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

PRINTED: 12/07/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  315179			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		B. WING		C	
NAME OF PROVIDER OR SUPPLIER  AUTUMN LAKE HEALTHCARE AT OCEANVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 2721 ROUTE 9 OCEAN VIEW, NJ 08230	03/16/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 000	INITIAL COMMENTS	3	F 000		
	COMPLAINT # NJ	00153160.			
	Census: 89.				
	Sample: 0.				
F 584 SS=E	THE REQUIREMEN SUBPART B, FOR L FACILITIES BASED VISIT. Safe/Clean/Comforta	ON THIS COMPLAINT able/Homelike Environment	F 584	1	5/10/22
	§483.10(i) Safe Envi The resident has a ri comfortable and hon but not limited to rec supports for daily livi	ight to a safe, clean, nelike environment, including eiving treatment and			
	homelike environme use his or her person possible. (i) This includes ensi- receive care and ser physical layout of the independence and d (ii) The facility shall e	vide- , clean, comfortable, and nt, allowing the resident to hal belongings to the extent  uring that the resident can rvices safely and that the e facility maximizes resident loes not pose a safety risk, exercise reasonable care for resident's property from loss			
		keeping and maintenance to maintain a sanitary, orderly, rior;			
LABORATORY	I DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUF	 RE	TITLE	(X6) DATE

Electronically Signed 04/28/2022

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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315179			B. WING _			03/16/2022		
NAME OF PROVIDER OR SUPPLIER  AUTUMN LAKE HEALTHCARE AT OCEANVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE  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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE			
F 584	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F5	1.All surgical masks and gloves ground in the parking lot were the away immediately.  2. The lid of the trash dumpster was closed immediately and for away.  3. The lid of the cardboard dum container was closed immediately and cardboard boxes were thrown a immediately.  4.Dietary, housekeeping, maintents taff were inserviced on the progarbage and refuse disposal For keeping lids always closed.	container od thrown  pster ely. The way  enance cedure for			
		en (15) used surgical masks lloves on the ground in the		keeping lids always closed.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		315179	B. WING			C 02/46/2022		
NAME OF PROVIDER OR SUPPLIER  AUTUMN LAKE HEALTHCARE AT OCEANVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE  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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD DEFICIENCY)			(X5) COMPLETION DATE		
F 584			F 584		2.All residents have the potential to be affected by this practice.  3.Dietary, housekeeping and maintenance staff are educated monthly by the Director of Food Service and Director of Environmental Services on Garbage and Refuse disposal. Director of Environmental Services Does multiple daily rounds as well as Maintenance to make sure Lids of dumpsters are closed and parking lot clean. The cardboard dumpster gets picked up by waste management more often weekly.  4. Weekly audit conducted by the Food Service Director/Director of Environmental			
					Service Director/Director of Environment Services/Designee for the next 6 month Quarterly audit completed by Administrator/Designee and reviewed a quarterly QAPI (Quality Assessment & Performance Improvement) meeting for the next 6 months.	ns. at		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED  C 03/16/2022	
		315179	B. WING				
NAME OF PROVIDER OR SUPPLIER  AUTUMN LAKE HEALTHCARE AT OCEANVIEW				272	REET ADDRESS, CITY, STATE, ZIP CODE 21 ROUTE 9 CEAN VIEW, NJ 08230	1 00/	10/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 584	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	584			