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 01/09/2025

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 000	INITIAL COMMENTS Standard Survey 01/09/2025 Census: 109 Sample Size: 25 + 1 closed record C/O # NJ 174550 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 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced	F 577		2/22/25

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

Electronically Signed | 01/31/2025

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 01/09/2025

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 577	Continued From page 1 by: Based on observation and interview, it was determined that the facility failed to make survey results readily accessible to residents and visitors. This deficient practice was evidenced by the following: On 01/07/2025 at 10:30 AM, the surveyor conducted the resident council task with five (5) facility long-term residents. When asked if the residents were made aware of the location of the most recent state survey results, 5 of 5 resident responded that they were not aware of the existence of a state survey book and were not notified as to where the most recent survey results were located. On 01/07/2025 at 11:30 AM, the surveyor went to the front reception area to look for the State Survey Result Book. The surveyor did not visualize the State survey book. The surveyor asked the receptionist where the State Survey Results Book was, she replied she was not familiar with the book. The Surveyor did observe a books behind the reception desk. The surveyor reviewed the books, and identified the unmarked State Survey Results Book. On 01/08/2025 at 09:46 AM, the surveyor went to the Serenity Unit Nursing Station. When the surveyor asked the staff at the desk where the State Survey Result Book was, they were not able to provide the book initially. The book was eventually located on a shelf behind the nursing station, above the counter, which would be unreachable and unattainable to a resident in a wheelchair. On 01/08/2025 at 10:19 AM, the surveyor met	F 577	Corrective Measures for Resident Affected: On 1/8/2025, The Administrator re- labeled all survey binders and made them accessible to the residents and visitors in designated areas, at the main lobby and on the residents' units. Cognitive intact residents were notified of the location of survey result binders through a memo. Identification of Residents with the potential to be affected: All residents residing in the facility are potentially at risk for this deficient practice. Systemic Change (Measures to prevent recurrence): The Administrator re-educated the receptionist to ensure the survey binder is readily accessible to the residents and visitors. This education will be included in the new hire orientation for the receptionist The Activity Director was educated by the Administrator to discuss Residents Right in the resident council meetings agenda to include survey results accessibility. Monitoring of Corrective Measures: The Administrator/designee will do an audit of the survey result binders to ensure they are readily accessible to residents and visitors weekly for 2 months, then monthly for 4 months. Any issues from the audit	

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 01/09/2025

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 577	Continued From page 2 with Administration to discuss the Resident Council Meeting. At that time, the concerns regarding the inaccessible State Survey Results were reviewed.	F 577	will be addressed immediately and reported to the Quality Assurance Committee quarterly for 2 quarters or until compliance is met.	
F 584 SS=E	N.J.A.C. 8:39-9.4 (b) 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. §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);	F 584		2/22/25

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 01/09/2025

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 §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 other facility documentation, it was determined that the facility failed to maintain the resident environment, equipment, and living areas in a safe, sanitary and homelike manner. This deficient practice was idenfied on 2 of 3 units, (NJ Exec Order 26.4b1) and was evidenced by the following: On 01/05/2025 at 10:44 AM, Resident # 3 approached Surveyor # 1 and stated that he/she wanted Surveyor #1 to go to his/her room (# NJ Exec Or) to observe a concern. Resident #3 stated that he/she "reported NJ Ex Order to the Maintenance Department many times yet it remains present in his/her room and that he/she is concerned that it is NJ Exec Order 26.4b1. Resident #3 directed Surveyor #1 to the area of the packaged terminal air conditioner unit (PTAC) under the window. Resident #3 pointed out an area in the corner to the left side of the PTAC and around 2 pipes protruding from the floor. Surveyor #1 observed the area to the left of the PTAC unit covered with a board, Surveyor #1 moved the board from the wall and observed NJ Ex Order 26.4(b)(1) in and around the	F 584	Room NJ Exec O dark black stains around the corners of the wall, cleaned and removed. Dark shiny substances and pipes cleaned and covered. The wall in room six on the right side of PTAC was fixed. The closet for drawers was replaced. The wardrobe stain was cleaned and removed. The dark colored stains on the baseboard on the hallway floor and serenity were cleaned and peeling wallpaper by the common area. The rainbow was repainted. The baseboard peeling by janitor closet was repaired. Wall board support column holes and paint were repaired and fixed. Chipped tiles outside room six were repaired 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 01/09/2025

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 corners of the wall and floor and in clustered groups. There were also dark shiny substances observed on the pipes. Resident #3 stated that the Maintenance Department did spray the area once, but the substance remains and that he/she was told that "they did all they could." Resident #3 [NJ Exec Order 26.4] [redacted] On 01/09/25 at 09:59 AM during an interview with Surveyor # 1, the US FOIA (b)(6) [redacted], stated that he was aware of the issue of "mold" and that there are other resident rooms affected by this. The [US FOIA (b)(6)] stated that they have been treating these areas however to rectify, the pipes from the old units need to be removed. The [US FOIA (b)(6)] stated that a plumber has been out to give an estimate and that they are waiting on approval to contract for repair. On 01/05/2025 at 9:30 AM, during the initial tour of the [NJ Exec Order 26.4] unit, Surveyor #2 observed the PTAC unit in room #[NJ E] the right side was damaged and peeling dry wall down the entire right side. On the left side of the PTAC unit was pool noodle type material affixed to it and damage to the wall beside it. The closet was missing a drawer for A-side bed and their wardrobe had a stain on the right side. On 01/07/2025 at 10:00 AM, Surveyor #2 observed the hallway floor on [NJ Exec Order 26.4] had [NJ Ex Orde] [redacted] and where the baseboard and floor meet were dark marks along the entire length of the baseboard in both hallways. On 01/08/2025, Surveyor # 2 observed the following on the [NJ Exec Order 26.4] Unit:	F 584	fixed. Chipped, paint and rust looking areas and door frames were repainted. Chipped floor tiles outside room three were repaired and fixed. The radiator cover in room [NJ Ex] was repainted. Room [NJ Ex] toilet grab bars in bathroom were cleaned. The missing wall tiles across from room nine were repaired. Peeling paint by nursing station and emergency station were repainted. The door was repainted peeling paint on nursing station door painted. The uneven cracked floors by the exit of Serenity unit were repaired. Outside room 103 paint was touched up and repainted. Paint was placed by room of 111 on the corner of the wall mismatch paint outside. Room 112 was repainted by the baseboard edging around Nursing station was repaired with cove base. Smoking cigarette butts were cleaned by the smoking patio.	

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 01/09/2025

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 12:01 PM, the wall in the small common area observed had peeling wallpaper by the rainbow. 12:02 PM, the baseboard was peeling off by janitor door. 12:03 PM, observed the wallboard on the support column had holes and was peeling paint. There were also chipped tiles on the wall outside room #6. 12:05 PM, observed the door frames of multiple rooms had chipped paint and rust looking areas exposed. 12:06 PM, observed chipped floor tiles outside room #3. 12:10 PM, observed the radiator cover in room #10 was chipped and peeling paint. 12:11 PM, observed in room #[redacted] the toilet grab bars in bathroom had a green and white colored substance on it. 12:12 PM, observed missing wall tiles in the hall across from room #9 by the fire extinguisher cabinet. 12:15 PM, observed the wall between the nurse's station and the emergency eye wash station the door had peeling paint and dark marks. 12:16 PM, observed the door frame to nurse's station had peeling paint. 12:17 PM, observed uneven, cracked floors upon entering and exiting the unit.	F 584	A switch plate on the wall in the B wing day room was repaired and replaced. The ledge in the B-Wing Day room was repaired. Paint was placed on the B wing day room door jam. An end cap was placed by the B Wing nursing station. The baseboard of the right side of the nursing station near the Unit Manager 's office was repaired. The ceiling tile outside room B Wing Day room in Ocean Hall was replaced. All Pictures to be provided 2. All residents have the potential to be affected by this deficient practice. 3. The U.S. FOIA (b) (6) was in-serviced by the regional administrator on 1/15/25 on the requirements of residents having a safe/clean/comfortable/homelike environment. All staff received in-servicing by the administrator on utilizing the maintenance log to indicate any identified areas in need of repair. The maintenance director will review the maintenance log on each unit during his daily rounds and note his awareness of the repair by initial the maintenance log	

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 01/09/2025

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 6 On 1/9/25 at 10:28 AM, Surveyor #3 observed on the following on [NJ Exec Order 2[illegible]] : 10:28 AM, outside room #[NJ Exec O[illegible]] the paint was peeling in patches exposing the previous paint beneath. 10:32 AM, paint was chipped outside room #111 on the corner of the wall. 10:33 AM, mismatched chipped paint outside room #[NJ Exec O[illegible]] 10:34 AM, the baseboard edging around the nurse's station was chipped and scuffed. 10:36 AM, observed in the smoking patio cigarette butts disposed of on the ground and not in the smoking materials receptacle. 10:37 AM, observed the switch plate on wall in B wing dayroom, was cracked and broken. 10:39 AM, observed the ledge in the B wing dayroom was chipped and lifting. 10:47 AM, observed the doorway to the B wing dayroom had chipped paint at the door jam. 10:47 AM, observed the endcap for the railing across from B wing nurse's station was missing. 10:51 AM, observed the baseboard was missing and the wall was damaged on right side of nurse's station near the [US FOIA (b)(6)]' office. 10:52 AM, observed the ceiling tile was stained outside B wing dayroom in the ocean hall,	F 584	4. The maintenance director and department will be responsible for conducting monthly audits x 6 months for 2 quarters and report findings to Quality Assurance committee. The Maintenance department will use a standardized inspection checklist that includes compliance with the standards for a homelike environment for the nursing home. The results of each audit will be reviewed and action taken as appropriate with QAPI and the QAA committee for 2 quarters. The QAA committee will determine if further action is needed and make necessary adjustments to maintenance protocols or corrective actions.	

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 01/09/2025

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 7 On 01/08/2025 at 12:53 PM, surveyor #2 interviewed the US FOIA (b)(6) who stated there was no current director of housekeeping at the facility at this time. When asked what the process was for cleaning rooms was the US FOIA (b)(6) stated the process for cleaning the units in morning was, they would pull the trash from the resident's rooms, when the food trucks arrived the housekeeping staff would move to the common areas to clean. The housekeepers would sweep, wipe horizontal surfaces with disinfectant, and mop the floors. In the bathrooms all surfaces were disinfected including the toilet and the floor was mopped. The porter was responsible for removing soiled linens and trash then dust and mop the floors using the auto scrubber machine daily. Unit inspections and individual room carbolizations were done monthly. If something is found to be in need of repair then staff were to verbally notify the US FOIA (b)(6)). Cleaning of corners and edges was a scheduled monthly task. On 01/09/2025 at 10:05 AM, surveyor #2 interviewed the US FOIA (b)(6) who stated the facility conducted environmental rounds and would look for things in the room that needed attention. When asked if there was a schedule or a checklist to follow when performing rounds and the US FOIA (b)(6) stated, "Can't say we have schedule of rounds or checklist". A review of the facility's undated "Resident Room Cleaning" policy revealed... All resident rooms are to be cleaned daily... the process of 7 steps of cleaning and disinfecting resident rooms... empty	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 01/09/2025

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 8 trash, ...using EPA approved solutions disinfect all horizontal surfaces... clean walls, wipe down all vertical surfaces...clean and disinfect the bathroom... dust mop... all corners and along all baseboards must be dust mopped to prevent buildup... damp mop... NJAC 8:39-31.4(a)	F 584		
F 695 SS=E	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, medical record review and review of other facility documentation, it was determined that the facility failed to contain NJ Exec Order 26.4b1 equipment (NJ Exec Order 26.4b1 delivery systems in protective coverings for 4 of 4 residents (Resident #26, #42, #55 and #368) reviewed for NJ Exec Order 26.4b1 care. This deficient practice was evidenced by the following: 1. On 01/05/2025 at 10:28 AM, Surveyor #1 observed a NJ Exec Order 26.4b1 machine on top of Resident #55's dresser. The NJ Exec Order 26.4b1 was not currently in use. The NJ Exec Order 26.4b1 was lying on top of the dresser with the NJ Exec Order 26.4b1	F 695	CORRECTIVE ACTION: On 01/5/25, the NJ Exec Order 26.4b1 for resident #55 was discarded and the order was discontinued by the US FOIA (b)(6)). On 1/6/25, Resident #26 NJ Exec Order 26.4b1 and NJ Exec Order 2 were discarded. The care plan could not be updated, the resident was transferred to the hospital on NJ Exec Order 26 and did not return. On 1/8/25, resident #42 NJ Exec Order 26.4b1 was discarded and replaced, NJ Exec Order 26.4b1 clearly dated and replaced the NJ Exec Order 26.4b1 bags for storage of NJ Exec Order 26.4b1 equipment by the US FOIA (b)(6). MDS was updated	2/22/25

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 01/09/2025

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 9 facing upwards. The [redacted] was not covered while not in use and was exposed to contamination. The [redacted] was dated but not able to determine exact date except "24." The surveyor asked Resident #55 if he/she had used the [redacted] and Resident #55 responded that he/she had not used the machine. On 01/07/2025 at 08:46 AM, Resident #55 was observed lying in bed, [redacted]. Resident #55 was [redacted]. No [redacted] machine was observed in the residents room on this observation Resident #55 was the only occupant of room. According to the Admission record, Resident #55 was admitted to the facility with the following but not limited to diagnoses: [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed that Resident #55 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated [redacted]. According to Section [redacted] of the MDS, Resident #55 did not receive [redacted]. On 01/07/2025 at 10:57 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #55 as follows: A review of the [redacted] Medication Administration Record (MAR) revealed that Resident #55 received [redacted] every 6 hours as needed for	F 695	to show that resident received [redacted] O1/5/25, resident #368 [redacted] was replaced and dated by the shift supervisor and provided a [redacted] bag for storage when not in use. On 1/8/25, The Unit Managers conducted a 100% audit on all residents receiving respiratory treatment, to ensure that supplies are labelled, dated and properly stored, no issues found from the audit. IDENTIFICATION OF AT RISK RESIDENTS: All residents receiving respiratory treatment are potentially at risk for deficient practice. This can be identified by reviewing the residents' Electronic Medical Administration Records (EMAR). SYSTEMIC CHANGE: The DON initiated re-education 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/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 supply to include respiratory bag changes are completed weekly and PRN and documented on the ETAR . 4. Staff were	

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 01/09/2025

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 10 NJ Exec Order 26.4b1 at 05:36. According to the MAR no other treatments were provided following the administration on NJ Exec Order 26.4b1. According to the MAR the order was discontinued on NJ Exec Order 26.4b1 at 1500, which indicated that the order was discontinued after the survey team left the facility on NJ Exec Order 26.4b1. The order was actively in place during the observation of the NJ Exec Order 26.4b1 on the initial tour/observation on NJ Exec Order 26.4b1 at 10:28 AM as described above. A review of Resident #55's comprehensive care plan did not reveal a care plan for the use of NJ Exec Order 26.4b1. On 01/08/2025 at 09:03 AM, a review of the EMR revealed a progress note dated NJ Exec Order 26.4b1, Resident has occasional NJ Exec Order 26.4b1 as RX (prescription) for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 heard in NJ Exec Order 26.4b1 During an interview with the surveyor on 01/08/2025 at 10:21 AM, Licensed Practical Nurse/ Unit Manager (LPN/UM #1) was asked what the facility practice was for NJ Exec Order 26.4b1 equipment when not in use. LPN/UM#1 responded that the NJ Exec Order 26.4b1 when not in use are to be placed in a plastic bag. The NJ Exec Order 26.4b1 is to be changed every Sunday on 11-7 shift. The surveyor then asked LPN/UM #1 why is was important to protect NJ Exec Order 26.4b1 when not in use and LPN/UM #1 responded, "It's an infection control practice to ensure resident safety."	F 695	IN serviced on the requirements of proper storage in a respiratory bag when not in use. QUALITY ASSURANCE: Unit Managers, supervisors or designee will audit all residents who require respiratory treatment daily for 4 weeks, weekly for 8 weeks, and then bi-weekly for 16 weeks, to ensure the facility is compliant with respiratory care policy and standard of practice. The auditing will be as follows: weekly respiratory supply changes are documented on the ETAR with the specific day of the week according to the physician order, proper storage of respiratory equipment when not in use, and the change of the storage bag. 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 01/09/2025

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 11 On 01/08/2025 at 02:17 PM during a meeting with the facility administration including the [US FOIA (b)(6)] [redacted] the surveyor asked what the facility practice was for [NJ Exec Order 26.4b1] equipment when not in use. The [US FOIA (b)] told the surveyors that the [NJ Exec Order 26.4b1] should be bagged when not in use and [NJ Exec Order 2] was to be dated weekly. The [US FOIA (b)] further explained that [NJ Exec Order 26.4b1] are to bagged when not in use and the reason was It is important for [NJ Ex Order 26.4(b)] prevention. 2. On 01/06/2025 at 11:28 AM, during the initial tour of the facility, Surveyor #2 observed Resident # 26 in bed. At that time, Resident # 26 was wearing a [NJ Exec Order 26.4b1 [redacted]). Upon further observation, the surveyor was unable to determine if the [NJ Exec Order 26.4b1] was dated however, Surveyor #2 also observed a [NJ Exec Order 26.4b1] [redacted] on top the nightstand attached to the [NJ Exec Order 26.4b1] by the elastic band of the [NJ Exec Order 26.4b1]. The [NJ Exec Order 26.4b1] not inside a container or bag exposing it to air. On 01/06/2025 at 12:48 PM, the surveyor reviewed Resident # 26's Electronic Medical Record (EMR) as follows: A review of Resident # 26's EMR revealed he/she had a diagnosis of but not limited to [NJ Exec Order 26.] [redacted] A review RFesident #26's most recent MDS dated [NJ Exec Order 26.4b1], under Section [NJ Exe] did not indicate that Resident #26 received [NJ Exec Order 26.4b1]. Under "Orders" section of EMR Resident #26 had	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 01/09/2025

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 12 a physician order for NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 every 4 hours as need for NJ Exec Order 26.4b1. According to the Medication Administration Record (MAR) for the month of NJ Exec Order 26.4b1, it was revealed that Resident #26 received NJ Exec Order 26.4b1 at 05:15 PM, NJ Exec Order 26.4b1 at 07:30 AM , and NJ Exec Order 26.4b1 at 08:00AM. A review of Resident #26's Comprehensive Care Plan did not address the use or care of NJ Exec Order 26.4b1. 3. During the initial tour on NJ Exec Order 26.4b1 at 09:26 AM, Surveyor #3 observed a NJ Exec Order 26.4b1 on the windowsill of Resident #42's room. It was unbagged with the interior NJ Exec Order 26.4b1. Resident #42 pointed to their NJ Exec Order 26.4b1 on the side table to their right. Another NJ Exec Order 26.4b1 was lying beside the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1 to the air and contamination.. The resident stated that they used the machine every night. On 01/07/2025 at 08:30 AM, Surveyor #3 observed a NJ Exec Order 26.4b1 in the same position as observed on the initial tour, unbagged and on the windowsill. An additional unbagged NJ Exec Order 26.4b1 was located on the side table to the with the interior exposed to air and contamination. On 01/08/25 at 09:55 AM, Surveyor #3 observed the unbagged NJ Exec Order 26.4b1 located on the windowsill and on the side table to the right.	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 01/09/2025

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 13 Surveyor #5 showed LPN #2 the masks and they stated that the [redacted] should have been bagged. LPN #2 proceeded to bag the [redacted]. According to the Admission Record, Resident #42 was admitted to the facility with diagnoses including but not limited to: [redacted]. A review of the most recent MDS, dated [redacted] reflected a BIMS score of [redacted] out of 15, which indicated that the resident was [redacted]. Section [redacted] of the [redacted] did not reflect that Resident #42 received [redacted]. A review of the active Physician's Orders (PO) did not reflect an order for [redacted] until [redacted], when an order to apply [redacted] at night with settings at [redacted] remove in AM was initiated. A further review of the PO revealed a previous order for [redacted] use initiated on [redacted] and was discontinued on [redacted]. 4. During the initial tour on 01/05/2025 at 10:02 AM, Surveyor #3 observed Resident #368 in bed with [redacted] per [redacted] via [redacted] The [redacted] was observed to be unlabeled and undated. According to the Admission Record , Resident #368 was admitted to the facility with diagnoses including but not limited to: [redacted]	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 01/09/2025

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 14 NJ Exec Order 26.4b1 [redacted] A review of the most recent comprehensive MDS dated NJ Exec Order 26.4b1, reflected a BIMS score of NJ Exec out of 15 which indicated that the resident was NJ Exec Order 26.4b1. A review of the active Physician's Orders reflected an order with an initiated date of NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1. The PO also included another order for changing the NJ Exec Order 26.4b1 every night shift every Sunday was initiated on NJ Exec Order 26.4b1. A review of the Baseline Care Plan initiated on NJ Exec Order 26.4b1 . On 01/08/2025 at 02:20 PM, the survey team met with the facility administration including the US FOIA (b)(6) The US FOIA (b) stated that the facility protocol would have the NJ Exec Order 26.4b1 and NJ Exec Order 2 bagged when not in use and dated. The US FOIA (b) stated that there should be an order for it. US FOIA (b) further stated that the same goes for NJ Exec Order 26.4b1 machine use. A review of a facility policy titled Oxygen Administration updated in October 2024, included under Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. 5.d. If applicable, change nebulizer tubing and delivery devices every 72 hours or per facility policy and as needed ...e. Keep delivery devices covered in plastic bag when not in use.	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 01/09/2025

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 15 The facility was unable to provide a policy addressing the use of Nebulizer equipment.	F 695		
F 712 SS=D	NJAC 8:39-27.1(a) Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission. This	F 712	CORRECTIVE ACTION: Resident #7 had a face-to-face visit on [redacted] with [redacted] physician. Resident #367 had a face-to-face visit with [redacted] physician on [redacted].	2/22/25

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 01/09/2025

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 712	Continued From page 16 deficient practice was observed for 2 of 25 sampled residents, (Resident #367 and #7) . This deficient practice was evidenced by the following: 1. On 01/05/2025 at 09:45 AM, the surveyor observed Resident #367 lying in bed. Resident #367 stated they had not seen the doctor but just saw their bills. A review of Resident #367's hybrid (electronic and paper) medical records (MR) from [redacted] revealed the following: The Admission Record (AR) reflected that the resident was admitted to the facility with diagnoses that included [redacted]. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed that Resident #367 had a Brief Interview for Mental Status (BIMS) score of [redacted] of 15 which indicated that the resident was [redacted]. A review of the Electronic Medical Record (EMR) revealed the [redacted] progress notes (PN) dated [redacted]. A further review of the PN did not reveal any PN from the attending physician from [redacted].	F 712	IDENTIFICATION OF AT RISK RESIDENTS: All residents residing in the facility are potentially at risk for the deficient practice. SYSTEMIC CHANGES: The physicians were in-serviced on the regulatory requirements of physician visits and electronic/ hybrid documentation in the progress note in the resident chart. QUALITY ASSURANCE: The DON/ADON/designee will conduct a random audit of 10 residents per unit monthly for 6 months to ensure the physicians are in compliance with a face-to-face visit per the facility policy and regulatory guidelines. Any issues from the audit will be addressed immediately. Results will be reported to the Administrator as well as the Quality Assurance Committee quarterly for 2 quarters 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 01/09/2025

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 712	Continued From page 17 A review of the paper medical records did not reveal any PN from the attending physician from [redacted]. 2. On 01/05/2025 at 09:55 AM, the surveyor observed Resident #7 waiting outside their room for a medical appointment. A review of Resident #7's hybrid medical records from [redacted] revealed the following: The Admission Record reflected that the resident was admitted to the facility with diagnoses that included [redacted]. A review of the most recent comprehensive MDS, an assessment tool used to facilitate the management of care, dated [redacted] revealed that the resident had a BIMS score of [redacted] of 15 which indicated that the resident was [redacted]. A review of the EMR revealed the NP visit progress notes PN dated [redacted]. A further review of the PN did not reveal any PN from the attending physician from [redacted]. A review of the paper medical records did not include documentation of the attending physician visit from [redacted]. During an interview with the surveyor on 01/08/2025 at 09:30 AM, Licensed Practical	F 712		

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 01/09/2025

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 712	Continued From page 18 Nurse (LPN #2) stated that physicians make rounds and update their notes. During an interview with the surveyor on 01/08/2025 at 10:05 AM , Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated that after the physicians see the patients, they will document and flag the paper charts. LPN/ UM #2 further stated that the doctors (MD #1 and MD#2) have access to the electronic medical record. During an interview with the surveyors on 01/08/2025 at 02:00 PM, the US FOIA (b)(6) stated that all physicians have access to the electronic medical record. The US FOIA (b) further said that some physicians did handwritten notes which should have been scanned and uploaded to EMR or placed in the residents' paper charts. A review of the facility provided policy titled Physician Visits and Physician Delegation revised in October 2022, included under Policy Explanation and Compliance Guidelines section: 2. The Physician should: a. See resident within 30 days of initial admission to the facility. d. Date, write and sign a progress note for each visit.	F 712		
F 756 SS=D	NJAC 8:39-23.2 (b) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		2/22/25

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 01/09/2025

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 756	Continued From page 19 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility records it was determined that the facility failed to follow through on recommendations made by the US FOIA (b)(6) during their monthly medication regimen review (MRR) in a consistent and timely manner. This deficient	F 756	Corrective Measures for Resident Affected: Resident #55's order for NJ Exec Order 26.4b1 was discontinued on NJ Exec Order 26 US FOIA (b)(6) audited the last two months pharmacy consultant (CP) recommendations drug regimen report for	

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 01/09/2025

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 756	Continued From page 20 practice was observed for 1 of 5 residents (Resident #55) and was evidenced by the following: On 01/07/2025 at 08:48 AM Resident #55 was observed lying in bed NJ Exec Order 26.4b1. Resident #55 was NJ Exec Order 26.4b1 and answered surveyor questions. No NJ Exec Order 26.4b1 were observed, and Resident #55 did not appear to be in NJ Exec Order 26.4b1. Resident #55 was observed to be NJ Exec Order 26.4b1. According to the Admission record, Resident #55 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 revealed that Resident #55 had a Brief Interview for Mental Status score of NJ/15 which indicated NJ Exec Order 26.4b1. On 01/07/2025 at 01:19 PM, the surveyor reviewed the NJ Exec Order 26.4b1 of consultant pharmacist (CP) therapeutic suggestions for Resident #55 during the monthly medication regimen review process. The CP made the following recommendation on NJ Exec Order 26.4b1: PRN (as needed) medications that have not been used for over 60 days are recommended to be discontinued. Please consider discontinuing NJ Exec Order 26.4b1). On NJ Exec Order 26.4b1 the facility responded to the CP's therapeutic suggestion and indicated that the NJ Exec Order 26.4b1 had been discontinued by writing "D/c'd" (discontinued) on the therapeutic	F 756	deficient practice, no further issues were found from the audit. Identification of Residents with the potential to be affected: All residents are potentially at risk for the deficient practice. This can be identified by reviewing the physician orders and the electronic medication administration record (EMAR). Systemic Change (Measures to prevent reoccurrence): The Unit Managers (UM) were re-educated by the director of nursing upon receiving the monthly consultant pharmacy (CP) reports, the recommendations must be reviewed and completed before the next subsequent review is available. The completed report will be reviewed by the director of nursing for completion and accuracy. Monitoring of Corrective Measures: Director of nursing and or designee will do random audits of monthly CP reports of 4 residents from each unit to ensure recommendations have been reviewed for accuracy and completion monthly X 6 months. Any issues found from the audit will be addressed immediately. Findings will be reported to the administrator as well as the Quality Assurance 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 01/09/2025

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 756	Continued From page 21	F 756		

suggestion sheet. However, when the surveyor reviewed the NJ Exec Order 26.4b1 Medication Administration Record (MAR) for Resident #55 to ensure that the medication had been discontinued by the facility, the MAR revealed that the order for NJ Exec Order 26.4b1 was discontinued on NJ Exec Order 26.4b1 at 0919 (9:19 AM). This was done approximately 45 days after recommendation and the same day the reports were made available to the survey team.

On 01/08/25 at 02:31 PM the surveyor conducted an interview with the facility US FOIA (b)(6) The surveyor asked the US FOIA (b) what the facility process was for responding to the CP's therapeutic suggestions once received by the facility and the US FOIA (b) told the surveyor that recommendations are addressed by unit managers, and they are completed prior to the next CP visit. I spot check them or I'll address something if I am notified. I do not regularly review them for accuracy or completion. The surveyor then asked the US FOIA (b) to provide the surveyor with the last date that the CP visited the facility for the monthly medication regimen review. The US FOIA (b) told the surveyor that the last visit to the facility by the CP was 12/23/2024.

A review of a facility policy titled Pharmacy Services-Role of the Consultant Pharmacist revealed the following under Policy Interpretation and Implementation:

Providing the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. The facility will review the reports before the next subsequent review is available.

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 01/09/2025

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 756	Continued From page 22 NJAC 8:39-29.3(a)(1)	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		2/22/25

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 01/09/2025

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 758	Continued From page 23 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to ensure that specific target behaviors exhibited were documented as well as the non-pharmacological interventions attempted prior to the administration of an NJ Exec Order 26.4b1 medication. This deficient practice was identified for 1 of 1 resident reviewed for NJ Exec Order [redacted] (Resident # 45) and was evidenced by the following: On 01/05/2025 at 09:52 AM, the surveyor observed Resident #45 in the unit activity room sitting in his/her wheelchair (w/c) at the table. Resident appeared NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in the w/c, and appeared to have NJ Exec Order 26.4b1 [redacted] A review of the EMR on NJ Exec Order 26.4b1 at 01:00 PM, revealed the following: According to the Admission Record, Resident #45 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1	F 758	Corrective Measures for Resident Affected: On NJ Exec Order [redacted], US FOIA (b)(6) [redacted] reviewed Resident # 45 PRN (as needed) NJ Exec Order 26.4b1 medication with MD with no further orders. On 1/8/25, Nurses were educated by the DON to document target behavior and non-pharmaceutical interventions must be attempted prior to administration of medication. Identification of Residents with the potential to be affected: All residents receiving PRN Psychoactive medications are potentially at risk for the deficient practice. This can be identified by reviewing physician orders and electronic mediation administration. Systemic Change (Measures to prevent reoccurrence) On 1/27/2025, re-education stared by the DON for all nurses on the facility policy regarding the administration of PRN Psychotropic medication. The education included documenting target	

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 01/09/2025

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 758	Continued From page 24 NJ Exec Order 26.4b1 A review of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care dated NJ Exec Order 26.4b1, revealed Resident #45 had a Brief Interview for Mental Status score of [redacted]/15, indicating NJ Exec Order 26.4b1. A further review indicated that the resident had wandering behavior 1 to 3 days and is taking an NJ Exec Order 26.4b1. A review of the Order Summary Report with Active orders as of NJ Exec Order 26.4b1, revealed a physician order for NJ Exec Order 26.4b1) Oral Tablet NJ Exec Order 26.4b1 by mouth every 6 hours as needed for NJ Exec Order 26.4b for 14 Days. A review of the EMAR (Electronic Medication Administration Record) progress notes from NJ Exec Order 26.4b1 as follows: Resident #45 received NJ Exec Order 26.4b1 There was no documentation in the EMAR progress notes for 23 of the 52 times of behaviors that Resident #45 exhibited and any non-pharmacological interventions that were attempted prior to administering the medication. Resident #45 received the medication on the following dates: NJ Exec Order 26.4b1 . A review of the care plan for Resident #45 revealed a Focus are of [resident name] has a behavior problem related to NJ Exec Order 26.4b1 with	F 758	behavior for the medication, and attempting non-pharmacological interventions prior to administration of medication. This education will be added to the newly hired staff nurses, as well as the welcome facility package for the Agency staff. Education will be completed on 2/20/25 Monitoring of Corrective Measures: The Unit managers /designee will do audits of residents receiving PRN psychoactive medication daily x 4 weeks, weekly x 5 months to ensure target behaviors for the medication are documented and non-pharmacological interventions are attempted prior to administration of the medication. The DON/designee will do a random audit of two residents on each unit receiving PRN Psychoactive medications weekly X 4 weeks then monthly X 5 months The Pharmacy consultant will do a monthly review of all residents receiving PRN psychoactive medications for target behaviors and non-pharmacological interventions. Any issues found from the audits will be addressed immediately and reported to the administrator as well as the Quality Assurance Committee quarterly for 2 quarters	

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 01/09/2025

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 758	Continued From page 25 NJ Exec Order 26.4b1 [redacted] with Date Initiated: NJ Exec Order 26.4b1. Under the Goal section resident will have fewer episodes of interfering with roommates' care. Interventions include but are not limited to: Approach/Speak in a NJ Exec Order 26.4b1. Remove from situation and take to alternate location as needed, monitor NJ Exec Order 26.4b1, and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. During an interview with the surveyor on 01/08/2025 at 10:31 AM, Licensed Practical Nurse (LPN #3) was asked what the facility policy was for a resident who is prescribed a PRN (as needed) NJ Exec Order 26.4b1 [redacted] LPN #3 replied psychiatry sees the resident and makes recommendations. We get family and physician approval. There is behavior charting for 14 days for adverse side effects or targeted behaviors. When asked where is this documented, LPN #3 stated in the EMR under progress notes. LPN #3 confirmed that "Absolutely it is expected to document non-pharmacological interventions prior to administration and the final effect of the medication." During an interview with the surveyor on 01/08/2025 at 10:36 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) was asked what the facility policy was for a resident is who is prescribed a PRN NJ Exec Order 26.4b1 medication. LPN/UM #1 replied that prn NJ Exec Order 26.4b1 medications are 14 days only, and after that we reach out for new order from the physician.	F 758		

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 01/09/2025

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 758	Continued From page 26 LPN/UM #1 went on to say for PRN we notify family and get consent prior to administering. The nurse prior to administration goes through nonpharmacological interventions such as walks, snacks and conversation. If that is ineffective, they administer the medication and document effective or not effective. LPN/UM #1 said the expectation is to document behaviors, non-pharmacological interventions attempted, and administer medication and document effect post administration. During an interview with the surveyor on 01/08/2025 at 01:59 PM, the[US FOIA (b)(6)] was asked what the facility policy was for a resident who is prescribed a PRN [NJ Exec Order 26.4b1] medication. The [US FOIA (b)] said it depends on the order. If the patient requests, or if they exhibit signs/symptoms of [NJ Exec Order 26.4b] we would give the medication. The nurses document on EMAR and there should be a section to note effective and go back and check. The [US FOIA (b)] confirmed yes, there should be documentation of any non-pharmacological interventions used and this would be in the EMAR progress notes. The [US FOIA (b)] also said yes, there should be documentation of signs and symptoms exhibited by the resident prior to administering the medication. On 01/08/2025 at 01:13 PM, a review of a facility policy titled Use of Psychotropic Medication with a reviewed date of October 2024, revealed under Policy Explanation and Compliance Guidelines section: 4. The indications for use of any psychotropic drug will be documented in the medical record. b. For psychotropic drugs that are initiated after admission into the facility, documentation shall include the specific condition as diagnosed by the physician. ii	F 758		

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 01/09/2025

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 758	Continued From page 27 non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation.	F 758		
F 812 SS=F	NJAC 27.1(a) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 01/05/2025 from 08:54 to 9:38 AM,, the	F 812	Food Prep store/prepare/serve-sanitary 1. During the kitchen walk-through, unlabeled food items were found in the walk-in refrigerator and storage area. The unlabeled food including the wilted lettuce, and large baked potato, dry pasta, red grapes, pieces of honey dew melon, the	2/22/25

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 01/09/2025

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 surveyor, accompanied by the US FOIA (b)(6) [redacted], observed the following in the kitchen: 1. Upon entry to the kitchen the surveyor observed three (3) staff actively working on the breakfast tray line. 3 of 3 female staff did not have hairnets and their hair was exposed while actively working with food. One (1) staff had lengthy hair in a ponytail, a second staff had lengthy hair in a bun style with a head band around their forehead and the third staff also had lengthy hair pulled back and in a hair tie. On interview the [redacted] told the surveyor, "Yes, we should have hair nets. I'm sorry." 2. Observation of the Walk-In refrigerator temperature log revealed that no temperatures were recorded for the following: 1/2/2025 PM, 1/3/2025 AM, 1/4/2025 AM and 1/5/2025 AM. According to the [redacted] the morning and evening cook were responsible for recording refrigeration temps. 3. Observation of the prep table/sink adjacent to the walk-in refrigerator revealed what appeared to wilted lettuce and an unidentified white substance on the tile floor. In addition, several plastic portion control cups were observed under the table. When interviewed the [redacted] agreed that the area had not been cleaned from the previous day. 4.In the dry storage area on a middle shelf of a multi-tiered storage rack a previously opened bag of dry pasta had no open or use by dates. On interview the [redacted] agreed that previously opened food products required an open and use by date.	F 812	pan was removed on 1/5/2025, Iceberg lettuce, heads of lettuce were all immediately removed and discarded including the prep sink area on 1/5/25. 2. All residents have the potential to be affected by this deficient practice. Immediate confirmation that all other food items were labeled properly by the Food Service Director. No other food items were unlabeled. 3. Staff were in-serviced on label/date requirements for all food items opened. Staff were In serviced by the regional food service director on the cleaning schedule including the prep sink areas on 1/10/25. The Food Service Director/ Designee will complete weekly random audits for dating and labeling adherence 1 x a week x 4 weeks., then 1 x a month x 2 months. 4. Results of the audits will be provided to the Administrator by the Food Service Director and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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 01/09/2025

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 5. On an upper shelf of the walk-in refrigerator a Styrofoam take out style container contained a large baked potato. The container had no dates. In addition, a deep 1/4 pan contained baked beans and was covered with plastic wrap. The pan had no dates. A second deep 1/4 pan covered with clear plastic wrap contained red grapes, pieces of pineapple and pieces of honey dew melon. The pan had no dates. On a middle shelf an opened cardboard box contained iceberg lettuce heads. Visual inspection of the lettuce revealed that several heads of lettuce were brown and slimy on appearance. When interviewed the US FOIA (b)(6) told the surveyor that all food products should be dated. The US FOIA (b)(6) told the surveyor that she would throw them out and proceeded to remove the undated foods from the walk-in. 6. Prior to entering the walk-in freezer the surveyor observed the walk-in freezer temperature log attached to the door. The temperature log did not have internal freezer temperatures recorded for the following dates: 1/2/2025 PM, 1/3/2025 AM, 1/4/2025 AM, and 1/5/2025 AM. When interviewed the US FOIA (b)(6) told the surveyor that the AM and PM cooks were responsible for recording the refrigerator and freezer temperatures. A review of a facility policy titled Food Storage: Cold Foods, [company name] Policy 019, revised 2/2023, revealed under Procedures: 4. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a	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 01/09/2025

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 manner to prevent cross contamination. A review of a facility policy titled Staff Attire, [company name] Policy 024, revised 10/2023, revealed under Procedures: 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. A review of a facility policy titled Food Storage: Dry Goods, [company name] Policy 018, revised 2/2023, revealed under Procedures: 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. N.J.A.C. 8:39-17.2 (g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris and failed to have a cover over the opening of 3 of 3 garbage containers/dumpsters. This deficient practice was evidenced by the following: On 01/05/2025 at approximately 9:30 AM, the surveyor, accompanied by the[redacted], observed four (4) yard	F 814	1. On 1/05/25 the surveyor observed 3 of the 4 dumpster lids open. The lids were immediately closed on 1/5/25. 2. All residents and staff have the potential to be affected by this deficient practice. All residential areas nearby have the potential to be affected by this deficient practice. 3 All housekeeping and dietary staff were in-serviced by the regional food service manager 1/10/25 on the importance of a	2/22/25

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 01/09/2025

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 814	Continued From page 31 dumpsters that were designated for garbage in the facility parking lot. According to the [redacted] three of the dumpsters were designated for garbage and one dumpster was designated for recyclables. 3 of 3 dumpsters designated for garbage had the contents of bagged trash exposed due to the dumpster lids not being fully closed. Each dumpster had two (2) plastic lids to cover the garbage dumpster. Dumpster #1 had 2 of 2 plastic lids in the open position which exposed the bagged garbage. Dumpster #2 had 1 of 2 lids opened exposing bagged garbage and dumpster #3 had 1 of 2 lids opened exposing bagged garbage. On interview the [redacted] told the surveyor that the garbage area was a shared responsibility between the kitchen staff and environmental staff, and they were responsible for the maintenance of the area. In addition to the exposed contents of the dumpsters the area surrounding the garbage dumpsters was observed to have garbage on the ground. The garbage included plastic cups, disposable gloves, plastic bags, plastic milk crates and other unidentified debris. On 01/09/2025 at 10:47 AM, during a meeting with facility administration the [redacted] agreed that garbage dumpsters must be covered at all times. A reviewed of a facility policy titled Dispose of Garbage and Refuse, [company name] Policy 030, dated 8/2017, revealed the following under Policy Statement: All garbage and refuse will be collected and disposed of in a safe and efficient manner. In addition, the following was revealed under Procedures: 1. The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding	F 814	clean and secure dumpster area. 4.EVS Account Manager will conduct audits daily to ensure lids are kept closed and all debris is cleaned up. The results of the audit will be reviewed monthly x 6 months with QAPI and quarterly for 2 quarters with the QAA committee or until substantial compliance is met in all areas that have the potential to have this deficient practice.	

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 01/09/2025

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 814	Continued From page 32 the exterior dumpster is maintained in a manner free of rubbish or other debris. NJAC 8:39-19.3(c)	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		2/22/25

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 01/09/2025

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 880	Continued From page 33 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records, and other facility documentation, it was determined that the facility failed to follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for 4 of 6	F 880	Corrective Measures for Resident Affected: on 1/7/25 Housekeeping (HSKP) 1 was immediately in- serviced by the Infection	

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 01/09/2025

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 880	Continued From page 34 staff (2 Housekeepers, 2 Certified Nursing Assistants) to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy. This deficient practice was evidenced by the following: Reference: Hand hygiene should be performed immediately before touching a patient; before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or patient's surroundings; after contact with blood, body fluids, or contaminated surfaces; immediately after glove removal. CDC recommendations for Hand Hygiene: Updated February 27, 2024: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html#cdc_clinical_safety_best_practices_recomm-recommendations 1. On 01/07/2025 at 09:16 AM, the surveyor observed the housekeeping staff (HSK #1) transfer bags of soiled linens wearing gloves from the subacute rehab (SAR) unit soiled linen room to a rolling covered linen cart. HSK #1 removed their gloves but did not wash nor sanitized their hands after removing the gloves. HSK #1 pushed the cart in the hallway until it reached the laundry soiled linen room. On 01/07/2025 at 12:35 PM, the surveyor observed Certified Nursing Assistant (CNA #2) in room 24 exit the bathroom with wet paper towels	F 880	Control Preventionist (IP) on proper hand washing technique with return demonstration through a handwashing competency. On 1/8/25 Certified Nursing Assistant (C,N.A) # 2 was immediately r-educated by the IP on proper hand hygiene technique through handwashing competency On 1/7/25 C.N.A # 1 was immediately in serviced by the IP on proper handling of solid lines and hand hygiene through competencies. On 1/7/25 HSKP # 1 and # 2 were immediately serviced by the IP on donning and doffing PPE when sorting out soiled linen in the laundry with return demonstration and through competency. Identification of Residents with the potential to be affected: All Residents are potentially at risk for the deficient practice. Systemic Change: (Measures to prevent reoccurrence) On 1/27/25, the IP re-in-serviced all staff on the Infection Control (IC)guidelines to include performing Hand hygiene, doing and doffing PPE, and handling soiled linens in a manner that would decrease the spread of infection per the facility policy. In-service training includes random observation of staff performing hand hygiene procedures, donning/doffing PPE according to facility policy. Findings are reviewed with all personnel. Corrective	

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 01/09/2025

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 880	Continued From page 35 in her hand. CNA #2 proceed to touch the cover of a foot-operated trash can with bare hands to discard the wet paper towels. CNA #2 did not wash nor sanitized hands after touching the trash can cover. On 01/08/2025 at 12:03 PM, the surveyor observed CNA #1 pickup soiled linens from the floor and place them in a plastic bag without wearing gloves. He then placed the bag into a bin in the soiled linen room. CNA #1 returned to the resident room and picked up a soiled pink blanket and walked in the hallway carrying the pink blanket unbagged. CNA #1 then opened the soiled linen door and threw the blanket into a bin. CNA #1 did not wash nor sanitized their hands after discarding the spoiled blanket. CNA #1 then went to the clean linen cart, obtained clean linen then proceeded to put the clean linen on the mattress in the resident's room. 2. On 01/07/2025 at 09:20 AM, the surveyor observed HSK #1 sort soiled linens in the laundry soiled linen room wearing only gloves. Another housekeeping staff #2 (HSK #2) put on gloves, opened the soiled linen plastic bags, and sorted dirty linens. Neither HSK staff wore any other PPE. On 01/07/2025 at 10:23 AM, the surveyor observed two yellow reusable gowns hanging from a wall in the laundry washing area next to the soiled linen room. When surveyor asked HSK #2 when they should use the reusable gowns, HSK #2 stated we have these things and I guess we are supposed to wear them. that they were supposed to wear them but have never used them.	F 880	action is provided as needed. Upon hire at the facility, all staff will receive in-services and competencies on handwashing and PPE per the facility policy and the CDC guidelines. In-service completion is 2/20/25. Monitoring of Corrective Measures: A random audit of 10 staff members will be done by the Infection Control Preventionist/ designee on Hand washing and donning and doffing of PPE to include sorting out soiled linen in the laundry room weekly X 4 weeks, Bi-weekly for 8 weeks, monthly for 3 months, then on-going as needed to ensure compliance with facility IC policy and guidelines. Any issues from the audit will be addressed immediately and reported to the Administrator and as well as the Quality Assurance Committee quarterly for 2 quarters 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 01/09/2025

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 880	Continued From page 36 On 01/08/25 at 01:05 PM, the surveyor interviewed the US FOIA (b)(6) [redacted]. The [redacted] stated that there were reusable yellow gowns in the sorting area to wear while sorting dirty laundry as well as gloves. During an interview with the surveyor on 01/08/2025 at 01:05 PM, the US FOIA (b)(6) [redacted] was asked who collects the soiled linens. The [redacted] stated that porters collect soiled linens and should be wearing gloves when transferring soiled linen bags to the rolling cart. [redacted] further stated that after transferring bags to the cart, porters should remove their gloves and wash their hands if soiled, if not soiled they need to use sanitizer to sanitize their hands. At that time, the [redacted] stated that there were reusable yellow gowns in the sorting area to wear while sorting dirty laundry as well as gloves. A review of the facility policy titled Hand Hygiene updated in April 2024, under Policy Explanation and Compliance Guidelines revealed: 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, ...after touching a patient or the patient's immediate environment; after contact with blood, body fluids or contaminated surfaces; immediately before putting on gloves and after glove removal. A review of facility policy titled Laundry Operation with a revised date of 06/2016, under section Transferring Soiled Linen included but was not limited to; Statement ... all soiled linen must be covered during transportation and while being stored on unit or floors. A review of facility policy titled Laundry Operation with a revised date of 06/2016, under section	F 880		

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 01/09/2025

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 880	Continued From page 37 Sorting Soiled Linen included but was not limited to; 2. As soiled linens are sorted out into the proper wash classifications, employees must wear the proper protective equipment (PPE), which includes gloves and a protective apron. NJAC 8:39-19.4 (a)(1); 21.1 (b)	F 880		

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 01/09/2025

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
H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5750	8:43E-13.4(b) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of the Electronic Medical Record (EMR), as well as other facility documentation, it was determined that the facility failed to complete in its entirety, the New Jersey Universal Transfer Form (NJUTF) when a resident was transferred to the hospital for 1 of 3 residents reviewed for hospital transfers, (Resident #167). This deficient practice was evidenced by the following: Reference: New Jersey Hospital Association "Provider Resources" Section 6: The NJ Universal Transfer Form (UTF) must be used by all licensed healthcare facilities and programs when the patient is transferred from one care setting to another. A review of the EMR on 01/06/2025 at 12:05 PM, revealed the following:	H5750	Corrective Measures for Resident Affected: Resident #167 was discharged to [redacted] and [redacted] to the facility On 1/8/25, The Director of Nursing (DON) in-serviced staff nurses complete the New Jersey (NJ)Universal Transfer form prior to residents transferring to other healthcare setting. Identification of others with the potential to be affected: All residents transferring to other healthcare settings are potentially at risk for the deficient practice. This can be identified by reviewing the medical records. Systemic Change (Measures to prevent	2/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/31/25

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 01/09/2025

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
H5750	Continued From page 1 According to the Admission Record Resident #167 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] A review of a progress note dated NJ Exec Order 26.4b1 timed ay 5:30 PM signed by Licensed Practical Nurse/Unit Manager (LPN/UM #2) revealed called to residents' room by charge nurse. Resident observed sitting in wheelchair, NJ Exec Order 26.4b1, responding to NJ Exec Order 26.4b1 , no complaints of NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 [redacted] . NJ Exec Order 26.4b1 was fluctuating from [redacted]. Resident was assisted into bed and placed on NJ Exec Order 26.4b1 [redacted]. Physician notified; order obtained to send to hospital for evaluation. Son notified. A review of the NJUTF sent with the resident to the hospital on [redacted] revealed the following: section 1 incomplete no name of transfer to, section 7. contact person including phone numbers, vital signs incomplete regarding pain, section 10, section 11, section 12, section 14, 15 an d 16, section 18, section 22 and 23 were left blank. A review of the NJUTF (form HFEL-7) revealed the following at the top of the form: "Items 1-29 must be completed." During an interview with the surveyor on	H5750	recurrence): On 1/27/25, the DON/designee imitated re-education for all staff nurses to fully complete the NJ Universal Transfer form when transferring residents to another healthcare setting. All discharges will be reviewed by the clinical team the next day to ensure the NJ Universal Transfer form is entirely completed and accurate. In the event the that the Universal form is not fully completed, the form will be updated with the missing information and forwarded to the receiving facility. Education will be completed on 2/20/25 Monitoring of Corrective Measures: The DON/designee will audit NJ Universal Transfer form for all residents transferred to other health care settings to ensure the form is fully completed daily for 3 months. Any issues from the audit will be addressed immediately and reported to the Administrator as well as the Quality Assurance committee quarterly for 1 quarter	

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 01/09/2025

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
H5750	Continued From page 2 01/08/2025 at 10:27 AM, Licensed practical Nurse (LPN #1) was asked who fills out NJUTF when a resident transfers to the hospital. LPN #1 replied the nurse fills out the NJUTF. When questioned what is to be filled out on the NJUTF, LPN #1 responded everything is put on it. When asked should the entire form be completed, LPN #1 replied "Oh yeah, the whole form is to be completed. We keep copy in front of the chart." During an interview with the surveyor on 01/08/2025 at 01:58 PM, the Director of Nursing (DON)was asked who fills out the NJUTF. The DON replied the nurse of the resident being sent out. When asked what is to be filled out on NJUTF. The DON responded as much as is applicable and confirmed yes the form should all be filled out. A review of a facility policy on 01/09/2025 at 09:02 AM, titled Universal Patient Transfer Form updated October 2022, revealed under the Policy Statement It is the policy of the facility to use a universal transform form. The form will document patient demographics, sending facility name, receiving facility name, vital signs, diagnosis, primary care physician, medications, allergies, respiratory needs and cardiac arrest resuscitation status. The policy does not address that the NJUTF is to be completed in its entirety.	H5750		
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	S 000		

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 01/09/2025

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	Continued From page 3 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 ensure the facility had the required direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 10 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 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.	S 560	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 the deficient practice. SYSTEMIC CHANGE: The facility has increased online recruitment with updated posting to hire more facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, shift differentials, referral and sign-on bonuses are being utilized to become more competitive in the marketplace. In addition, the director of nursing will continue to meet daily with the staffing coordinator to ensure appropriate	2/22/25

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 01/09/2025

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 4 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 Nurse Staffing Reports completed by the facility for the weeks of 12/22/2024 and 12/29/2024, the facility was deficient in CNA staffing on 10 of 14 day shifts as follows: -12/22/24 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/24/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/26/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/28/20 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/29/24 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -12/30/24 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/01/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -01/02/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -01/03/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -01/04/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. During an interview with the surveyor on	S 560	staffing. Job fair scheduled on 2/18/25 efforts to recruit more facility employees. Facility has contracted with an additional staffing agency, Clip-Board health agency on 2/4/25 to fill open shifts. QUALITY ASSURANCE: The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for one year for all shifts. The administrator or designee will review the staffing schedule once a week for 90 days to ensure adequate staffing is met. Findings from the review will be reported to the Administrator and director of nursing. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly for 4 quarters.	

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 01/09/2025

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 5 01/08/2025 at 1:57 PM, the Director of Nursing (DON) was asked if she was familiar with the minimum staffing requirements. The DON replied on 7-3 shift 1 CNA to 8 residents, 3-11 shift 1 CNA to 10 residents and 11-7 shift 1 CNA to 14 residents. The DON stated that most times yes we meet those (requirements). A review of a facility policy on 01/08/2025 at 9:45 AM titled Staffing updated 2/2023, revealed under the Policy Interpretation and Implementation section One CNA to every eight residents for the day shift. One direct care staff member (Registered Nurse, Licensed Practical Nurse, CNA) to every 10 residents and one direct care staff member (Registered Nurse, Licensed Practical Nurse, CNA) to every 14 residents for the night shift.	S 560		

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 _____	R 02/28/2025

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 000}	INITIAL COMMENTS	{F 000}		
{F 880} SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	{F 880}		2/22/25

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

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 _____	R 02/28/2025

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 880}	Continued From page 1 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	{F 880}		

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	2/28/2025 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 F0577	Correction	ID Prefix F0584	Correction	ID Prefix F0695	Correction
Reg. # 483.10(g)(10)(11)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(i)	Completed
LSC	02/22/2025	LSC	02/22/2025	LSC	02/22/2025
ID Prefix F0712	Correction	ID Prefix F0756	Correction	ID Prefix F0758	Correction
Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed
LSC	02/22/2025	LSC	02/22/2025	LSC	02/22/2025
ID Prefix F0812	Correction	ID Prefix F0814	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed	Reg. #	Completed
LSC	02/22/2025	LSC	02/22/2025	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?
1/9/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
060505	A. Building B. Wing	2/28/2025

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 H5750 Reg. # 8:43E-13.4(b) LSC	Correction Completed 02/22/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/9/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060505 Y1	A. Building B. Wing Y2	2/28/2025 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 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/22/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/9/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. BUILDING **01** B. WING _____	**01/09/2025**

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		
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 01/06/2025, 01/07/2025, 01/08/2025 and 01/09/2025. 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 separations 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 power approximately 60% of the facility as per the (new) Maintenance Director. Generator #1 (annex) located: outside in front lot next to the Parsonage. (old yellow house) Emergency Power to "A" unit nursing.	K 000		

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

Electronically Signed | 01/31/2025

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 _____	**01/09/2025**

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 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 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 with a census of 109. The fire sprinkler system water is supplied by an exterior above ground water tank filled by well water.	K 000		
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	K 321		2/22/25

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 _____	**01/09/2025**

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 2 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 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 observations and interviews on 01/08/2025 and 01/09/2025 in the presence of the [redacted], it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7 and 8.4. This deficient practice had the potential to affect 109 residents and was evidenced by the following: 1. An observation on 01/08/2025 at 1:36 PM of the second laundry room door revealed it had a	K 321	1. The laundry door was identified to be tied preventing it from closing. The plastic bag tied to the laundry door was removed immediately on 1/10/25 by maintenance from the door and the door now closes with a self-closing device. Pictures to be provided The left kitchen door was identified to not be closing all the way into its frame. The left door at the kitchen service hallway was adjusted with a new hinge on 1/14/25 by Maintenance to ensure the door closed all the way. Pictures to be provided	

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 _____	01/09/2025

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 3 required self closing device but was held open by a plastic bag tied from a wall mounted clothes hanger to the door lever handle. This prevented the door from self closing and protecting the corridor from the hazardous area. In interviews at the time, the US FOIA (b)(6) [redacted] confirmed the observations. 2. An observation on 01/09/2025 at 11:07 AM revealed the service hall double doors to the kitchen did not close all the way. The left door leaf hit and stopped at the edge of the right fixed door leaf. The test was repeated 2 times with the same results. 3. An observation on 01/09/2025 at 11:36 AM revealed the service hall dietary dry storage room door was not equipped with a self closing or automatic closing device. The storage room was greater than 50 square feet and stored combustible boxes. In interviews at the times, the US FOIA (b)(6) [redacted] confirmed the observations. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/09/2025 at 2:36 PM. N.J.A.C 8:39-31.2(e)	K 321	The dry storeroom was identified to not have the proper door closure device. The dry storage room in the service hall by the kitchen was corrected and outfitted with an automatic door closure device on 1/14/25 by maintenance. Pictures to be provided 2. All residents have the potential to be affected by this. 3. The US FOIA (b)(6) [redacted] was educated by the regional administrator 1/15/25 on the importance of fire safety requirements from NFPA for fire rated safety and door closure requirements. All areas were identified and corrected to ensure proper door closure. 4. The maintenance director and department will be responsible for conducting monthly audits on the NFPA requirements for proper door closures in all areas throughout the facility x 6 months for 2 quarters. in all areas throughout the facility that have potential to have this deficient practice x 6 months then quarterly for 2 quarters. The Maintenance department will use a standardized	

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 _____	**01/09/2025**

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 4	K 321	checklist that includes compliance with NFPA standards, door alignment, latching mechanisms functionality, and seal integrity. The results of each audit will be reviewed and action taken as appropriate with QAPI and the QAA committee for 2 quarters. The QAA committee will determine if further action is needed and make necessary adjustments to maintenance protocols or corrective actions. Completion date set for 2/22/25	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		2/22/25

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 _____	01/09/2025

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 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/09/2025 in the presence of the US FOIA (b)(6) [redacted] it was a determined that the facility failed to perform monthly owners inspections of the range-hood fire wet chemical suppression system in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect 109 residents and was evidenced by the following: An observation at 11:29 AM of the kitchen range-hood fire suppression system wet chemical inspection tag, revealed the semi-annual inspection was performed on 08/16/2024 and there were no monthly inspections listed. The facility did not have the monthly inspection documentation indicating the monthly owners inspection had been performed for the previous 12 months. No further documentation was provided. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference at 2:36 PM. NJAC 8:39-31.2(e) NFPA 17 A, 96	K 324	1. The Kitchen hood was identified to be missing from the owner's kitchen Owners inspection per the NFPA requirement. The Kitchen monthly owners hood inspection was inspected 1/14/25 to ensure the NFPA requirement was met. A new log was created to ensure the monthly owner's inspection is completed monthly per the NFPA requirement on 1/14/25 Inspection to be provided 2. All residents have the potential to be affected by this. 3.The U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted] was educated by the regional administrator 1/15/25 on the importance of ensuring the kitchen range-hood wet fire suppression system monthly owners' inspection are checked and inspected per the NFPA requirements. 4. The maintenance director and department will be responsible for conducting monthly audits on the Kitchen hood owner's inspection in all areas throughout the facility x 6 months for 2 quarters. The results of the audit will be reviewed monthly x 6 months with QAPI and quarterly for 2 quarters with the QAA committee. The Maintenance department will use a standardized checklist that includes compliance with NFPA standards for Monthly Owners Kitchen Hood Inspection. The results of each audit will	

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 _____	01/09/2025

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 6	K 324	be reviewed and action taken as appropriate with QAPI and the QAA committee for 2 quarters. The QA committee will determine if further action is needed and make necessary adjustments to maintenance protocols or corrective actions. Date of completion set for 2/22/25	
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, 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, documentation review and interview on 01/07/2025, 01/08/2025 and 01/09/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to A.) inspect, test	K 353	1. The Facility Sprinkler Holding Tank was identified to be missing the required inspection. A tank specialist was contracted and inspected the tank to ensure the NFPA requirements are met on 1/29/25 by a tank specialist. Inspection to	2/22/25

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 _____	**01/09/2025**

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 7 and maintain the sprinkler water storage tank and fire hydrant, B.) maintain sprinkler heads and C.) maintain ceiling barrier openings in accordance with NFPA 25: 2011 Edition, Sections 5.2.1, 7.2.2.4, 7.3.2, 7.4.2, 9.1.1.2, and 13.4.4.2.9. and NFPA 101:2012 Edition. This deficient practice had the potential to affect 109 residents and was evidenced by the following: A.) An observation on 01/07/2025 revealed an exterior above ground fire sprinkler system water storage tank and a dry barrel fire hydrant located on the right side of the building at the edge of the parking lot. 1. A documentation review on 01/07/2025 revealed no documentation of required inspections, tests and maintenance for the above ground water storage tank. In an interview on 01/09/2025 the US FOIA (b)(6) [redacted] confirmed the documentation review. 2. A documentation review on 01/07/2025 revealed a fire hydrant test report from the service vendor dated 08/16/2024. The hydrant report listed in the deficiency summary on page 1. On page 2 under fire hydrant data there were no values for the flow test and results were checked as Fail. Under inspection performed it was checked as NO. There was no other record of the annual inspection, test and maintenance performed provided. In an interview on 01/09/2025 the US FOIA (b)(6) [redacted] confirmed the documentation review.	K 353	be provided. The Fire Hydrant was missing the flow test. The fire hydrant was tested on 2/5/25 by a fire safety vendor for flow test and values to meet the NFPA requirements. Inspection to be provided Several Sprinkler Escutcheons identified to have gaping. The sprinkler escutcheon at rooms 8,9,15,17,16,14,12,10, lounge in A wing, kitchen housekeeping closet and breakroom by the kitchen were adjusted on 1/14/25 by maintenance and no longer/ have gaps. Pictures to be provided Room 110 was identified as missing an escutcheon plate. Room 110 had a escutcheon plate placed by Maintenance. Pictures to be provided Room 5 identified as having penetration near sprinkler head. Room 5-bathroom missing sheet rock was sealed and repaired on 1/14/25 by maintenance. Pictures to be provided Missing drop ceiling tile was identified by the Environmental director office The drop ceiling in front of the environmental director's office was repaired and sealed on 1/14/25 by maintenance. Pictures to be provided The breakroom ceiling was identified as having penetration. The breakroom sheet rock patch was repaired and sealed properly on 1/14/25. Pictures to be provided	

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 _____	01/09/2025

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 8 B.) Observations on 01/08/2025 between 11:55 AM and 2:00 PM revealed: 1. Ceiling sprinkler escutcheons were coming down 1/2-inch to 3/4-inch from their proper place in the following resident rooms: 8, 9, 15, 17, 16, 14, 12, 10, the lounge in A wing, kitchen housekeeping closet, and break room by the kitchen. Room 110 had no escutcheon on the sprinkler head. 2. Room 5 bathroom had a 8-inch by 7-inch hole cut out in the sheetrock ceiling around the smoke detector and next to the sprinkler head that smoke and hot gasses could pass through delaying the activation of the two devices. The bottom piece of the sprinkler escutcheon was missing. 3. The drop ceiling in front of the Environmental Service Directors office had a 1-foot by 2-foot ceiling tile missing in front of the areas sprinkler head. In interviews at the times the US FOIA (b)(6) [redacted] confirmed the observations. C.) Observations on 01/09/2025 between 10:47 AM and 12:19 PM revealed: 1. The breakroom by the kitchen sheetrock ceiling had a 4-foot by 2-foot sheetrock patch that was not taped and spackled leaving 1/2-inch to 1-1/4 inch unfinished open spaces at the patch edges. 2. The kitchen housekeeping closet had a 18-inch by 18-inch unfinished sheetrock patch and a 5-inch by 7-inch hole through the sheetrock	K 353	The housekeeping kitchen closet was identified to have penetration. The kitchen housekeeping closet penetration was repaired and sealed properly on 1/14/25 by maintenance. Pictures to be provided The kitchen storage room identified to have penetration in the ceiling. The kitchen storage room Penetration was repaired and sealed properly on 1/14/25 by maintenance. Pictures to be provided The Subacute basement ceiling was identified to have penetration on the ceiling. The Subacute basement sheet rock penetration that was missing was repaired and sealed properly on 1/14/25 by maintenance. Pictures to be provided. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] was educated on by the regional administrator 1/15/25 on the importance of ensuring the hydrants are functional and operational and inspected as required, the maintenance director on the NFPA requirements that there is no penetration or vertical openings throughout, nothing be attached to the sprinkler and there shall be no gaping in between the sprinkler head and the ceiling.	

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 _____	**01/09/2025**

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 9 ceiling into the attic space. 3. The kitchen storage room had a 8-1/2 inch by 16-inch hole in the sheetrock ceiling going through to the attic space. 4. The subacute basement had a 2-foot by 2-foot hole in the plaster ceiling. In interviews at the times the US FOIA confirmed the observations. The facility US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/09/2025 at 2:36 PM. N.J.A.C. 8:39-31.2 (e) NFPA 25	K 353	4. The maintenance director and department will be responsible for conducting monthly audits on the NFPA requirements for penetration and tank/hydrant inspection in all areas throughout the facility that have potential to have this deficient practice x 6 months for 2 quarters. The results of the audit will be reviewed monthly x 6 months with QAPI and quarterly for 2 quarters with the QAA committee. The Maintenance department will use a standardized checklist that includes compliance with NFPA standards for penetration and tank and hydrant requirements. The results of each audit will be reviewed and action taken as appropriate with QAPI and the QAA committee for 2 quarters. The QA committee will determine if further action is needed and make necessary adjustments to maintenance protocols or corrective actions. Date of completion set for 2/22/25	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller	K 363		2/22/25

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 _____	01/09/2025

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 363	Continued From page 10 latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 01/08/2025 in the presence of the[US FOIA (b)(6)] [redacted], it was determined that the facility failed to ensure that doors in the corridor could resist the passage of smoke and had positive latching hardware in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.5 and 19.3.6.3.10. This deficient practice had the potential to affect 109 residents and was evidenced by the following:	K 363	1. The door for room 11 was identified to be misaligned, preventing it from latching properly. On 1/13/25 maintenance fixed the door was realigned, and the latching mechanism was replaced to ensure it meets NFPA standards for safety compliance and latches properly. Picture to be provided. The door to the B-Wing nurses supply closet was Identified to be misaligned,	

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 _____	**01/09/2025**

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 363	Continued From page 11 Observations on 01/08/2025 between 11:55 AM and 2:00 PM revealed the following: 1. The door to resident room 11 did not positively latch when closed. The test was repeated with the same results. 2. The door to the B wing nurses supply closet did not positively latch when closed. The test was repeated with the same results. 3. The door to the B wing clean linen room did not positively latch when closed. The test was repeated with the same results. 4. The door to the Sub-acute soiled linen room did not positively latch when closed. The door strike hit the door frame and the strike plate on the door frame had tape over it to prevent latching. The test was repeated with the same results. 5. The door to the Sub-acute AED room did not positively latch when closed. The test was repeated with the same results. In interviews at the times, the[redacted] confirmed the observations. The[redacted] was informed of the deficient practice at the Life Safety Code exit conference on 01/09/2025 at 2:36 PM. N.J.A.C 8:39-31.2 (e)	K 363	preventing it from latching properly. On 1/13/25 maintenance fixed the door was realigned, and the latching mechanism was replaced to ensure it meets NFPA standards for safety compliance and latches properly. Picture to be provided. The B-Wing clean linen was identified to be misaligned preventing it from latching properly. On 1/13/25 maintenance fixed the door was realigned, and the latching mechanism was replaced to ensure it meets NFPA standards for safety compliance and latches properly. Picture to be provided. Picture to be provided. The door to the subacute soiled linen room was identified to not be sealing properly. The door seal was replaced and the door frame adjusted on 1/13/25 maintenance fixed to ensure a proper seal, complying with safety regulations. Picture to be provided. The door to the AED room was identified to be misaligned, preventing it from latching properly. On 1/13/25 maintenance fixed the door was realigned, and the latching mechanism was replaced to ensure it meets NFPA standards for safety compliance and latches properly. 2. All residents and staff have the potential to be affected by this deficient practice.	

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 _____	**01/09/2025**

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 363	Continued From page 12	K 363	3. The US FOIA (b)(6) was educated by the regional administrator 1/15/25 on the importance of the NFPA requirements pertaining to having proper door alignment, latching function, and seal integrity for proper door closures. 4. The maintenance director and department will be responsible for conducting monthly audits on proper door alignment, latching function, and seal integrity in all areas throughout the facility that have potential to have this deficient practice x 6 months then quarterly for 2 quarters. The Maintenance department will use a standardized checklist that includes compliance with NFPA standards, door alignment, latching mechanisms functionality, and seal integrity. The results of each audit will be reviewed and action taken as appropriate with QAPI and the QAA committee for 2 quarters. The QAA committee will determine if further action is needed and make necessary adjustments to maintenance protocols or corrective actions. date of completion set for 2/22/25	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that	K 374		2/22/25

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 _____	01/09/2025

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 374	Continued From page 13 resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 01/08/2025 and 01/09/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure smoke and fire barrier doors closed into their door frame when released from their hold open devices or closed leaving only the minimum clearance necessary for proper operation to resist the passage of smoke and fire for 4 of 11 smoke and fire barrier doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.7 to 19.3.7.9, 8.3.3, 8.5.4, 8.5.4.1 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect 109 residents and was evidenced by the following: 1. An observation on 01/08/2025 at 11:10 AM of the serenity wing smoke barrier double doors by room 008, revealed the left door leaf did not close all the way into its frame when released from the fully open position. The test was repeated 2 times with the same result. 2. An observation on 01/08/2025 at 1:20 PM of the B wing smoke barrier double doors by room 114, revealed the left door leaf did not close all	K 374	1. The Smoke barrier door were identified to not be closing into its frame. The smoke barrier doors by room 8 were adjusted by tightening door frame on 1/13/25 by maintenance and fixed to ensure they close all the way into the frame. Pictures to be provided The Smoke barrier doors by room 114 were identified to not be closing into its frame The smoke barrier doors by room 114 were adjusted by replacing hardware on 1/13/25 by maintenance and fixed to ensure they close all the way into the frame. Pictures to be provided The Smoke barrier door was identified to not be closing into its frame. The smoke barrier doors by room 117 were adjusted by replacing hardware and tightening of hardware on 1/13/25 by maintenance and fixed to ensure they close all the way into the frame. Pictures to be provided. The Smoke barrier door was identified to not have the magnetic lock release device The doors connecting to the Assisted	

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 _____	01/09/2025

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 374	Continued From page 14 the way into its frame when released from the fully open position. The hardware bar on the left door leaf was loose and it hit the door jamb at the top, preventing it from closing. The test was repeated 2 times with the same result. 3. An observation on 01/08/2025 at 1:26 PM of the B wing double smoke barrier doors by room 117, revealed both door leafs did not close all the way into their frames when released from their hold open devices. The test was repeated 2 times with the same result. In interviews at the times, the U.S. FOIA (b) (6) U.S. FOIA and U.S. FOIA (b) (6) confirmed the observations. 4. An observation on 01/09/2025 at 10:53 AM of the 90 minute fire barrier double doors separating the Long Term Care occupancy from the Assisted Living occupancy, revealed the right door leaf was held fully open by a floor positioned door wedge tension fit between the bottom of the leaf and the floor. The right door leaf had no bracket to attach it to the wall mounted magnetic door hold open device that communicates with the fire alarm system and was designed to automatically drop out and release the door when the fire alarm was activated. In the event of a fire in either occupancy 1 of 2 door leaves separating them would not be able to automatically close. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code survey exit conference on 01/09/2025 at 2:36 PM.	K 374	Living were fixed with a bracket and a magnetic device on the wall on 1/13/25 by maintenance to ensure it would be released in an emergency event. Pictures to be provided. 2. All residents and staff have the potential to be affected by this deficient practice. 3. The U.S. FOIA (b) (6) was educated by the regional administrator 1/15/25 on the importance of the NFPA requirements pertaining to having door closures sealed properly for safety. 4. The maintenance director and department will be responsible for conducting monthly audits on door closures to ensure they are sealed properly for safety in all areas throughout the facility that have potential to have this deficient practice x 6 months then quarterly for 2 quarters. The Maintenance department will use a standardized checklist that includes compliance with NFPA requirements pertaining to having door closures sealed properly for safety. The results of each audit will be reviewed and action taken as appropriate with QAPI and the QAA committee for 2 quarters.	

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 _____	**01/09/2025**

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 374	Continued From page 15 NJAC 8:39-31.2 (e) NFPA 80	K 374	The QAA committee will determine if further action is needed and make necessary adjustments to maintenance protocols or corrective actions. Date of completion set for 2/22/25	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other 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 and interview on 01/08/2025 and 01/09/2025 in the presence of the US FOIA (b)(6)), it was determined the facility failed to guard live electrical parts in accordance with NFPA 99: Section 6.3, 2012 Edition and NFPA 70: 2011 Edition. The deficient practice had the potential to affect 32 residents and was evidenced by the following: 1. An observation on 01/08/2025 at 11:55 AM of the front office revealed a 4-inch by 4-inch recessed electrical box in the dry wall ceiling that had no device, receptacle or cover plate and had exposed wires coming out of it. 2. An observation on 01/08/2025 at 12:37 PM of the US FOIA (b)(6) office revealed a 4-inch by 4-inch recessed electrical box in the dry wall ceiling that had no device, receptacle or	K 911	1. The front office was identified to have missing electrical plate covers on the ceiling. The front office was fixed with a plate cover on 1/13/25 by maintenance so no wires would be exposed. Pictures to be provided The Director of Nursing DON) Office was identified to be missing an electrical plate cover above the DON desk. The director of nursing office was fixed on 1/13/25 by maintenance with a plate cover so no wires would be exposed. Pictures to be provided The Serenity Kitchenette was identified to have a missing electrical plate cover. The serenity kitchenette electrical box was	2/22/25

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 _____	01/09/2025

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 16 cover plate and had exposed wires coming out of it. In interviews at the times on 01/08/2025, the [redacted] confirmed the observations. 3. An observation 01/09/2025 at 10:47 AM of the serenity unit kitchenette revealed a recessed electrical box in the dry wall ceiling by the sink had no device, receptacle or cover plate and had exposed wires coming out of it. 4. An observation on 01/09/2025 at 11:15 AM of the service hall revealed an electrical duplex receptacle on the wall 2 feet down from the drop ceiling had no cover plate. In an interviews at the times on 01/09/2025, the US FOIA (b)(6) confirmed the observations. The US FOIA (b)(6) were informed of the deficient practice at the Life safety Code exit conference on 01/09/2025 at 2:36 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	fixed on 1/13/25 by maintenance with a plate cover so no wires would be exposed. Pictures to be provided The Kitchen service was identified to have a cracked electrical receptacle. The service hallway electrical duplex was fixed on 1/13/25 by maintenance with a plate cover so no wires would be exposed. Pictures to be provided 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 regional administrator 1/15/25 on the importance of the NFPA requirements pertaining to Electrical systems NFPA 101 requirements. 4.The maintenance director and department will be responsible for conducting monthly audits on plate covers and electrical boxes exposed in all areas throughout the facility that have potential to have this deficient practice. The results of the audit will be reviewed monthly x 6 months with QAPI and quarterly for 2 quarters with the QAA committee The Maintenance department will use a	

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 _____	**01/09/2025**

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 17	K 911	standardized checklist that includes compliance with NFPA requirements for electrical covers throughout the facility. The results of each audit will be reviewed and action taken as appropriate with QAPI and the QAA committee for 2 quarters. The QAA committee will determine if further action is needed and make necessary adjustments to maintenance protocols or corrective actions. date of completion set for 2/22/25	

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	2/28/2025 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 K0321	02/22/2025	LSC K0324	02/22/2025	LSC K0353	02/22/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	02/22/2025	LSC K0374	02/22/2025	LSC K0911	02/22/2025
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	
1/9/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO