mechanical rooms). The fire rated protection was repaired and added to the I-beam section. 2. All residents and staff personnel have the potential to be affected by this deficient practice 3. The US FOIA (b)(6) [redacted] were educated by the regional administrator on the importance of not having any areas of less than the two-hour fire rated requirement for potential penetration. In addition, the maintenance director was also educated on the floor plan requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 161	Continued From page 5 The US FOIA (b)(6) confirmed during document review, that there was only one floor plan and could not provide any documentation on the 3 boiler/mechanical rooms. b.) At 12:42 PM, the surveyor, US FOIA (b)(6), observed in the B-wing boiler room with generator #2, that the protected I-beam was missing approximately 4' section of its protective coating now observed to not have any fire protection rating in that area. The US FOIA (b)(6) confirmed the above observations and stated they were unaware the fire protection coating was missing on the beam. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 01/08/24.	K 161	4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	
K 211 SS=F	NJAC 8:39-31.2(e) Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on interviews and documentation review on 01/04/24 and 01/05/24, in the presence of the US FOIA (b)(6)	K 211	1. 8 of the 8 fire doors were inspected in accordance with the NFPA 80 & 105 Standards to ensure that the requirements and fire safety requirements were met.	2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 211	Continued From page 6 US FOIA (b)(6) it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC documented on the provided facility floor plans for 8 of 8 fire doors observed and was evidenced by the following: On 01/04/24 at approximately 9:45 AM, the surveyor asked the US FOIA (b)(6) to provide the annual testing requirements for fire door assemblies. The US FOIA stated that indicated that currently he did not have any documentation that the fire doors were annually inspected in accordance with NFPA 80 and NFPA 105 Standard for Smoke Doors Assemblies and other Opening Protectives. The US FOIA (b)(6) both confirmed the findings during the observations stated above. The US FOIA (b)(6) was informed of the finding's at the Life Safety Code Exit Conference on 01/08/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 and 105: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	2. All resident and staff personnel have the potential to be affected by this deficient practice 3. The US FOIA (b)(6) were educated on the Policy and Procedure for maintaining "Exits or Means of Egress" and importance of not having all fire smoke compartment doors inspected annually to ensure it meets the code requirements for the NFPA 80 & 105 codes 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress	K 281		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 281	Continued From page 7 Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews conducted on 01/05/24, in the presence of facility [redacted], it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 3 of 12 occupied access areas and corridors observed and was evidenced by the following: 1). At 11:02 AM, the surveyor, in the presence of the [redacted], observed in the corridor identified from resident rooms #[redacted] to #[redacted] that 2 wall light switches shut-off all 6 ceiling light fixtures, leaving the means of egress with no lighting when the wall switch was in the off position. 2). At 10:10 AM the surveyor, in the presence of the [redacted], observed in the (occupied) dining room by resident room [redacted] that 3 wall light switches shut-off all 11 ceiling light fixtures, leaving the means of egress with no lighting when the wall switch was in the off position. 3). At 01:52 PM the surveyor, in the presence of the [redacted], observed in the (occupied) dayroom by the nurse station that 2 wall light switches shut-off all 6 ceiling light fixtures, leaving	K 281	1. The light switches were outfitted with key switches to prevent all lights from being turned off. 2. All residents and staff personnel have the potential to be affected by this deficient practice 3. The [redacted] was educated by the administrator on the importance of the NFPA 101 requirements for emergency illuminations of the lighting 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 281	Continued From page 8 the means of egress with no lighting when the wall switch was in the off position. The areas were not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The US FOIA (b)(6) both confirmed the finding's at the time of observations. The US FOIA (b)(6) was informed of these findings at the Life Safety Code survey exit conference on 01/08/24. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 321	Continued From page 9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/04/24 and 01/05/24, in the presence of the [redacted], it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in fifteen (15) of nineteen (19) hazardous storage areas in the facility, and was evidenced by the following: 1). The kitchen door identified as door #2 by the loading dock was observed to be a Dutch door. The wood door was not labeled, and did not fully close and latch into its frame. 2). The door to the corridor from the employee break room to the loading dock (outside the kitchen area) was observed to not have any fire rating label.	K 321	1. 1.) A new fire rated door to replace the Dutch door by the kitchen was ordered. 2.) (the door was inspected to ensure it is fire rated with a label). 3.) A new double door to replace the double doors by the kitchen was ordered to ensure requirements are met. 4.) The door to the boiler room sticker for fire rating was cleaned to ensure sticker is visible.5.) The door to the water supply closet was adjusted to ensure it latches into the frame 6.) The door to the kitchen sticker for fire rating was cleaned to ensure sticker it is visible. 7.) A new door to the door to the medical supply room was ordered that is fire rated. 8.) The sticker for the medical supply room was cleaned to ensure the sticker is visible. The door was adjusted to ensure it latched into the frame 9.)The door was inspected and is fire rated. An astrgal was installed to ensue no gaps on the door. 10.) A new self-door closure was placed on the door. 11.) A new fire rated door was ordered for the sprinkler room door.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 321	Continued From page 10 3). The set of double doors to the kitchen both did not fully close as the doors (2) rubbed onto the floor, both sets of hardware on the doors were loose and the lower section of the center door divider seperating the 2-doors was compromised and not attached (hanging unsecured). The right-side door was blocked from opening by a small cabinet. The door were in bad shape and did not offer any fire protection. 4). The door to the front boiler room was observed to have a fire rating label, but it was painted. 5). The door to the water supply closet was observed to not close and latch into it frame. 6). The door to the kitchen supply room was observed to have a fire rating label, but it was painted. 7). The door to the medical supply room was observed to have no fire rating label, and did not close into its frame, as the door rubbed onto the floor. 8). The door to the medical equipment room was observed to have a fire rating label, but it was painted and the door did not close into it frame and latch. 9). The double doors to the corridor by the front desk, were observed to not have any fire rating label and the astragal was not properly installed, as the lower gap on the doors was approximately 1/2". 10). The director of environmental services office/storage room was observed to store	K 321	12.) The hazardous storage room was emptied, and the sheetrock was taken down as per plan submitted to DOH and DCA. 13.) The room with the generator annunciator panels was emptied. The wall was taken down and was turned into a nursing station as per the plans submitted to DOH and DCA. Unfished seams and compromised holes in the wall board were closed. The hollow door was removed. The interior was completed, and all wires exposed were removed. Approvals for both #12 & #13 were given to the facility by DCA and DOH. 14.) The laundry door label that was painted over was cleaned to ensure the label is visible. The door was adjusted to ensure it latches into its frame 15.) The laundry door #2 label that was painted over was cleaned to ensure the label is visible. The box of clothes hangers was removed. 2. All staff and residents have the potential to be affected by this deficient practice 3. The US FOIA (b)(6) was educated by the administrator on the importance of fire safety requirements from NFPA for fire rated safety and on maintaining or installing door closure requirements on areas with a high amount of combustible storage. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 321	Continued From page 11 chemicals and combustible resident linen. The door to the room was not self-closing. 11). The door to the fire sprinkler room was observed to not have any fire rating label, including an unrated glass pane approximately 2' x 4" in size and was not provided with an auto closing device. 12). The hazardous storage room by the conference room, was observed to have unfinished wall board facing the corridor, with unfinished seams and holes open to the interior of the room (not smoke resistant), The hollow door to the room was not labeled. The interior to the room was unfinished exposing untreated wood. The room was greater than 50 square feet in size and stored 100 plus combustible cardboard boxes. 13). The two (2) generator annunciator panels, were located in a unstaffed room. The room was observed to have unfinished wall board in the corridor with unfinished seams and compromised holes in the wall board, a hollow door was installed with no fire protection rating. the unfinished interior of the room was observed to have exposed untreated wood, exposed BX cable electrical wiring. The room was filled with combustible items including a wood pallet leaning on the unfinished wall. * At entrance the US FOIA (b)(6) was asked if any new construction was performed and they indicated not at this time, It was noted that the two (2) unfinished rooms identified as # 12 and 13 in this deficiency, did not have any DCA and Health department approval and no further documentation was provided to the surveyor.	K 321	assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 321	Continued From page 12 14). In the laundry room the door marked #1 to the soiled linen room was observed to have a painted label and did not latch into its frame. 15). The door to the laundry room identified as door #2 was observed to have a painted label and was open approximately 6" by a box of clothes hangers. The US FOIA (b)(6) both confirmed the findings, during the observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code Exit Conference on 01/08/24.	K 321		
K 324 SS=E	NJAC 8:39-31.2(e) 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 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	K 324		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 324	Continued From page 13 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, on 01/05/24, in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that 2 of 2 kitchen class K fire extinguishers were inspected monthly in accordance with NFPA 96 and NFPA 10.The deficient practice was evidenced by the following: At 11:27 AM, the surveyor, US FOIA (b)(6) observed in the facility kitchen that 2 of 2 portable class K fire extinguishers were last inspected in October 2023. The monthly inspections of the 2-extinguishers lacked documentation of monthly "quick check" or inspection as required by NFPA 96. At that time, the surveyor interviewed the US FOIA (b)(6) who confirmed that the ansul monthly inspection tags were not completed since 10/23. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 01/08/24. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324	1. The 2 Fire extinguishers K type in the kitchen were inspected to ensure that they met the requirement of the NFPA 96 requirements. 2. All residents and employees have the potential to be affected by this deficient practice 3. The US FOIA (b)(6) was educated by the Administrator on the importance of ensuring all fire extinguishers are checked and inspected per the NFPA 96 requirements. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 345	Continued From page 14	K 345		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 01/04/24 and 01/05/24, in the presence of the[US FOIA (b)(6)) and[US FOIA (b)(6) it was determined that the facility failed to ensure: a.) that their fire alarm system annunciator panel was in normal mode as per NFPA 70 and 72. and b.) smoke detection sensitivity testing were completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. c.) that the fire alarm system was inspected on a semi-annual basis in accordance with NFPA 70 and 72. The deficient practice was identified for 2 of 2 inspection reports and was evidenced by the following: a.) On 01/04/24 and 01/05/24 at 9:15 AM, on both days, the surveyor,[US FOIA (b)(6)] observed the fire alarm remote annunciator panels and main panel were in trouble mode indicating: The " TROUBLE : main building 2721 was identified at the front entrance annunciator panel	K 345	1. A.) 1.) The Trouble and repair for the butterfly valve was completed on 1/11/24 3.) system was restored on 1-11-24 upon completion of service. B.) The Fire safety vendor completed a smoke detector sensitivity test. C.) The fire vendor conducted the semiannual fire alarm inspection and the sealed acid batters were inspected by the fire safety vendor. 2. All residents and staff have the potential to be affected by this deficient practice 3. The[US FOIA (b)(6) was educated by the Administrator on the importance of ensuring the alarm is not kept in trouble mode and on the requirements for the smoke alarm sensitivity test for the fire alarm testing on a semiannual basis. Maintenance staff were educated on scheduling smoke detection sensitivity testing with contractor. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in	2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 345	Continued From page 15 outside the front receptionist desk. The receptionist indicated the fire alarm panel was in trouble mode for a few weeks. The [US FOIA (b)(6)] provided a signed proposal from the fire alarm and sprinkler vendor dated: 12/20/23 indicating that the vendor would: 1). Remove and replace the existing failed butterfly valves. 2). Two 6" and 4" butterfly valves will be removed and replaced. 3). Systems will be restored to service at the completion of work. * On 01/08/24 it was unconfirmed if the fire alarm/sprinkler vendor received the signed proposal. The document stated that upon receipt of the signed proposal, the vendor will procure the material and schedule the work. The [US FOIA (b)(6)] all stated and confirmed that all the fire alarm annunciator panels were in trouble mode, no further updated documentation was provided. b.) On 01/04/24 at 9:48 AM, the surveyor, [US FOIA] confirmed that no fire alarm smoke detector sensitivity report was provided in the Life Safety Code Inspection book. The last semi-annual fire alarm inspection report's were dated: 01/05/23 and 09/02/22, and did not indicate when the last smoke detector sensitivity test was conducted in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The [US FOIA (b)(6)] were interviewed during the document review, where they stated currently, that no smoke detector	K 345	all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 345	Continued From page 16 sensitivity report was performed and they could not provide any documentation on when it was last conducted. c.) On 01/04/24 at approximately 09:50 AM, the surveyor reviewed all documentation from the fire alarm vendor. The document was for the (main building) and indicated Date of Work: 01/05/23 frequency: Annual, with Date of last repair: 07/14/23. The prior inspection report was dated: 09/02/22. It was undetermined from the report provided on 07/14/23, if this was a repair work order only, as the fire alarm inspection and testing report was not identified as a semi annual inspection and testing report. The US FOIA (b)(6) could not confirm it the fire alarm system was inspected semi-annually. *The fire alarm system was observed to have sealed lead acid batteries that required a semi annual inspection. The US FOIA (b)(6) was informed of the findings at the Life Safety Code Exit conference on 01/08/24. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 353	Continued From page 17 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/04/24 and 01/04/24, in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to a.) maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25, b.) to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated as evidenced by the following: in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1, and c.) to ensure documentation was provided on the condition of the outside post indicator valves and (3) three fire hydrants as per NFPA 13 and 25. d.) ensure the electric fire pump churn test inspection report was fully documentated by the operator as per NFPA 20: fire pump requirements. E.) ensure fire sprinkler piping was not compromised with any attached and/or hanging materials on the pipe as per NFPA 13 compliance section 2-2.2 of standard	K 353	1. A-1) The Fire Safety Vendor replaced the sprinkler heads identified. B-1) The section of ceiling in the boiler room was repaired. B-2) The hole in room 005 was repaired. The sprinkler Escutcheon was placed. B-3) The janitor closets close to room 007 were fitted with Escutcheon plate on the sprinkler. B-4) The Section of ceiling was repaired. B-5) The linen closet with ceiling missing was repaired. B-6) The vertical opening with the foam like substance was removed and replaced with fire rated material. C.) The fire hydrant outside the well tank is operational. The facility reached out to the engineer who installed that fire hydrant, and he informed the facility that he only installed that one hydrant by the tank and the other two were not necessary due to the new sprinkler system which he installed at the time and that there was no NFPA requirement to have fire hydrant. The facility reached out to the local fire marshal, and he recommended the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 353	Continued From page 18 states. These deficient practices was identified for and evidenced by the following: A-1), On 01/04/24 at 11:28 AM, the surveyor, US FOIA [redacted] observed in the facility kitchen that 5 of 8 fire sprinkler heads were loaded with a dark greasy substance. The US FOIA (b)(6) both confirmed the findings during the kitchen observations B-1), On 01/0424 at 01:42 PM, the surveyor, US FOIA [redacted] observed in the front boiler room that a section of ceiling was missing approximately 3' x 12" in size. B-2), On 01/0424 at 10:47 AM, the surveyor, US FOIA [redacted] observed in resident room NJ Exec D that the shared bathroom ceiling was open approximately 1' x 1' in the wall board. Also the fire sprinkler head (1 of 1) escutcheon plate, was not in place leaving an opening approximately 3/4" gap. B-3), On 01/05/24 at 10:52 AM, the surveyor, US FOIA [redacted] observed in the janitor closet by resident room NJ Exec D that 1 of 1 fire sprinkler heads were missing an escuteheon plate. B-4), On 01/05/24 at 10:52 AM, the surveyor, US FOIA [redacted] observed in the PT room that an approximately 15" x 9" section of ceiling was missing by the exit door.	K 353	apply for a land use variance and have them removed. The facility applied for a land use variance and has bagged the hydrants that are no longer in service. D.) Maintenance director created a new fire churn log and included the person who performed the test. E.) The cable wires were removed from the sprinkler pipe. 2. All residents and staff have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] was educated by the Administrator on the importance of ensuring the hydrants are functional and operational, there is no penetration or vertical openings throughout, nothing be attached to the sprinkler or alarm pipes, churn fire pump testing requirements and not having anything attached to the sprinkler pipe. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 353	Continued From page 19 B-5), On 01/05/24 at 10:52 AM, the surveyor, US FOIA [redacted] observed the linen closet by PT that an approximately 2' x 1' section of ceiling was missing. B-6), On 01/05/24 at 10:59 AM, the surveyor, US FOIA [redacted] observed in the maintenance corridor that a verticle opening in the ceiling was filled with a foam-like substance. The US FOIA (b)(6) confirmed the findings above during the observations. C). On 01/05/24 at 11:45 AM, the surveyor, US FOIA (b)(6) [redacted] observed 3 of 3 private fire hydrants along with post indicator valves outside the facility in 3-seperate locations. The facility could not produce any documentation on the status of these devices. The US FOIA (b)(6) [redacted] indicated that the (3) hydrants were out of service and were not annually inspected. The surveyor had the US FOIA open one hydrant and when the US FOIA opened the valve with the hydrant wrench, no water was produced. It seems the (3) hydrants and post indicator valves were not connected to any water source. The observed post indicator valves and 3 of 3 fire hydrants, did not have any signs or postings that they were out of service and/or not connected to any water source. * It was noted that the facility has well water and a large water tank that provides water to the to the facility fire sprinkler system that was in service. The US FOIA (b)(6) [redacted] could not produce any douumentation from there fire sprinkler	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 353	Continued From page 20 vendor, uniform fire code inspections, and any local building information from the township that the post indicator valves and 3 of 3 fire hydrants were not connected to a water source. D.) On 01/04/24 the surveyor, US FOIA (b)(6) provided the documentation for the testing of the Electric Fire Pump Churn Test Inspection Report. The report provided did not indicate who performed the weekly inspection as the inspector section of the form was blank for the entire year of 2023. The US FOIA (b)(6) confirmed that the report provided did not indicate who performed the weekly test as the inspector section of the form was blank for the entire year of 2023. E.) On 01/05/24 at approximately 10:39 AM, the surveyor, US FOIA (b)(6) observed in the maintenance shop and maintenace corridor that data and cable wires were zip-tied to the fire sprinkler pipe. The data and cable wires were attached to approximately 20' of the horizontal installed sprinkler pipe. The US FOIA (b)(6) stated and confirmed the finding, during the observations, and were aware the fire sprinkler pipe was never to be used for hanging any material in the facility. NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems with property owners. The Administrator was informed of the finding's at	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 353	Continued From page 21 the Life Safety Code exit conference on 01/08/24. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25 NFPA 20: fire pump requirements	K 353		
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/05/24, in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that electrical equipment had approved wiring and electrical outlets in accordance with NFPA 70, 2011 Edition, Section 19.5.1.1, 9.1.1 and 9.1.2. The deficient practice was evidenced for 1 of 10 electrical outlets observed by the following: At 11:10 AM, the surveyor, US FOIA (b)(6) observed in the physical therapy room, that the portable hydrocollator was full of water and plugged into a standard electrical outlet. The US FOIA [redacted] stated that the current electrical	K 511	1. The Hydroculator was removed and plugged into a GCFI outlet. 2. All staff and residents have the potential to be affected by this deficient practice 3. The US FOIA (b)(6) [redacted] was educated by the administrator on the importance of ensuring that items that require a GCFI outlet are plugged into the correct outlets.Maintenance department reviewed all other outlets to identify any unusual findings, prior to date of compliance. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in	2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 511	Continued From page 22 duplex outlet could not be identified as a ground-fault circuit interrupter (GFCI). The [US FOIA (b)(6)] was informed of the finding at the Life Safety Code exit conference on 01/08/24. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 511	all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	
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 conducted from 01/04/24, 01/05/24 and 01/08/24, in the presence of the [US FOIA (b)(6)] [redacted], it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in a safe and optimal condition. This deficient practice was identified for 45 of 45 PTAC units observed and was evidenced by the following: While touring the facility on 01/05/24 from	K 521	1. All Ptacs were cleaned. A new cleaning schedule log was created to ensure all Ptac units are on a schedule for cleaning and safety. 2. All residents and staff have the potential to be affected by this deficient practice. 3. The [US FOIA (b)(6)] was educated by the administrator on the importance of ensuring that Ptacs are on schedule for cleaning. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in	2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 521	Continued From page 23 approximately 09:00 AM, to 01:30 PM, the surveyor, US FOIA (b)(6) observed PTAC filters that were clogged and dirty throughout the facility including broken grills and older PTAC units that were missing filters and filters not in place (observed on the floor). When interviewed at the time of the observations, the US FOIA (b)(6) agreed that PTAC unit's had clogged and dirty filters including broken grills along with older PTAC units that were missing filters and filters not in place (observed on the floor) throughout the facility. The US FOIA (b)(6) indicated they did not have a PTAC unit maintenance log and did not provide a policy and procedure for PTAC unit maintenance at the time of the Life Safety Code exit. The US FOIA (b)(6) was notified of the findings at the Life Safety Code exit conference on 01/08/24. N.J.A.C. 8:39 - 31.2(e) 19.5.2.1 Heating, Ventilating, and Air-Conditioning.	K 521	all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the	K 741		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 741	Continued From page 24 international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/04/24, in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. for 2 of 2 smoking areas as follows: At 11:55 AM, the surveyor, US FOIA (b)(6), observed in the smoking areas (2) that the oasis style combustible plastic ashtrays were provided for cigarette buts only, the area was observed to not have an approved ash tray or a self-closing covered metal container for the disposal of cigarette butts and ashes. At 12:02 PM, the surveyor, US FOIA (b)(6), observed in the smoking porch that 1 of 3 oasis	K 741	1. The plastic combustible ash trays were removed and approved ash trays were placed. The Combustible items were removed immediately. Fire rated paint was applied to the smoking porch. 2. All residents and staff have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] were educated by the admistraor on the proper ash trays, & fire rated coating needed for safety per the NFPA 101 requirements. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 741	Continued From page 25 style plastic ashtrays were observed to have combustible cigarette boxes in with the cigarettes butts. At 12:15 PM, the surveyor, US FOIA (b)(6), observed in the occupied smoking porch, that the combustible wood wall constructed on the outer section of the smoking porch, had multiple burn marks on the combustible wood shelf from cigarette butts. The surveyor interviewed the [redacted] and they could not determine if the wood was provided with any fire rating coating. The finding's were verified by the US FOIA (b)(6), at the time of the observation. No smoking policy and procedure was provided. The US FOIA (b)(6) was informed of the finding's at the Life Safety Code exit conference on 01/08/24. *Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. *Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. NJAC 8:39-31.2(e) NFPA 101 2012 edition Life Safety Code 19.7.4* (5) Smoking NFPA 101 2012 edition Life Safety Code 19.7.4* (6) Smoking	K 741	assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other	K 911		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 911	Continued From page 26 List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 01/04/24, in the presence of th US FOIA (b)(6) [redacted], it was determined that the facility failed to a.) demonstrate reliability regarding fuel supply for (2) two natural gas generators as per the [redacted] in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. b.) maintain the required clearance around electrical panels, guarding of live parts of electrical equipment and controls with unlocked panels in resident accessible areas in accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas was by the following: a.) At 9:30 AM, the surveyor and [redacted] reviewed all the facility's generator documentation. The facility currently has one (2) natural gas generators. The US FOIA (b)(6) [redacted] could not produce a documented reliability letter from the natural gas provider.	K 911	1. The Fuel company responsible for the generators provided a letter with the requirements per the NFPA code. The Electrical Panels were outfitted with a proper lock and signage per the NFPA requirements. 2. All residents and staff have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] was educated by the administrator on the importance of the NFPA requirements pertaining to having a letter of reliability and ensuring proper electrical boxes are secured and clearly marked. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 911	Continued From page 27 Reliability letters from the natural gas vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The US FOIA (b)(6) both confirmed there was no reliability letter available from the natural gas provider for the (2) natural gas generators, for the facility to present to the surveyor. No additional information was received. b.) At 9:30 AM, the surveyor, US FOIA (b)(6) observed that the corridor electrical panels: SHOI by resident room NJ Exec and P21 panel by the front receptionist desk were unlocked. There was no guarding of live parts or arc-flash hazard warning signs on the panel. An interview was conducted with the US FOIA during the observation, he varified the above electrical panels were open and did not have a locking feature and/or were unlocked. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 01/08/24. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 01/04/24 and 01/05/24, in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 50 of 62 resident rooms observed by the following:	K 914	1. An inspection of all non-hospital grade outlets was tested for functionality of grounding, polarity, and Blade tension in accordance with the NFPA 99 requirements. 2. All residents and staff have the potential to be affected by this deficient practice 3. The US FOIA (b)(6) [redacted] was educated by the administrator on the importance of having nonhospital grade electrical receptacles tested annually per the NFPA 99 requirements.	2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 914	Continued From page 29 On 01/04/24 and 01/05/24, from approximately 09:45 AM, to 12:45 PM, while reviewing documentation provided by the US FOIA (b)(6) [redacted] he facility electrical inspection from the facility vendor dated: 03/08/23 did not indicated that rooms with non-hospital grade outlets were annually inspected. The US FOIA (b)(6) confirmed that the facility had non-hospital outlets and hospital grade installed in resident rooms, but could not provide a log indicating what type of outlet was installed in each resident room. No further documentation was provided. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 01/08/24. NJAC 8:39-31.2(e) NFPA 99	K 914	4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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	K 918		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING 01 B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

(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
K 918	Continued From page 30 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 01/04/24 and 01/05/24, in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure a remote manual stop station for 4 of 4 generators, providing emergency power to approximately 60% of Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 4 of 4 generators by the following: While touring the facility on 01/04/24 from 01/05/24 from 09:00 AM, to approximately 01:30 AM, the surveyor, US FOIA (b)(6) observed that 4 facility generators did not have a remote manual stop station observed outside the	K 918	1. The facility generator contractor has installed the required remote manual shut offs for all 4 of 4 generators the facility operates per the NFPA requirements. 2. All residents and staff have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was educated by the Administrator on the importance of the Remote manual shut offs for each generator per the NFPA requirements. 4. The maintenance director and department will be responsible for conducting monthly audits x 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	**2721 ROUTE 9** **OCEAN VIEW, NJ 08230**

(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
K 918	Continued From page 31 area of the individual generator locations: Generator #1 outside in front lot next to the Parsonage. (old Yellow house). Gennerator #2 boiler room #3/mechanical room, next to dietary office. Generator #3 boiler room #4 mechanical room under laundry "B". Generator #4 outside door #2, "B" unit, in back field behind the fence. An interview was conducted during the time of the observation with the US FOIA (b)(6), who all stated and confirmed that the facility generators, did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current (4) generators in service. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 01/08/24. 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	assessment and performance improvement committee for review and action as appropriate. The QAPI committee meets quarterly. The committee will determine if further action is needed	

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
315179 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OCEANVIEW	2721 ROUTE 9 OCEAN VIEW, NJ 08230

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 K0131	02/14/2024	LSC K0161	02/14/2024	LSC K0211	02/14/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	02/14/2024	LSC K0321	02/14/2024	LSC K0324	02/14/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	02/14/2024	LSC K0353	02/14/2024	LSC K0511	02/14/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	02/14/2024	LSC K0741	02/14/2024	LSC K0911	02/14/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0914	02/14/2024	LSC K0918	02/14/2024	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	
1/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO