STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING _____ B. WING _____	01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

(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 Survey Date: 01/17/2023 Census: 114 Sample: 23 plus 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	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	F 584		1/24/23

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

Electronically Signed | 01/27/2023

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was identified that the facility failed to: a.) maintain the cleanliness of floors on the [NJ Exec. O]-unit and b.) maintain the cleanliness of a resident's room who was receiving a [NJ Exec. Order 26:4.b.1]. This deficient practice was identified on one (1) of three (3) nursing units, ([NJ Exec. O]-unit) and for one (1) of 23 residents, (Resident #15) reviewed for comfortable, clean rooms. This was evidenced by the following: 1. On 01/04/23 at 10:52 AM, during initial tour the surveyor observed that the left and right hallway floors on the [Ex Order] unit were visibly dirty with brown debris, discolored with brownish/black upraised oval and circular marks scattered throughout out the halls. There was also paper debris and a used inside out glove lying on the hallway floor. On 01/04/23 at 10:30 AM, the surveyor interviewed the Director of Housekeeping (DOH)	F 584	Corrective Action: On 01/04/23 the HK Director had the entire building cleaned thoroughly. Staff worked overtime specially to address the [Ex Order] hallway which was identified as a concern, as well as to clean the dirty IV pole. On 01/04 All Housekeeping have been in serviced on proper cleaning of the hallway floors. Evening Housekeepers have been in serviced on proper cleaning of the floors. Schedules have been reviewed and revised as needed. Identification of Residents at Risk: The residents who reside on the [Ex Order] unit as well as those who reside in the room that has a dirty [Ex Or] pole have the potential to be affected. These residents can be identified by reviewing the resident roster. Systemic Change: Floor cleaning and [Ex Or] poll cleaning have	

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F 584	Continued From page 2 who stated that renovations were occurring on the [Ex Order] unit and that the floors were not scrubbed with the scrubber since November. The surveyor asked the DOH regarding infection control aspect of clean floors and he stated that the floors in the halls were cleaned with disinfectant every evening shift. When the surveyor questioned the DOH regarding the condition of the floors and the dirt on the floor, he stated that the floors were usually cleaned at night on the evening shift. On 01/04/23 at 10:45 AM, the surveyor approached the nurse station and interviewed a nurse that identified herself and a Regional Register Nurse (RRN). The RRN was in agreement that the floors were dirty, however could not provide the surveyor with addition information and referred the surveyor to speak with the DOH. On 01/04/23 at 12:09 PM, the surveyor observed the same used glove laying inside out on the hallway floor on the [Ex Order] unit. On 01/05/23 at 11:08 AM, the surveyor observed the hallway floors on the [Ex Order] unit to have improved in the cleanliness after surveyor inquiry. On 01/13/23 at 11:06 AM, in the presence of the survey team, the surveyor interviewed the Administrator who stated that regardless of how old or new the floors on the [Ex Order] unit were, he would always expect the building to be in "tip top shape." He agreed that the hallways in [Ex Order] unit looked a "little dirty" but that the housekeeping department took care of it right away. He stated that the facility never stopped mopping the floors but was not sure about the scrubbing of the floors. He stated that every floor should be	F 584	been identified on the housekeeping in-service requirements. The Housekeeping Director will conduct a weekly audit of the hallway floors for one year. For one year, the Housekeeping Director or designee will also receive a weekly list of all residents utilizing [NJ Exec. Order 26:4.b.] in the facility. The Housekeeping Director or designee will document a weekly audit for one year ensuring that they remain clean. Quality Assurance: A quarterly review of both audits will be conducted and documented by the Food Service Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. Results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year	

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F 584	Continued From page 3	F 584		

stripped and waxed every six months and that every night the floors were mopped.

2. On 01/05/23 at 11:38 AM, the surveyor observed Resident #15 laying in bed. The surveyor further observed the resident was receiving [redacted] via a *Ex Order 26. 4B1* [redacted] The surveyor observed that there was tan, brown spillage on the bottom of the *Ex Order 26. 4B1* pole in the room and on the floor beneath the [redacted] pole. The surveyor attempted to interview the resident. The resident was able to answer questions by shaking his/her head for yes and no answers.

On 01/09/23 at 10:19 AM, the surveyor observed the resident laying in bed with his/her eyes closed. The surveyor further observed tan, brown colored spillage on the *Ex Order 26. 4B1* pole and underneath the *Ex Order 26. 4B1* pole in the resident's room.

On 01/10/23 at 10:15 AM, the surveyor observed the same tan, brown colored spillage on the [redacted] pole and underneath the *Ex Order 26. 4B1* pole in the resident's room. At that time, the surveyor interviewed the housekeeper on the [redacted]-unit. The housekeeper stated that it was her responsibility to clean the *Ex Order 26. 4B1* pumps, poles, and floors whenever she saw that it was dirty.

On 01/10/23 at 10:36 AM, the surveyor entered Resident #15's room with the resident's Certified Nursing Aide (CNA) and Licensed Practical Nurse (LPN) and observed the housekeeper cleaning the floor underneath the resident's *Ex Order 26. 4B1*

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F 584	Continued From page 4 pole. Both the CNA and LPN stated that it was the housekeeper's responsibility to clean the floor if the Ex Order 26. 4B1 formula spilled. They further stated that if they had known the floor was dirty, they would have notified housekeeping staff to clean it On 01/13/23 at 11:05 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the Ex Order 26. 4B1 formula should have been cleaned by the housekeeping staff and it was part of their daily cleaning routine. A review of the facility's Housekeepers Job Description indicated, "The housekeeper works to ensure continued sanitary conditions within the facility. The housekeeper performs all tasks in assigned areas such as dusting, vacuuming rugs, spot cleaning walls, cleaning doors, washing beds, and cleaning floors in all specified areas of the facility." A review of the undated facility policy titled, "Routine Cleaning and Disinfection" indicated it was the policy of the facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infection to the extent possible. The policy specified that the definition of "cleaning" refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products.	F 584		
F 607 SS=D	NJAC 8:39-31.4(a) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)	F 607		1/24/23

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F 607	Continued From page 5 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was identified that facility staff failed to appropriately implement their Abuse, Neglect and Exploitation Policy and Procedure. This deficient practice was identified for one (1) of one (1) resident's reviewed, (Resident #24) for abuse and	F 607	Corrective Action: LPN #1 was in service on accurate objective documentation that is specific to what actually occurred. The alleged allegation was called into NJ DOH immediately following DON discovery of [NJ Exec. Order 26:4.b.1] Note. Investigation	

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F 607	Continued From page 6 was evidenced by the following: On 01/05/23 at 12:16 PM, the surveyor observed Resident #24 seated in the lounge area of the [redacted] unit. The resident was observed wearing a surgical mask, with their rolling walker next to the table. The surveyor attempted to interview the resident. The resident did not respond verbally back to the surveyor, instead the resident lifted his/her cup up and nodded at the surveyor. The surveyor reviewed the medical record for Resident #24. A review of the resident's Admission Record reflected that the resident was admitted to the facility in [redacted] and had diagnoses which included but were not limited to [redacted]. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/13/22, revealed that the resident had a Brief Interview for Mental Status, (BIMS) score of [redacted] out of 15 which indicated the resident had [redacted]. A further review of the resident's MDS, Section E - [redacted] reflected that the resident had exhibited NJ Exec. Order 26:4.b.1 directed toward others one (1) to three (3) days during the seven-day assessment review period. A review of the resident's [redacted] Progress Notes (PN) dated 11/13/22 and timed at 13:12 (1:12 PM), revealed a note written by Licensed Practical Nurse (LPN#1) which indicated, "this resident began [redacted] the table in dining room	F 607	completed including obtaining statements from staff present on 11/13/22; and summary was sent to NJ DOH that evening. Facility wide abuse prevention and reporting initiated on 1/12/23. Identification of Residents at Risk: All residents have the potential to be affected by abuse. Residents can be identified on the resident roster. Systemic Change: [redacted] progress notes will be printed for the quarter (or last GDR meeting) and attached to Quarterly GDR Meeting forms. All notes will be reviewed by unit manager, DON and [redacted] at each meeting. Any documentation with potential of abuse will be reported and investigated immediately. Unit managers and MDS coordinator were in-serviced 1/12/23, on utilizing the dashboard daily to review any high alert documentation. Any documentation indicating potential abuse will be reported to DON and or Administrator immediately upon discovery. DON, ADON, Administrator, and nurse managers will receive a daily email of progress notes written on previous day that include high alert words that could potentially indicate an allegation of abuse. Quality Assurance: ADON, or designee, will conduct biannual continuing education including reporting, prevention, and understanding reportable events.	

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F 607	Continued From page 7 into another patient [resident], patient redirected by staff, resident moved to another table away from patient. Resident then began [redacted] another patient and was redirected by staff." A complete review of the resident's [redacted] PN did not reveal that the resident had any prior incidents of a [redacted] with another resident. A review of the facility's Reportable Event Record/Report completed by the Director of Nursing (DON) dated 01/09/23 and timed at 3:00 PM, reflected that on 01/09/23 at approximately 2:15 PM, the DON was made aware of the PN dated 11/13/22, by a New Jersey Department of Health surveyor. The DON's Investigation and Summary of the event revealed that she met with LPN#1 who wrote the PN on 11/13/22 to determine what events that had occurred. When the DON asked LPN#1 what happened LPN#1 clarified that Resident #24 did not make [redacted] contact with another resident nor did the table. LPN#1 told the DON that the resident was shaking the table back and forth but did not touch anyone. The DON explained in her Investigation and Summary that a lounge aide was present at the time of the event and when she started to redirect the resident, the resident started [redacted] his/her [redacted] under the table, in the direction of another resident but did not actually [redacted] anyone. A further review of the Investigation and Summary revealed that the DON interviewed the lounge aide who did not recall Resident #24 [redacted] another resident with a table or [redacted] another resident. The lounge aide further indicated in her statement to the DON that when the resident became [redacted], he/she would shake or bang on the table, but never touched	F 607	DON, or designee, will conduct 5 random interviews of staff weekly for 4 consecutive weeks to verify understanding for reporting any allegation of abuse were identified reported , and properly investigated reeducation will be provided at the time of interview, if needed. DON will document any findings of possible abuse documented that has not previously been reported, as indicated. Including review or [redacted] progress notes and quarterly GDR meetings, review of dashboard and progress note alert emails. Required reporting will take place to appropriate parties as indicated immediately. Findings will be reviewed with LNHA and QA committee quarterly for 1 year.	

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F 607	Continued From page 8 another resident. The Investigation and Summary further revealed that the lounge aide elaborated that the resident was easily redirected to another table and remained calm for the rest of the day and the residents seated at the table with Resident #24 and the other residents in the lounge were not phased by the resident's behaviors. The DON concluded in her Investigation and Summary that a NJ Exec. Order 26:4.b.1 between Resident #24 and another resident had not taken place based on interviews with staff that were present at the time. The DON documented that she had educated LPN#1 to document objectively with specific details. A review of the resident's Care Plan (CP) reflected a focus area that the resident had a diagnosis of *Ex Order 26. 4B1* [redacted]. The goal of the resident's CP was the resident's NJ Exec. Order 26:4.b.1 would be managed over the next quarter. Interventions in the residents CP included to always approach the resident in a calm reassuring manner and attempt to re-direct NJ Exec. Order 26:4.b.1 with distraction, make a one-on-one connection, take the resident to a calm, quiet place, offer the resident a walk outside or movies to watch. A complete review of the resident's CP did not reveal that the resident had NJ Exec. Order 26:4.b.1 directed toward other residents. On 01/11/23 at 11:19 AM, the surveyor conducted an interview over the telephone with LPN#1 who	F 607		

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stated that she had been a nurse for almost two years. LPN#1 further stated that the resident was Ex Order 26. 4B1 if he/she was over stimulated. LPN#1 explained that the resident was easy to re-direct by asking the resident if he/she wanted to go for a walk. LPN#1 told the surveyor that Resident #24 was seated at a small square table in the lounge area on 11/13/22, directly across from another resident. LPN#1 explained that she was standing at the medication cart in the hallway and observed the resident Ex Order 26. 4B1 the table back and forth and Ex Order 26. 4B1 his/her feet underneath the table. LPN#1 stated that we asked the resident if he/she wanted to move and the resident agreed, so she moved the resident to another table alone. The surveyor asked LPN#1 what constituted abuse. LPN#1 stated that Ex Order 26. 4B1 contact and Ex Order 26. 4B would be considered Ex Order 26. 4B1 abuse. LPN#1 further stated that if the resident would have made Ex Order 26. 4B1 contact, she would have reported it to a supervisor and it appeared as if the resident could have Ex Or another resident if he/she continued Ex Order 26. 4B1 his/her feet, so she documented in the NJ Exec. Order 26:4.b.1 I PN that the resident could have Ex Or another resident if staff was not there to intervene. LPN#1's statement contradicted what was documented in the resident's NJ Exec. Order 26:4.b.1 PN.

On 01/11/23 at 11:50 AM, the surveyor interviewed the lounge aide who stated that her job responsibility included making sure the residents were safe while seated in the lounge area. The lounge aide stated that Resident #24 walked with a Ex Order 26. 4B1, was NJ Exec. Order 26:4.b.1 needs, and had NJ Exec. Order 26:4.b.1 when he/she became Ex Order 26. 4B1 such as NJ Exec. Order 26:4 at staff, Ex Order 26. 4B1 tables, and NJ Exec. Order 26:4.b.1. The surveyor asked

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the lounge aide if she recalled an incident that happened on 11/13/22. The lounge aide stated that the DON had recently asked her to write a statement about that the incident. The lounge aide further stated she recalled that she was in the lounge the entire time that day and saw that there was no [redacted] contact between Resident #24 and another resident. The lounge aide told the surveyor that she recalled the resident seated at a table, and the resident was [redacted] the table, so her and LPN#1 moved the resident away from other residents and he/she was, "fine." The lounge aide stated that she did not recall the resident [redacted] his/her feet under the table.

On 01/11/23 at 12:09 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was [redacted] needs. The CNA stated that she had seen the resident throw water at staff before, but she had never observed the resident to have had [redacted] behaviors toward other residents. The CNA told the surveyor that she was unaware of any event that ever happened in the lounge area.

On 01/11/23 at 12:18 PM, the surveyor interviewed the resident's LPN#2 who stated that the resident was [redacted], had days where he/she was more [redacted] than others, and had a diagnosis of [redacted]. LPN#2 stated that the resident liked to sit in the lounge area during the day, would sometimes become [redacted], would look for his/her spouse, and had to be reminded where he/she was. LPN#2 told the surveyor that the resident could be [redacted]. LPN#2 could not speak to an incident in the lounge area on 11/13/22. LPN#2 told the surveyor

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F 607	Continued From page 11 that if he read a note where another a resident Ex Order 26. 4B1 another resident, he would report it to a nurse manager because it was considered Ex Order 26. 4B1 abuse. On 01/11/23 at 12:41 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that the resident had resided at the facility for NJ Exec. Order 26:4.b.1 and throughout the resident's time at the facility, their Ex Order 26. 4B1 had progressed. The LPN/UM told the surveyor that the resident's NJ Exec. Order 26:4.b.1 were more prominent at nighttime and sometimes the resident would NJ Exec. Order 26:4.b.1, but he/she had never become Ex Order 26. 4B1 with another resident. The LPN/UM stated that she usually would review the NJ Exec. Order 26:4.b.1 PN, but she couldn't get to them all. The surveyor reviewed the NJ Exec. Order 26:4.b.1 PN documented by LPN#1 on 11/13/22 with the LPN/UM and asked what she would have done if she read the note. The LPN/UM stated that she would have immediately investigated the documented NJ Exec. Order 26:4.b.1 PN as abuse and notified the DON. On 01/11/23 at 12:55 PM, the surveyor interviewed the DON in the presence of the Regional/Registered Nurse (R/RN) who stated that if she read the NJ Exec. Order 26:4.b.1 PN she would have immediately followed up with an abuse investigation. The DON further stated that she educated LPN#1 that she should not have written a PN that indicated Ex Order 26. 4B1 abuse occured between two residents, when it did not happen. The DON could not speak to why LPN#1 would have written a note like that if abuse did not occur. On 01/13/23 at 11:30 AM, the surveyor	F 607		

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	315237	A. BUILDING _____ B. WING _____	01/17/2023

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F 607	Continued From page 12 interviewed the Administrator who stated that if [redacted] contact was not made and it was a [redacted] of the resident, it should have been appropriately documented and clarified in the [redacted] PN. A review of LPN#1 education file reflected that she had been educated on abuse and understanding abuse on 03/09/21, 06/22/21, 07/27/21, and 09/16/22. The 03/09/21, 07/27/21, and 09/16/22 education gave an example of abuse and when asked on a multiple-choice test, LPN#1 indicated that she would have reported her observation of abuse to the supervisor right away. The education material did not include information on documenting abuse. A review of the facility's Abuse, Neglect, and Exploitation Policy and Procedure revised October 2022 indicated, that physical abuse, "includes, but is not limited to hitting, slapping, punching, biting and kicking." The Policy Explanation and Compliance Guidelines indicated that the facility would develop and implement written policies and procedures that include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident's property, reporting procedures, dementia management, and resident abuse prevention. The facility's Abuse, Neglect, and Exploitation Policy and Procedure further included that employee training would include identifying what constitutes abuse such as physical indicators and the reporting process for abuse. In regard to Reporting /Response to abuse allegations the facility's Abuse, Neglect, and Exploitation Policy revealed that the facility would train staff on changes made and demonstration of staff competency after training	F 607		

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F 607	Continued From page 13 was implemented.	F 607		
F 644 SS=D	NJAC 8:39-13.4(c)2. Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview, review of medical records and review of other pertinent facility documentation, it was determined that the facility failed to conduct a new Preadmission Screening and Resident Review (PASRR) [redacted] assessment after residents were newly diagnosed with a *Ex Order 26. 4B1* [redacted]. This deficient practice was identified for Residents #1 and Resident #25, (two) 2 of (two) 2 residents reviewed for the PASRR requirement and was evidenced by:	F 644	Corrective Action: Resident #1 was diagnosed with [redacted] and had a new PASRR done immediately. Resident # 25 was diagnosed with *Ex Order 26. 4B1* and had a new PASRR done immediately. Identification of Residents at Risk: All residents with [redacted] services have potential to be affected by this practice.	1/24/23

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F 644	Continued From page 14 1. The Admission Record (AR) dated 08/09/22, indicated that Resident #1 initial admission to the facility was on Ex Order 26. 4B1 with a diagnoses of Ex Order 26. 4B1. The AR reflected that on 05/13/19 the resident was diagnosed with Ex Order 26. 4B1 and on 05/19/20 was diagnosed with Ex Order 26. 4B1. The AR also reflected that on 02/27/20 the resident was diagnosed with Ex Order 26. 4B1. Resident #1's annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 05/25/22, indicated that the resident was Ex Order 26. 4B1 and had the diagnoses of Ex Order 26. 4B1. The MDS also revealed that the resident was not considered by the state for a state Ex Order 26. 4B1 PASRR (Preadmission Screening and Resident Review) even though the resident had Ex Order 26. 4B1. Resident #1's Care Plan (CP) page nine (9) reflected that the resident had the diagnoses of Ex Order 26. 4B1. The PASRR that was completed prior to admission by the facilities Ex Order 26. 4B1 (SW) dated 05/04/19, indicated that the resident did not have a diagnoses or evidence of a Ex Order 26. 4B1. The PASRR reflected a negative screen for Ex Order 26. 4B1 (NJ Exec) and therefore the resident was not referred for a PASRR Ex Order 26. 4B1 NJ Exec. Orde. Resident #1 had an initial Ex Order 26. 4B1 evaluation	F 644	All residents can be identified by medical diagnosis audit. Systemic Change: Ex Order 26. 4B1, MDS, and Unit Managers were in-serviced on completing a new PASRR for all residents who are newly diagnosed with Ex Order 26. 4B1 after admission to facility. Unit Managers were in-serviced to report to Ex Order 26. 4B1 any resident receiving a new diagnosis of Ex Order 26. 4B1 and Ex Order 26. 4B1 will review the resident to determine if a new PASRR is warranted. An audit of all resident diagnosis will be completed by Unit Mangers and reviewed by Ex Order 26. 4B1 for new PASRR requirements to assure all PASRR are accurate. Quality Assurance: PASRR audit will be completed monthly by Social Services or designee and results will be reported to DON and Administrator for a year. Social workers or designee will report their findings to the Quarterly QA committee quarterly for the next year.	

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F 644	Continued From page 15	F 644		

dated 05/06/19 which reflected that the resident was diagnosed with Ex Order 26. 4B1 [redacted]. The resident had a negative Ex Order 26. 4B1 pre-screen on preadmission dated 05/04/2019 and was later identified with newly evident or possible serious [redacted] was not referred to the appropriate state-designated authority for Ex Order 26. 4B1 PASARR evaluation and determination.

2.) The AR dated Ex Order 26. 4B1 indicated that Resident #25 was admitted to the facility however there were no diagnoses documented on the AR form. The annual MDS dated 11/18/22 indicated that the resident had the diagnose of Ex Order 26. 4B1 [redacted]. The MDS also revealed that the resident was not considered by the state for a state Ex Order 26. 4B1 PASRR (Preadmission Screening and Resident Review) even though the resident had Ex Order 26. 4B1 [redacted].

The resident's PASRR Ex Order 26. 4B1 Screen that was completed by the facility's SW prior to the resident's admission to the facility dated Ex Order 26. 4B1, indicated that Resident #25 did not have a diagnoses or evidence of a Ex Order 26. 4B1 [redacted].

A review of the progress note dated 02/22/22, indicated that the Ex Order 26. 4B1 evaluated Resident #25 regarding his/her complaints of Ex Order 26. 4B1 [redacted]. The progress notes also indicated that the Ex Order 26. 4B1 and the primary care physician determined that

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F 644	Continued From page 16	F 644		

the resident had "classic signs" of Ex Order 26. 4B1 [redacted]. On 02/22/22, the resident was diagnosed with *Ex Order 26. 4B1* [redacted].

On 01/06/23 at 09:53 AM, the surveyor interviewed the facility SW for the [redacted] unit who completed Resident #1 and Resident #25 initial PASRR. The SW stated that he had been employed in the facility for four (4) years. The SW stated that if a resident was diagnosed with [redacted] it would be required to have a PASRR level [redacted] completed. The SW stated that he was not aware of any resident in the facility that was newly diagnosed with a *Ex Order 26. 4B1* after admission, so he never had to do a PASRR [redacted] for someone newly diagnosed. The SW stated that Resident #25 had PASRR *Ex Order 26. 4B1* screening done on [redacted] but did not know the resident had the diagnosis of *Ex Order 26. 4B1* because it was not on the residents' diagnoses form. The SW stated that he was not sure why he wasn't aware that the resident was newly diagnosed with *Ex Order 26. 4B1* after admission considering the facility had quarterly care conferences. He stated that once the resident was diagnosed with *Ex Order 26. 4B1* that he should have been notified so he could have completed a PASRR *Ex Order 26. 4B1* and referral should have been sent to the proper authorities.

On 01/06/23 at 10:52 AM, in the presence of the survey team the surveyor interviewed the DON who stated she would get the surveyor more information about the PASRR [redacted] and [redacted] as she was not familiar with this process and not sure why Resident #25 would have had to have a *Ex Order 26. 4B1* PASAR completed after

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F 644	Continued From page 17 newly diagnoses with [redacted].	F 644		

On 01/13/23 at 11:14 AM, in the presence of the surveyor team the Licensed Practical Nurse Infection Preventionist and the Regional Director of Nursing (RDON) stated that the Unit Manager should add the new [redacted] diagnoses into the system and forward any new [redacted] diagnoses to the SW. The RDON stated she would meet with SW and MDS Coordinator regarding policy on PASRR to assure that the process for PASRR was being followed.

According to the instructions on the PASRR [redacted] screen, for first time identification of [redacted] and/or NJ Exec. Order 26:4.b.1 [redacted]), the [redacted] screener must provide written notice to the applicant and/or legal representative the [redacted] is suspected or known and that a referral is being made to the Division of Mental Health and Addiction Services (DMHAS) and/or Division of Developmental Disabilities (DDD) for a PASRR [redacted] evaluation.

The facility policy titled, "Resident Assessment -Coordination with PASARR Program.

The facility's policy indicated that the facility coordinates assessment with preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a [redacted], or a related condition receives care and services in the most integrated setting appropriate to their needs. The policy explanation and compliance guidelines indicated that all applicants to the facility would be screened for [redacted] and or [redacted]

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F 644	Continued From page 18 Ex Order 26. 4B1 and related condition in accordance with the state's Medicaid rules for screening. The policy specified that if the resident had a negative Ex Order 26. 4B1 screen- permits admission to proceed and ends the PASRR process unless a possible Ex Order 26. 4B1 arises later.	F 644		
F 658 SS=E	NJAC 8:39-27.1 (a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice for not following a physician's order for one (1) of 23 residents, (Resident #74) reviewed. The deficient practice was evidenced by the following: Refer to 756 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching,	F 658	Corrective Action: On 1/17/23, it was identified that Resident #74 was not given an as needed medication per a standing order to check Ex Orde prior to Ex Order 26. 4B1. All appropriate parties notified; Medication error report completed. Request NP to change order to standing with a hold parameter if Ex Order 26 is NJ Exec. Orde. No actual harm as a result of medication omissions; confirmed with dialysis center, that Ex Order 26 has never been less than NJ Exec. Orde upon arrival. Nurses responsible for medication omissions were in-serviced on following physician orders. DON audited all residents medication orders to assure no other residents had a standing parameter order in conjunction with a PRN medication. No other findings	1/24/23

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F 658	Continued From page 19 health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 01/05/23 at 10:00 AM, the Resident #74 was observed in the room sitting up in the Ex Order 26. 4B1. The resident had no complaints or issues to discuss with the surveyor and appeared to be getting ready for the day. The surveyor reviewed the medical record for Resident #74. According to the Admission Record, Resident #74 was admitted with diagnoses which included but was not limited to; *Ex Order 26. 4B1* [redacted]. The quarterly Minimum Data Set (MDS) an assessment tool that facilitates the management of care dated 12/03/22, indicated that the resident was *Ex Order 26. 4B1* and required NJ Exec. Order 26:4.b.1 with *Ex Order 26. 4B1* [redacted]. The MDS further reflected that the resident received Ex Order 26. 4B1 services.	F 658	identified. Identification of Residents at Risk: All residents with physician orders for medication have the potential to be affected. These residents can be identified by viewing physician orders. Systemic Change: *Ex Order 26. 4B1* [redacted] will audit all physician orders monthly. Any orders with parameters that are linked to a PRN order will be recommended to be changed to a standing order with a parameter. *Ex Order 26. 4B1* [redacted] will audit Physician orders in conjunction with Medication Administration Record, any discrepancies will be reported and corrected immediately. Nursing in-service conducted on writing orders- PRN medication should not be attached to a standing order parameter as any time. Quality Assurance: Unit managers, or designee, will complete a monthly audit on all medications with parameters and submit to Director of Nursing. Any discrepancies will be addressed immediately. Audit will be completed monthly for 1 year. The results of the audits will be conducted and documented quarterly by the Director or Nursing, or designee. Results of quarterly audit will be reported to LNHA and QAA committee, for 1 year.	

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F 658	Continued From page 20 A review of Resident #74's Electronic Medication Administration Record (EMAR) dated [redacted], reflected a Physician's Order (PO) dated 07/07/22, for [redacted] the [redacted] and increasing [redacted]. [redacted] is used to [redacted] give one tablet by mouth one time a day every Monday, Wednesday, and Friday for low [redacted] below 110/60. Give [redacted] prior to leaving for [redacted]. The EMAR indicated that on Wednesday 07/13/22, the residents [redacted] was [redacted] and on Wednesday 07/15/22, the resident [redacted] was [redacted]. There was no documentation on the EMAR that the medication [redacted] was administered as ordered by the physician for [redacted] less than [redacted]. A review of Resident #74's EMAR dated August 1, 2022, to August 31, 2022, reflected PO dated 08/17/22, to monitor Resident #74's [redacted] prior to [redacted] on Monday, Wednesday, and Friday and if the resident's [redacted] was less than [redacted] then to administer prn (as needed) [redacted] one time a day. There was a separate PO dated 08/17/22, for [redacted] to be given as needed for [redacted] every Monday, Wednesday, and Friday for [redacted] below [redacted], give prior to leaving for [redacted]. The EMAR revealed that on Wednesday 08/31/22, the resident was documented as having a [redacted] of [redacted] at 7:30 AM and there was no documentation on the EMAR that the medication [redacted] was administered as ordered by the physician for [redacted] less than [redacted]	F 658		

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A review of Resident #74's EMAR dated September 1, 2022 to September 30, 2022, reflected a PO dated 08/17/22, to monitor Resident #74's [Ex Orde] prior to [Ex Order 26. 4B1] on Monday, Wednesday, and Friday and if the resident's [Ex Orde] was less than [NJ Exec. Order 26:4.] then to administer prn (as needed) [Ex Order 26. 4B1] one time a day. There was a separate PO dated 08/17/22 for [Ex Order 26. 4B1] [Ex Order 26. 4B1] to be given as needed for [Ex Order 26. 4B1] every Monday, Wednesday, and Friday for [Ex Orde] below 110/60, give prior to leaving for [Ex Order 26. 4B1]. The EMAR revealed that on 09/09/22 at 7:30 AM the resident's [Ex Orde] was [NJ Exec. Order 26:4.] and on 09/16/22 at 7:30 AM the resident's [Ex Orde] was [NJ Exec. Order 2]0 and there was no documentation on the EMAR that the medication [Ex Order 26. 4B1] was administered as ordered by the physician for [Ex Order 26. 4B1] less than [NJ Exec. Order 26:4.].

A review of Resident #74's EMAR dated October 1, 2022 to October 31, 2022, reflected a PO dated 09/28/22, to monitor Resident #74's [Ex Orde] prior to [Ex Order 26. 4B1] on Monday, Wednesday and Friday and if the resident's [Ex Orde] was less than [NJ Exec. Order 26:4.] then to administer prn (as needed) [Ex Order 26. 4B1] one time a day. There was a separate PO for [Ex Order 26. 4B1] administer one tablet by mouth as needed for [Ex Orde] less than [NJ Exec. Order 26:4.] prior to [Ex Order 26. 4B1]. The EMAR revealed that the resident's BP on 10/08/22 at 7:30 AM the resident's [Ex Orde] was [NJ Exec. Order 26:4.] and on 10/12/22 at 7:30 AM the resident's [Ex Orde] was [NJ Exec. Order 26:4.] and on 10/19/22 at 7:30 AM the resident's [Ex Orde] was [NJ Exec. Order 26:4.]. There was no documentation on the EMAR that the medication [Ex Order 26. 4B1] was administered as ordered by the physician for [Ex Order 26. 4B1] less than [NJ Exec. Order 26:4.b.]

A review of Resident #74's EMAR dated November 1, 2022 to November 30, 2022,

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reflected a PO dated 09/28/22, to monitor Resident #74's [redacted] prior to [redacted] on Monday, Wednesday and Friday and if the [redacted] was lower than [redacted] to administer the medication [redacted]. There was a separate PO dated 09/28/22, for [redacted] give one tablet by mouth as needed for [redacted] lower than [redacted] prior to [redacted]. The EMAR revealed that on Wednesday 11/23/22 at 7:30 AM, the resident's [redacted] was [redacted] and there was no documentation on the EMAR that the medication [redacted] was administered as ordered by the physician for [redacted] less than [redacted]

A review of Resident #74's EMAR dated December 1, 2022 to December 31, 2022, reflected a PO dated 09/28/22, to monitor Resident #74's [redacted] prior to [redacted] on Monday, Wednesday and Friday and if the [redacted] was lower than [redacted] then to administer prn (as needed) [redacted] one time a day. There was a PO dated 09/28/22, for [redacted] give one tablet by mouth as needed for [redacted] lower than [redacted] prior to [redacted]. The EMAR revealed that on Wednesday 12/21/22 at 07:30 AM the resident's [redacted] was [redacted] and on 12/23/22 at 07:30 AM the resident's [redacted] was [redacted] and there was no documentation on the EMAR that the medication [redacted] was administered as ordered by the physician for [redacted] less than [redacted]

On 01/10/23 at 11:44 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) for the [redacted] unit who stated that when a nurse administered a medication on the computer system (EMAR), it would show as a "check mark" on the EMAR. She stated that if a medication was held or not given due to resident refusals or if there were physician ordered parameters, the

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AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069**

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nurse would have to select a code on the computer program that the medication was held or refused. The LPN#1 further stated if a medication was not administered, the reason the medication was not given would need to be documented on the EMAR. LPN#1 also confirmed that if a medication was an "as needed (prn)" medication, then the nurse would be expected to document that the medication was given on the prn order on the EMAR. LPN#1 further explained that if there was no documentation on the EMAR indicating that a prn medication had been administered, it was not administered.

On 01/10/23 at 11:49 AM, the surveyor interviewed the LPN #2 on the [redacted] unit. LPN #2 stated that if a medication was administered it would show up that it was given on the EMAR by "check" mark on the EMAR. She added that if a medication was held or not administered, the nurse would document the reason why the medication was not administered on the EMAR. LPN#2 further stated that the nurse would be expected to write a progress note and call the MD if a medication was held or not given.

LPN #2 stated that she never administered the medication [redacted] to Resident # 74. She stated that according to the PO she thought she was just monitoring Resident #74's [redacted]. She explained that according to the way the order was written in the computer, she could not see the entire order and did not know that there was a medication included in the order. She stated that the order needed to be clarified and changed so that any nurse could see that there was a medication order for [redacted] with parameters included in the order. LPN#2

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admitted that it could be, "an issue" and that the resident did not receive the medication as ordered by the physician when the [redacted] was out of physician ordered parameters.

On 01/10/23 at 12:15 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) for the [redacted] unit. The LPN/UM reviewed Resident #74's EMAR in the presence of the surveyor and stated that the PO for the medication [redacted] was confusing and she could not tell by looking at the EMAR if Resident #74 received the medication [redacted] or not.

On 01/10/23 at 12:47 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the PO for [redacted] for Resident #74 was confusing in the EMAR and that the medication [redacted] was a prn (as needed) order. The DON further stated according to the EMAR when the [redacted] was recorded as being [redacted] and out of physician ordered parameters, the resident should have received the medication [redacted]. The DON confirmed that there was no documentation in the EMAR that the medication [redacted] was administered according to physician ordered [redacted] parameters.

On 01/11/23 at 10:19 AM, the surveyor interviewed the resident's Primary Care Physician (PCP) who stated that according to the order he gave for the medication [redacted] for Resident #74, he would have expected that the medication [redacted] be administered if Resident #74's [redacted] was less than [redacted]. The PCP further stated that the resident could experience low [redacted] during [redacted]

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F 658	Continued From page 25 because during the [Ex Order 26. 4B1] process, fluid was being removed from the resident and could cause a fluctuation in the [redacted]. He added that the resident's systolic number would be the most important number to monitor especially with a [Ex Order 26. 4B1] resident. He stated that the medication should be administered if the *Ex Order 26. 4B1* was less than [redacted] The PCP explained that he was not concerned with the [Ex Order 26. 4B1] [redacted], just the systolic number. On 01/13/23 at 11:22 AM, the DON confirmed that there was an error regarding following PO for Resident #74's medication [Ex Order 26. 4B1] and that the PO was changed so that the order was not confusing to the nurses. The DON also added that Resident #74 did not experience a negative outcome to the resident's health and provided a history of the resident's *Ex Order 26. 4B1* to the surveyor. The undated facility policy titled, "Administering Medications" indicated that medication shall be administered in a safe and timely manner, and as prescribed and that medications must be administered in accordance with orders. NJAC 8:39-27.1(a)	F 658		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		1/24/23

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F 732	Continued From page 26 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to post the nurse staffing information in a prominent location that was readily accessible for residents and visitors to see. This deficient practice was evidenced by the	F 732	Corrective Action: On 01/09/23 the staffing sheet was updated to reflect the requirement of being filled out at the beginning of each shift and posted in a central location. Identification of Residents at Risk:	

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F 732	Continued From page 27 following: On 01/04/23, 01/05/23, and 01/06/23, the surveyors did not observe the nurse staffing information posted in the facility. On 01/09/23 at 10:12 AM, the surveyor asked the facility's Administrator where the nurse staffing information was posted. The surveyor observed the Administrator call the Director of Nursing (DON) on his cell phone to ask where the nurse staffing information was posted and overheard him say, "it's on the board." The surveyor followed the Administrator down the hallway to a bulletin board that had no nurse staffing information posted at that time. The surveyor observed the location of the bulletin board. It was located to the left of the [redacted]-unit hallway and connected to the [redacted]-unit hallway making it not prominent and readily accessible to residents and visitors in the [redacted]-unit hallway. At that time, the Administrator stated that the DON just took down the daily nurse staffing information to update it. The DON came down the hallway and posted the nurse staffing information in front of the surveyor. The surveyor observed that the nurse staffing information included the staffing for the 7:00 AM - 3:00 PM shift for that day. The surveyor did not observe nurse staffing information posted for the 3:00 PM - 11:00 PM shift or the 11:00 PM to 7:00 AM shift for that day. On 01/10/23 at 12:52 PM, the surveyor interviewed the DON who stated that the nurse staffing information was to be posted in a common area that was visible to residents and family members and the posted staffing information should contain information for all	F 732	The residents who reside on the [redacted] and [redacted] Units are affected by being unable to see the staffing sheet located closer to the [redacted] Unit. These residents can be identified by reviewing the resident roster. Systemic Change: Daily staffing sheets will be correctly posted in a central location for all residents and visitors to see, and will be audited weekly by the Director of Human Resources or designee for one year. Quality Assurance: A quarterly review of the audit will be conducted and documented by the HR Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. Results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	

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F 732	Continued From page 28 shifts that day. A review of the facility's Nurse Staffing Posting Information Policy revised October 2022 indicated, "It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time." The facility's Nurse Staffing Posting Information Policy further indicated that the nurse staffing information was to be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors.	F 732		
F 756 SS=E	NJAC 8:39-41.2 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 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,	F 756		1/24/23

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F 756	Continued From page 29 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, record review and review of other pertinent facility documentation, it was determined that the facility failed to ensure the Consultant Pharmacist (CP) identified and reported on irregularities in the resident's medical record to the facility staff and the attending physician. This deficient practice was identified for one (1) of 23 residents reviewed, (Resident #74) for medication management and was evidenced by the following: Refer to F658 According to the Admission Record, Resident #74 was admitted with the diagnoses which included but was not limited to *Ex Order 26. 4B1* [redacted]. The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/03/22, indicated that the resident was *Ex Order 26. 4B1* and required *Ex Order 26. 4B1* [redacted]	F 756	Corrective Action: On 1/17/23, it was identified that Resident #74 was not given an as needed medication per a standing order to check [redacted] prior to [redacted]. All appropriate parties identified; Medication error report completed. Request NP to change order to standing with a hold parameter if [redacted] is [redacted] No actual harm as a result of medication omissions; confirmed with dialysis center, that [redacted] has never been less than [redacted] upon arrival. Consulting Pharmacist was made aware of the errors. Consulting pharmacist will audit all physician orders monthly. Any orders with parameters that is linked to a PRN order will be recommended to be changed to a standing order with a parameter. Identification of Residents at Risk:	

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F 756	Continued From page 30 Ex Order 26. . The MDS reflected that the resident received NJ Exec. Order 26:4.b.1. The surveyor reviewed the medical record for Resident #74. 1. A review of Resident #74's Electronic Medication Administration Record (EMAR) dated July 1, 2022 to July 31, 2022, reflected a PO dated 07/07/22, for *Ex Order 26. 4B1* [redacted] *Ex Order 26. 4B1* give 1 (one) tablet by mouth one time a day every Monday, Wednesday, and Friday for *Ex Order 26. 4B1* below NJ Exec. Order 26:4. Give *Ex Order 26. 4B1* prior to leaving for *Ex Order 26. 4B1*. The EMAR indicated that on Wednesday 07/13/22, the residents *Ex Order 26. 4B1* was NJ Exec. Order 26 and on Wednesday 07/15/22, the resident Ex Orde was NJ Exec. Order 2. There was no documentation on the EMAR that the medication *Ex Order 26. 4B1* was administered as ordered by the physician for *Ex Order 26. 4B1* less than NJ Exec. Order 26:4. 2. A review of Resident #74's EMAR dated August 1, 2022, to August 31, 2022, reflected a PO dated 08/17/22, to monitor Resident #74's Ex Orde prior to *Ex Order 26. 4B1* on Monday, Wednesday, and Friday and if the resident's Ex Orde was less than NJ Exec. Order 26:4 then to administer prn (as needed) *Ex Order 26. 4B1* one time a day. There was a separate PO dated 08/17/22 for *Ex Order 26. 4B1* [redacted] to be given as needed for *Ex Order 26. 4B1* every Monday, Wednesday, and Friday for Ex Orde below NJ Exec. Order 26:4. give prior to leaving for *Ex Order 26. 4B1*. The EMAR revealed that on Wednesday 08/31/22, the resident was documented as having a Ex Orde of NJ Exec. Order 26:4 at 07:30 AM and there was no	F 756	All residents with physician orders for medication have the potential to be affected. These residents can be identified by viewing physician orders. Systemic Change: Consulting Pharmacist will audit Physician orders in conjunction with Medication Administration Record, any discrepancies will be reported and corrected immediately. Findings of order reviews will be sent to DON monthly. Weekly parameter report will be forwarded to Pharmacy Consultant as an additional resource. Quality Assurance: ADON, or designee, will complete an audit on all consulting pharmacist recommendations, to assure addressed accurately. Any discrepancies will be addressed immediately. Audit will be submitted to Director of Nursing monthly for 1 year. The results of the audits will be conducted and documented quarterly by the Director or Nursing, or designee. Results of quarterly audit will be reported to LNHA and QAA committee for one year.	

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F 756	Continued From page 31 documentation on the EMAR that the medication Ex Order 26. 4B1 was administered as ordered by the physician for Ex Order 26. 4B1 less than NJ Exec. Order 26:4. 3. A review of Resident #74's EMAR dated September 1, 2022 to September 30, 2022, reflected a PO dated 08/17/22, to monitor Resident #74's Ex Orde prior to Ex Order 26. 4B1 on Monday, Wednesday, and Friday and if the resident's Ex Orde was less than NJ Exec. Order 26:4. then to administer prn (as needed) Ex Order 26. 4B1 one time a day. There was a separate PO dated 08/17/22 for Ex Order 26. 4B1 to be given as needed for Ex Order 26. 4B1 every Monday, Wednesday, and Friday for Ex Orde below NJ Exec. Order 26:4., give prior to leaving for Ex Order 26. 4B1. The EMAR revealed that on 09/09/22 at 7:30 AM the resident's Ex Orde was NJ Exec. Order 26:4 and on 09/16/22 at 7:30 AM the resident's Ex Orde was NJ Exec. Order 26:4 and there was no documentation on the EMAR that the medication Ex Order 26. 4B1 was administered as ordered by the physician for Ex Order 26. 4B1 less than NJ Exec. Order 26:4. 4. A review of Resident #74's EMAR dated October 1, 2022 to October 31, 2022, reflected a PO dated 09/28/22, to monitor Resident #74's Ex Orde prior to Ex Order 26. 4B1 on Monday, Wednesday and Friday and if the resident's Ex Orde was less than NJ Exec. Order 26:4. then to administer prn (as needed) Ex Order 26. 4B1 one time a day. There was a separate PO for Ex Order 26. 4B1 administer 1 tablet by mouth as needed for Ex Orde less than NJ Exec. Order 26:4. prior to Ex Order 26. 4B1. The EMAR revealed that the resident's Ex Orde on 10/08/22 at 7:30 AM the resident's Ex Orde was NJ Exec. Order 26:4 and on 10/12/22 at 7:30 AM the resident's Ex Orde was NJ Exec. Order 26:4. and on 10/19/22 at 07:30 AM the resident's Ex Orde was NJ Exec. Order 26:4. There was no documentation on the EMAR that the medication Ex Order 26. 4B1 was administered as ordered by the	F 756		

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F 756	Continued From page 32 physician for Ex Order 26. 4B1 less than NJ Exec. Order 26:4. 5. A review of Resident #74's EMAR dated November 1, 2022 to November 30, 2022, reflected a PO dated 09/28/22, to monitor Resident #74's Ex Orde prior to Ex Order 26. 4B1 on Monday, Wednesday and Friday and if the Ex Orde was lower than NJ Exec. Order 26:4. to administer the medication Ex Order 26. 4B1. There was a separate PO dated 09/28/22, for Ex Order 26. 4B1 give 1 tablet by mouth as needed for Ex Orde lower than NJ Exec. Order 26:4. prior to Ex Order 26. 4B1. The EMAR revealed that on Wednesday 11/23/22 at 07:30 AM, the resident's Ex Orde was 98/53 and there was no documentation on the EMAR that the medication Ex Order 26. 4B1 was administered as ordered by the physician for Ex Order 26. 4B1 less than NJ Exec. Order 26:4. 6. A review of Resident #74's EMAR dated December 1, 2022 to December 31, 2022, reflected a PO dated 09/28/22, to monitor Resident #74's Ex Orde prior to Ex Order 26. 4B1 on Monday, Wednesday and Friday and if the Ex Orde was lower than NJ Exec. Order 26:4. then to administer prn (as needed) Ex Order 26. 4B1 one time a day. There was a PO dated 09/28/22, for Ex Order 26. 4B1 give 1 tablet by mouth as needed for Ex Orde lower than NJ Exec. Order 26:4. prior to Ex Order 26. 4B1. The EMAR revealed that on Wednesday 12/21/22 at 7:30 AM the resident's Ex Orde was NJ Exec. Order 26 and on 12/23/22 at 07:30 AM the resident's Ex Orde was 105/61 and there was no documentation on the EMAR that the medication Ex Order 26. 4B1 was administered as ordered by the physician for Ex Order 26. 4B1 less than NJ Exec. Order 26:4.b The surveyor reviewed the Ex Order 26. 4B1 Monthly Reports (CPMR) dated 08/05/22, 09/08/22, 10/07/22, 11/03/22, and 12/06/22 and the CPMR did not reflect	F 756		

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(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 33 documentation from the CP that the medication Ex Order 26. 4B1 was not being administered when Resident #74's Ex Order 26. 4B1 was out of physician ordered parameters. On 01/11/23 at 11:01 AM, the surveyor conducted a telephone interview with the facility's CP in the presence of another surveyor who stated that she had been coming to the facility for 1 (one) and 1/2 years. She explained what her job responsibilities included such as reporting in with the Administrator and Director of Nursing (DON), performed 1 medication pass each month, performed resident chart medication review, unit inspections, inspections of storage rooms, medication carts, and in-services. The CP further added that she reported discrepancies with medication review to the Unit Manager, DON, and Administrator. The CP explained that after inspection and review of resident's medication reviews, she would email the Administrator and DON the results of her review. She stated that resident medication reviews were completed monthly. The CP stated that medication reviews included the review of allergies, crushable medication, medication interactions, duplicate therapies, medications with physician ordered parameters, appropriateness of drugs, appropriate of antibiotic selected according to cultures and made sure medications were being held or given according to physician ordered parameters. The PC stated that on 01/10/23, the facility made her aware that there were concerns regarding Resident #74's medication orders for the medication Ex Order 26. 4B1 not being administered as ordered and confirmed that she did "overlook" the fact that the resident was not given the medication as ordered by the physician. The CP	F 756		

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F 756	Continued From page 34 stated, "I did review the resident's medical record to see how the error occurred and I usually complete a thorough evaluation of each patient and unfortunately this error occurred and was not picked up. I will assure that this is not going to happen again." On 01/13/23 at 11:22 AM, the DON confirmed that there was an error regarding following physician's orders for Resident #74's medication Ex Order 26. 4B1 and that the PO was changed so that the order was not confusing to the nurses. She also added that resident #74 did not experience a negative outcome to the resident's health and provided a history of the resident's Ex Order 26. 4B [redacted] to the surveyor. The DON confirmed that the CP should have detected the error during the monthly medication review that Resident #74 was not administered the medication Ex Order 26. 4B1 when the resident was Ex Order 26. 4B1 [redacted], and that the medication was not administered as the physician ordered. The facility policy dated April 2021 and titled, "Pharmacy Services-Role of the Consultant Pharmacist" indicated that the CP shall develop mechanisms for communicating, addressing, and resolving issues related to pharmaceutical services, strive to assure that medications are requested, received and administered in a timely manner as ordered by authorized prescriber and provide appropriate communication of information to prescribers and facility leadership about potential or actual problems to any aspect of medication and pharmacy services including medication irregularities and pertinent resident specific documentation in the medical record. NJAC8:39-29.3(c)	F 756		

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to: a.) store, label, and date potentially hazardous foods to prevent food-borne illness and b.) discard potentially hazardous foods past their date of expiration. This was evidenced by the following: On 01/04/23 at 10:10 AM, the surveyor conducted an initial tour of the kitchen in the presence of the Food Service Director (FSD). 1. At 10:18 AM, the surveyor observed above the sink in the kitchen a spice rack that contained a variety of 20 different spices. Five of the spice's lids were observed to be open, in the upright	F 812	Corrective Action: On 01/04/23 the open spices were immediately thrown out. The sweet potatoes, gallon of mayo, chocolate syrup, coleslaw, deli mustard, relish, Italian dressing, maraschino cherries, ribs, salads, and pears were all immediately thrown out. Dietary staff were in serviced regarding food storage, proper labeling and dating, expirations, handling open items, and ruined items as well as the need to ensure proper covers on all spices.. Identification of Residents at Risk: The residents who eat food from our	1/24/23

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F 812	Continued From page 36 position. At that time, the FSD stated that the lids to the spices should not have been left open. 2. At 10:23 AM, the surveyor inspected the dairy walk in refrigerator and observed in a cardboard box on the right bottom shelf 12 sweet potatoes that were covered in a white film. The FSD removed the items in the presence of the surveyor. 3. At 10:25 AM, the surveyor inspected the meat walk in refrigerator and observed a one gallon opened container of mayo that was dated 12/1. The manufacturer expiration date on the one-gallon container of mayo was dated 10/6/22. 4. The surveyor observed in the meat walk in refrigerator, an opened and undated bottle of chocolate syrup. The bottle of chocolate syrup had a white coating surrounding the container. 5. The surveyor observed in the meat walk in refrigerator, an undated one-gallon container of coleslaw that was half full. 6. The surveyor observed in the meat walk in refrigerator, an opened one-gallon container of deli mustard dated 8/15. There was no use by date on the deli mustard container. 7. The surveyor observed in the meat walk in refrigerator, an opened one-gallon container of relish dated 6/22. The manufacturer use by date on the container was dated 12/26/22. 8. The surveyor observed in the meat walk in refrigerator, an opened one-gallon container of Italian dressing dated 9/29. The manufacturer use by date on the container was dated 8/24/22	F 812	kitchen have the potential to be affected. These residents can be identified by reviewing the meal tickets and snack lists. Systemic Change: Daily rounds by the Food Service Director updated to reflect a focus on labeling and dating, expirations, food, and container conditions including proper closure. Dietary Director or designee will for one year conduct a weekly audit of the labeling and dating, expirations, food, and container conditions. Quality Assurance: A quarterly review of the audit will be conducted and documented by the Food Service Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. Results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	

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F 812	Continued From page 37 9. The surveyor further observed in the meat walk in refrigerator, an opened and undated one-gallon container of maraschino cherries. The expiration date on the container was dated 12/24/22. 10. At 10:32 AM, the surveyor observed in the walk-in freezer an undated, unsealed plastic bag of unidentifiable food. The FSD stated that the food in the bag were ribs and threw the bag away in the presence of the surveyor. 11. At 10:34 AM, the surveyor observed in the reach-in nourishment refrigerator three, nine once salads that were undated. 12. On 01/10/23 at 9:56 AM, the surveyor re-entered the kitchen and observed in the second meat walk-in refrigerator in the presence of the FSD, 16 small plastic containers of pears. One of the containers of pears was dated 1/9. The FSD stated that the pears were made the night before and 1/9 was, "probably" supposed to be date for the whole tray. The FSD further stated that the staff should have labeled the pears individually or the whole tray. The FSD did not speak to if there was a use by date for the containers of pears. On 01/11/23 at 10:04 AM, the surveyor interviewed the facility's Administrator who stated that the FSD oversaw all functions of the kitchen and was required to have knowledge regarding food safety and food preparation to prevent food borne illness. A review of the facility's Dating and Labeling Policy reviewed, and updated November 2022 indicated that it was the policy of the facility for	F 812		

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F 812	Continued From page 38 the kitchen to assure food safety by maintaining proper dates and labels to all food products. The facility's Dating and Labeling Policy further indicated, "use a pen, marker, stickers, or date gun with legible writing to date and label products" and to throw away all foods that were expired immediately. NJAC 8:39-17.2(g)	F 812		
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 §483.70(e) 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:	F 880		2/6/23

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F 880	Continued From page 39 (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; (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		

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F 880	Continued From page 40 Based on observation, interview, and review of other pertinent documentation, it was determined that the facility failed to ensure: a.) staff practiced appropriate hand hygiene in accordance with the Centers for Disease Control (CDC) and Prevention guidelines for infection control during the distribution of the lunch meal trays to residents on the Ex Order unit (Resident #58, #102, #316, #318, #319, #320, and #321), b.) staff performed appropriate hand hygiene prior to donning (putting on) appropriate Personal Protective Equipment (PPE) in accordance with CDC guidelines for infection prevention and control upon entering the room of residents who were identified as *Ex Order 26. 4B1*, c.) staff maintained appropriate CDC guidelines by bringing a dietary meal cart into a resident's room who were *Ex Order 26. 4B1* during the lunch meal tray distribution on the Ex Order unit, (Resident #322 and #323), d.) store *Ex Order 26. 4B1* equipment in a way to prevent the spread of infection for, (Resident #315) and e.) adhere to accepted standards of infection control practices for the proper storage of an *Ex Order 26. 4B1* for, (Resident #315). This deficient practice was evidenced by the following: 1). On 01/05/23 at 11:54 AM, the surveyor observed a staff member (who was later identified as a Nursing Assistant (NA)) remove a meal tray off the meal truck on the Ex Order unit, entered the room of Resident #316 and placed the meal tray on the overbed table. The NA then removed the dome lid of the meal plate to assist with setting up the resident's meal tray. The NA asked the resident if he/she needed anything else prior to exiting the room.	F 880	Corrective Action: Staff member identified as (NA) was individually educated on hand hygiene, procedure of meal pass, and PPE; (NA) provided an accurate return demonstration. Resident #315 was educated on importance of keeping *Ex Order 26. 4B1* off the floor and to secure on chair or bed rail. Care plan updated on education and monitoring compliance and reeducation. Resident #315 was educated on proper storage of *Ex Order 26. 4B1* when not in use. *Ex Order 26. 4B1* replaced. Care plan updated on education and monitoring compliance and reeducation. Identification of Residents at Risk: All residents have the potential to be affected by the spread of infection. Residents can be identified on the resident roster. Systemic Change: On 1/5/23, facility wide in servicing conducted on proper procedure of meal pass including hand hygiene and donning and doffing PPE. On 1/9/23, facility wide in servicing on *Ex Order 26. 4B1* (proper placement, storage, and what to do if Ex Order 26. 4B becomes contaminated). On 1/9/23, facility wide in servicing on placement of *Ex Order 26. 4B1*. Quality Assurance: An audit will be conducted and documented monthly on each unit by the ADON or designee, to evaluate that	

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F 880	Continued From page 41 On 01/05/23 at 11:56 AM, the surveyor observed the NA wearing a black hand brace on her right hand and without performing hand hygiene, the NA retrieved another meal tray off the meal truck and entered the room of Resident #102 and placed the meal tray on the resident's overbed table. The NA asked the resident if he/she needed anything else prior to exiting the room. Without performing hand hygiene, the NA went back to the meal truck and retrieved the meal tray for Resident #58. The NA placed the meal tray on the overbed table and asked the resident if they needed any further assistance prior to exiting the room. Upon exiting the room, the NA did not perform hand hygiene and proceeded back to the meal truck and retrieved another meal tray and entered the room of Resident #318 and placed the meal tray in the overbed table without performing hand hygiene and then exited the room. The NA went back to the meal truck and retrieved another meal tray. On 01/05/23 at 11:58 AM, the NA entered the room of Resident #320 placed the meal tray on the overbed table. The NA then removed the dome lid of the meal plate to assist with setting up the resident's meal tray. The NA asked the resident if he/she needed anything else prior to exiting the room. On 01/05/23 at 11:59 AM, the NA entered the room of Resident #319 and placed the meal tray on the overbed table. The NA then removed the dome lid of the meal plate to assist with setting up the resident's meal tray. The NA asked the resident if he/she needed anything else prior to exiting the room. The NA retrieved another meal tray without performing hand hygiene in between	F 880	proper infection control practices (including donning PPE, handwashing, etc.) are implemented during meal pass. Individual staff members will be addressed as needed based upon results of audit. Audits will be submitted to DON monthly for one year. An audit of *Ex Order 26. 4B1* and *Ex Order 26. 4B1* will be conducted monthly by IP Nurse, or designee, to evaluate proper placement, storage, and changing of devices as indicated. Individual staff members will be addressed as needed based upon results of audit. Audits will be submitted to DON monthly for 1 year. The results of the audits will be conducted and documented quarterly by the Director or Nursing, or designee. Results of quarterly audit will be reported to LNHA and QAA committee for one year. Southgate Rehabilitation and Nursing Center DPOC/RCA for tag F-880 Problem: □Facility failed to ensure (a) staff practiced appropriate hand hygiene in accordance with CDC and prevention guidelines for infection control during the distribution of meal trays. (b.) Facility failed to ensure staff performed appropriate hand hygiene prior to donning appropriate PPE. (c) Staff failed to maintain CDC infection control prevention guidelines when bringing a dietary cart into a *Ex Order 26. 4B1* room. (d) Facility failed to store *Ex Order 26. 4B1* equipment in a way to prevent the spread of infection (e)	

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F 880	Continued From page 42 residents. At that time, the NA entered the room of Resident #321 and placed the meal tray on the overbed table. The NA asked the resident if he/she needed anything. The NA exited the room and without performing hand hygiene proceeded back towards the meal carts that was in the hallway. The surveyor observed the NA go from resident room to resident room delivering meal trays and setting up meal trays without performing hand hygiene in between residents. On 01/05/23 at 12:05 PM, the surveyor interviewed the NA regarding hand hygiene during passing of the meal trays. The NA stated that the only times she performed hand hygiene was before she began passing the meal trays, if something had got on her hands, and after she was done passing all the meal trays. The NA stated that she did not have to use hand sanitizer in between the resident during the passing of the meal trays unless something had gotten on her hands. On 01/06/23 at 10:37 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP), who stated that staff should perform hand hygiene before and after setting up each resident's meal tray. She then stated that if the staff was not setting up the meal tray, then staff did not have to perform hand hygiene between each resident. On 01/06/23 at 11:28 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that regardless of the isolation status, hand hygiene should always be performed during	F 880	the facility failed to maintain accepted standards of infection control practices for proper storage of *Ex Order 26. 4B1* [redacted]. RCA: (a) and (b) Handwashing was indicated at the time of meal tray service and donning isolation gown. The identified CNA□s deficient handwashing practice occurred because of the identified staff□s forgetfulness and work intensity is a barrier for non-compliance with required handwashing practice. Lack of knowledge and understanding on indicated times for handwashing is also a cause for being remiss in the aide performing handwashing when indicated. (c) The dietary cart became contaminated upon entering the isolation room□the identified CNA□s deficient practice of not following isolation precautions and contaminated equipment was due to lack of knowledge and forgetfulness as well as work intensity is a barrier for non-compliance with following isolation guidelines. (d) and (e)The *Ex Order 26. 4B1* and *Ex Order 26. 4B1* was contaminated once it contacted furniture and floor in room--- The deficient practice was related to residents□ lack of knowledge regarding infection control and contaminating equipment and staffs lack of knowledge regarding resident behavior with improper placement of equipment. Corrective Action: CNA was provided corrective action immediately and retraining. The identified staff was	

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F 880	Continued From page 43 the passing of the meal trays between each resident. On 01/10/23 at 10:10 AM, the surveyor interviewed the Director of Nursing (DON) who stated that if staff was setting up meal trays, then the staff should perform hand hygiene in between each resident and especially for resident's that are on isolation. On 01/13/23 at 11:40 AM, in the presence of Licensed Nursing Home Administrator (LNHA), the Regional Nurse and survey team both the DON and LPN/IP acknowledged that the NA should have performed hand hygiene in between each resident during the passing of meal trays. A review of the facility's Serving a Meal Policy updated 10/2022, reflected 2. Place tray on dining table or overbed table if the resident eats in their room. 3. Remove dome lid from the tray, and check to be sure everything is included on the meal tray that is required by the diet card, and the resident's preference. 4. Arrange the dishes and silverware so the resident can reach them easily. A review of the facility's Hand Hygiene Policy undated, reflected all staff will perform proper hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 2.) On 01/05/23 at 12:01 PM, the surveyor observed the meal pass on the [redacted] units for the residents identified as Ex Order 26. 4B1 . At that time, that surveyor observed the NA	F 880	corrected immediately, and the dietary cart was removed and carbolized. The resident and staff were educated immediately, and the resident was provided with new Ex Order 26. 4B1 and Ex Order 26. 4B1. Resident care plan was updated to reflect newly identified behavior and staff made aware. All identified staff received immediate in-servicing. All staff will received education that includes CDC keep [redacted] out, CDC clean hands, CDC closely monitoring residents, CDC use PPE correctly for Ex Order 26. 4B1 Environmental cleaning and disinfecting, Hand Hygiene, principles of standard precautions, and principles of transmission based precautions, in addition top line staff and infection preventionist will also have training on infection prevention and control program, outbreaks, infection surveillance, and reprocessing reusable resident care equipment, ongoing training and competencies, infection control video presentations, visual cues, and direct observation. Follow up is QA/QAPI All facility staff have watched required videos per DPOC and completed by Feb 6, 2023. The below in-services were completed: (Sign in sheets will be emailed to NJ Exec. Order 26:4.b.1 @doh.nj.gov and NJ Exec. Order 26:4.b.1 @doh.nj.gov) Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program	

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AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069**

(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 44 wearing Personal Protective Equipment (PPE) an N-95 mask with a surgical mask over it and eye protection. The NA donned (put on) a yellow disposable gown and retrieved a pair of gloves from the PPE caddy. The surveyor observed the NA wearing a Ex Order 26. 4B1 on Ex Order 26. 4B1 and without performing hand hygiene, she donned a pair of gloves. The NA doffed her yellow disposable gown and gloves prior to exiting the room. The NA then removed the Ex Order 26. 4B1 from Ex Order 26. 4B1 and performed hand hygiene at the sink located near the nurses' station. On 01/05/23 at 12:05 PM, the surveyor interviewed the NA who stated, "you don't have to perform hand hygiene before you gown up." The NA further stated, she only had to perform hand hygiene after she doffed (removed) the PPE. On 01/06/23 at 10:37 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP), who stated it was the facility's first time sheltering in place (refers to quarantining in room) of with Ex Order 26. 4B1 since the guidelines have changed. The LPN/IP stated the process for entry into a resident's room that was on Transmission Based Precautions (TBP) should be hand hygiene first and then donning a gown and a pair of gloves. She stated that since the facility was in an outbreak all staff wore an N-95 mask with a surgical mask over it and eye protection. On 01/06/23 at 11:25 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the process for entry into a TBP room was to perform hand hygiene before donning PPE which included a gown, a pair of	F 880	https://www.train.org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtu.be/xmYMUly7qiE Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents https://youtu.be/1ZbT1Njv6xA Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTATw9yav4 Provide the training to: Frontline staff Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/1081803/ Provide the training to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module IIB - Environmental Cleaning and Disinfection https://www.train.org/main/course/108l815/ Provide the training to: All staff including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING _____ B. WING _____	01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069**

(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 45 gloves, N-95 mask with a surgical mask over it and eye protection. On 01/10/23 at 10:10 AM, the surveyor interviewed the Director of Nursing (DON) who stated that prior to entry into a TBP, staff should perform hand hygiene prior to donning the "full" PPE which included the N-95 mask with a surgical mask over it, a gown, a pair of gloves, and eye protection. On 01/13/23 at 11:40 AM, in the presence of the Administrator, the Regional Nurse and survey team both the DON and LPN/IP acknowledged that the NA should have performed hand hygiene prior to donning PPE. A review of the facility's Hand Hygiene Policy undated, reflected the use of gloves does not replace hand hygiene. If your task requires gloves, perform hygiene prior to donning gloves, and immediately after removing gloves. 3.) On 01/05/23 at 12:01 PM, the surveyor observed the meal pass on the Ex Order2 units for residents identified as positive for Ex Order 26. 4B1. At that time, that surveyor observed the NA push a black meal cart down the hallway that had two (2) regular meal trays with disposable items on it. The surveyor observed the NA enter the Ex Order 26. 4B1 room with the black meal cart that had the two (2) meal trays on it. The NA delivered the lunch meal trays to both Resident #322 and #323. The NA doffed (removed) her yellow disposable gown and gloves prior to exiting the room. The NA placed the black meal cart next to the other two (2) meal carts and meal truck	F 880	topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/1081802/ Provide the training to: Topline staff and infection preventionist only Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/108l806/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module IIA - Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/1081814/	

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F 880	Continued From page 46 that was on the unit. On 01/05/23 at 12:05 PM, the surveyor interviewed the NA who stated that the staff utilized the black meal carts by placing the meal trays on them to deliver the meals to the residents. She explained the black meal carts made it easier for staff during the passing of the meal trays to the residents. She further explained, the black meal carts "ensured the food did not get cold." The NA then stated that staff was allowed to bring the black meal carts into the rooms including resident's rooms that were on [redacted] for [redacted]. She further stated they also used the black meal carts to collect the meal trays. The NA stated it did not matter which black meal cart was used to collect the meal trays because the carts "goes back to the kitchen to be cleaned and disinfected." The NA explained the staff could identify the black isolation meal cart because it was smaller than the other two (2) meal carts on the unit. On 01/06/23 at 10:37 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP), who stated it was the facility's first time sheltering in place with [redacted] since the guidelines have changed. The LPN/IP stated the black meal carts were allowed in the [redacted] rooms but not the [redacted] rooms. The LPN/IP explained prior to this new process of sheltering in place they had a [redacted] unit and there was a designated [redacted] meal cart. She stated that since they started this new process there was no specific [redacted] meal tray. She then stated the isolation meal trays arrived on a separate meal cart from the meal truck. The LPN/IP stated that the kitchen did disinfect the black meal carts. The	F 880	Provide the training to: Topline staff and infection preventionist only Further optional training is available in the Nursing Home Infection Preventionist Training Course located at https://www.train.org/cdctrain/training_plan/3814.	

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F 880	Continued From page 47 LPN/IP acknowledged the black meal cart should not have been brought inside of the isolation room. On 01/06/23 at 11:25 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the black meal carts were not brought inside of the resident's room that were on [redacted] because of potential spread of infection and that the meal carts should remain in the hallway. On 01/10/23 at 10:10 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the black meal carts should not be taking inside of the resident's rooms that were *Ex Order 26. 4B1* and was "not sure" if the black meal carts were disinfected. 4.) On 01/04/23 at 11:45 AM, during the initial tour, the surveyor observed Resident #315 lying in bed resting with his/her eyes closed. The surveyor observed Resident #315 wearing the *Ex Order 26. 4B1* [redacted] and an *Ex Order 26. 4B1* [redacted] next to their bed running and set at three (3) liters (L). At that time, the surveyor observed the *Ex Order 26. 4B1* and *Ex Order 26. 4B1* bottle were not labeled and dated. Resident #315 acknowledged the surveyor and stated they were doing great and that the staff changed the [redacted]. On 01/05/23 at 11:11 AM, the surveyor observed an *Ex Order 26. 4B1* in Resident #315's room next to their bed. The *Ex Order 26. 4B1* was not running at the time of the surveyor observation. The surveyor observed the *Ex Order 26. 4B1* dated 01/05/23.	F 880		

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F 880	Continued From page 48 The surveyor further observed the *Ex Order 26. 4B1* draped over the *Ex Order 26. 4B1* with the prongs of the *Ex Order 26. 4B1* in direct contact to the surface of the *Ex Order 26. 4B1*. The surveyor reviewed Resident #315's electronic medical record: The Admission Record revealed that the resident was admitted to the facility in *Ex Order 26. 4B1*, with diagnoses which included: *Ex Order 26. 4B1* The January Order Summary Report revealed that Resident #315 had a 12/27/22 active physician order for the following: - *Ex Order 26. 4B1* every night shifts every Wednesday. - *Ex Order 26. 4B1*, via *Ex Order 26. 4B1* continuously. A review of the electronic individualized comprehensive Care Plan (CP) for January 2023, reflected the resident had *Ex Order 26. 4B1* related to *Ex Order 26. 4B1*. On 01/06/23 at 10:27 AM, the surveyor entered Resident #315's unoccupied room and observed the *Ex Order 26. 4B1* in the room. The *Ex Order 26.* dated 01/05/23 and was observed draped over the *Ex Order 26. 4B1* with the prongs of the *Ex Order 26. 4B1* lying in direct contact to the surface of the *Ex Order 26. 4B1*. On 01/06/23 at 10:44 AM, the surveyor	F 880		

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F 880	Continued From page 49 interviewed the LPN/IP who stated that the [redacted] was dated every Wednesday and when the *Ex Order 26. 4B1* was not in use, it was stored in a plastic bag. The LPN/IP stated that the [redacted] should not be lying directly on the surface of the *Ex Order 26. 4B1*. She further stated the reason the *Ex Order 26. 4B1* should be kept inside of the plastic bag when not in use was to prevent the [redacted] from falling on the floor and because of infection control. On 01/06/23 at 10:55 AM, the surveyor interviewed the LPN who stated Resident #315 used [redacted], but his [redacted] levels were around [redacted] He stated that he was going to inform the medical doctor (MD) and [redacted] to see if Resident #315 could change the [redacted] order to as needed (PRN). At that time, the surveyor inquired the last time Resident #315 used the [redacted]. The LPN stated that Resident #315 was wearing the [redacted] that morning while he/she was lying in bed. On 01/06/23 at 11:30 AM, the surveyor interviewed the CNA who stated the proper way to store the *Ex Order 26. 4B1* was to place it inside of the plastic bag. He stated that the *Ex Order 26. 4B1* should not be hanging directly on the surface of the *Ex Order 26. 4B1* because it could fall on the floor and because it could become contaminated and breech infection control. The CNA concluded that staff could not watch the *Ex Order 26. 4B1* 24/7 and that placing it in the plastic bag ensured it did not become contaminated. On 01/09/23 at 10:30 AM, the surveyor entered Resident #315's unoccupied room and observed a plastic bag attached to the *Ex Order 26. 4B1* in the room. The *Ex Order 26. 4B1* dated	F 880		

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F 880	Continued From page 50 01/05/23 was observed draped over the [redacted] with the prongs of the *Ex Order 26. 4B1* lying in direct contact of the [redacted] surface. On 01/10/23 at 10:20 AM, the surveyor interviewed the DON who stated that when not in use the *Ex Order 26. 4B1* should be stored in the plastic bag to prevent infections. On 01/13/23 at 11:40 AM, in the presence of Administrator, Regional Nurse and survey team both the DON and LPN/IP acknowledged that the *Ex Order 26. 4B1* dated 01/05/23 should have been changed immediately after the surveyor informed them of the *Ex Order 26. 4B1* lying directly on the *Ex Order 26. 4B1* surface. A review of the facility's Oxygen Administration undated, reflected under General Guidelines - The *Ex Order 26. 4B1* is to be placed in a bag when not in use. 5.) On 01/04/23 at 11:45 AM, during the initial tour the surveyor observed Resident #315 lying in bed resting with his/her eyes closed. At that time, the surveyor observed Resident #315 [redacted] with a *Ex Order 26. 4B1* with a privacy cover flap over it, lying directly on the floor. Resident #315 acknowledged the surveyor and stated they were doing great and that the staff was responsible for emptying the *Ex Order 26. 4B1*. On 01/05/23 at 11:11 AM, the surveyor observed Resident #315 lying in bed with his/her eyes closed. At that time, the surveyor observed the	F 880		

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F 880	Continued From page 51 Ex Order 26. 4B1 hanging off the side of the resident's bed with the bottom of the Ex Order 26. 4B1 touching the floor. The surveyor reviewed Resident #315's electronic medical record: The Admission Record revealed that the resident was admitted to the facility in Ex Order 26. 4B1, with diagnoses which included: Ex Order 26. 4B1 . The January Order Summary Report revealed that Resident #315 had a 12/27/22 active physician order for the following: - Change Ex Order 26. 4B1 monthly on the 15th, and as needed every night shift starting on 15th and ending on the 15th every month. - Ex Order 26. 4B1 care every shift. A review of the electronic individualized comprehensive CP for January 2023 reflected the resident had potential alteration in Ex Order 26. 4B1 output due to hx [history] of Ex Order 26. 4B1 and having an Ex Order 26. 4B1 . On 01/06/23 at 10:27 AM, the surveyor observed the Ex Order 26. 4B1 lying flat directly on the floor. At that time, a staff member (who was later identified as the LPN/IP) entered the room of Resident #315 and picked up the Ex Order 26. 4B1 off the floor. The LPN/IP stated that "it must've fell on the floor" The surveyor informed the LPN/IP that it was observed on the floor on prior occasions. The LPN/IIP stated that the Ex Order 26. 4B1	F 880		

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F 880	Continued From page 52 should be hung on the side of the bed and not be lying on the floor. She emphasized that it was "not okay" because the resident could get an infection. The LPN/IP stated the resident was new but did not think he/she had a Ex Order 26. 4B1 and that the resident had a hx of Ex Order 26. 4B1 . On 01/06/23 at 11:29 AM, the surveyor interviewed the CNA who stated that the Ex Order 26. 4B1 should be hung on the side of the bed and below the level of the Ex Order 26. 4B1 to prevent the Ex Order 26. from backing up into the Ex Order 26. 4B1 . The CNA stated the Ex Order 26. 4B1 should not be touching the floor or lying directly in contact with the floor because the floor was dirty, and the Ex Order 26. 4B1 could get contaminated and cause an infection. On 01/10/23 at 10:15 AM, the surveyor interviewed the DON who acknowledged the Ex Order 26. 4B1 should not have been lying directly on the floor. The DON stated that this process could put the resident at risk for injury if it was dragged along the floor and at risk for infection. She stated that the Ex Order 26. 4B1 should be hung on the side of the bed or attached to the resident's Ex Order 26. 4B1 . A review of the facility's Ex Order 26. 4B1 Care, Ex Order 26. 4B1 Policy undated, reflected under Infection Control - Be sure the Ex Order 26. 4B1 and Ex Order 26. 4B1 are kept off the floor. NJAC 8:39-27.1(a)	F 880		

New Jersey Department of Health

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	061706	A. BUILDING: _____ B. WING _____	01/17/2023

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S 000	Initial Comments The facility is 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 deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in Certified Nursing Aide (CNA) staffing for five (5) of 14-day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	Corrective Action: Efforts to hire more facility staff to allow us to have adequate or more than adequate staff to serve our residents have been ramped up. In the meantime the facility will utilize agency to fill open slots in the schedule. Identification of Residents at Risk: The residents who reside on the [redacted] and [redacted] Units are affected by having insufficient staffing. These residents can be identified by reviewing the resident roster. Systemic Change: The facility has now contracted with a new	1/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/27/23

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 12/18/23 through 12/24/23 and 12/25/23 through 12/31/23, revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on five (5) of 14 day shifts as follows: -12/18/22 had 12 CNAs for 109 residents on the day shift, required 14 CNAs. -12/19/22 had 12 CNAs for 108 residents on the day shift, required 13 CNAs. -12/24/22 had 10 CNAs for 107 residents on the day shift, required 13 CNAs. -12/25/22 had 11 CNAs for 107 residents on the day shift, required 13 CNAs. -12/31/22 had 12 CNAs for 109 residents on the day shift, required 14 CNAs.	S 560	online portal which allows for faster and more streamlined applicants and a smoother hiring system. Hiring and recruitment efforts now include referral bonuses, sign on bonuses, weekend bonuses amongst other incentives to bring in good staff and quickly. Agency contracts are in place as well to fill the gaps. Quality Assurance: A daily review of staffing levels will be done by the Director of Nursing or designee to ensure that we are adequately staffed. Results of this review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 On 01/10/23 at 12:55 PM, the surveyor interviewed the Director of Nursing (DON) who was responsible for staffing the facility. The DON stated that she utilized agency staffing for one Licensed Practical Nurse (LPN) just recently, and the rest of the staffing agency assisted in staffing the facility with CNAs. The DON further stated that the state guidelines mandated one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for every ten residents on the 3:00 PM - 11:00 PM shift, and one CNA for 14 residents on the 11:00 PM - 7:00 AM shift.	S 560		

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
315237 Y1	A. Building B. Wing Y2	2/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0607	Correction	ID Prefix F0644	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.20(e)(1)(2)	Completed
LSC	01/24/2023	LSC	01/24/2023	LSC	01/24/2023
ID Prefix F0658	Correction	ID Prefix F0732	Correction	ID Prefix F0756	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed
LSC	01/24/2023	LSC	01/24/2023	LSC	01/24/2023
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	01/24/2023	LSC	02/06/2023	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?
1/17/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061706 (Y1)	A. Building B. Wing (Y2)	2/24/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/24/2023	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 1/17/2023	☐ 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
	315237	A. BUILDING **02** B. WING _____	**01/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD** **CARNEYS POINT, NJ 08069**

(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 . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/09/23. The facility was found to be in compliance with 42 CFR 483.73.	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 01/09/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The facility is one story first occupied in 1989. A second structure was added in 1995 and is used as the subacute care unit. The facility has concrete flooring, wood frame roofing and bearing walls. The facility is noted to be a type V (111) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has a 500 KW (kilowatt) diesel generator that is tested above 30% routinely each month. The facility has 11 smoke compartments. The facility has 114 occupied beds.	K 000		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		2/8/23

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

Electronically Signed | 01/27/2023

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
	315237	A. BUILDING **02** B. WING _____	**01/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD** **CARNEYS POINT, NJ 08069**

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K 341	Continued From page 1 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility to complete a smoke detection sensitivity test for all 176 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2. This deficient practice had the potential to affect all 114 residents. Findings include: A review of fire safety records from the "Fire Alarm" folder revealed the most recent two fire alarm inspections on 01/12/22 and 07/20/22 did not include a smoke detection sensitivity test. A interview with the Maintenance Director on 01/09/23 at 3:00 PM revealed he did not have the test from the past two years and does not have a	K 341	Corrective Action: A sensitivity test quote has been signed off and scheduled for Feb 1st for all smoke detectors in the building. Identification of Residents at Risk: The residents of [redacted], and [redacted] units who reside within the areas relying on the smoke detection system. These residents can be identified by reviewing the resident roster. Systemic Change: Maintenance Director will update his yearly audits to include the sensitivity test documentation to ensure we are up to date, as well as sign up for scheduled test service from our vendor.	

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	315237	A. BUILDING **02** B. WING _____	**01/17/2023**

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K 341	Continued From page 2 smoke detection sensitivity test for all 176 photo electric smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 341	Quality Assurance: An annual review of the audit will be conducted and documented by the Maintenance Director or designee for 5 years. Any concerns/recommendations will be made at that time and addressed as needed. The results of the review will be reported to the Administrator as well as the Quality Assurance committee at their first quarterly meeting for each year for 5 years.	
K 363 SS=E	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 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	K 363		2/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING **02** B. WING _____	**01/17/2023**

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AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD** **CARNEYS POINT, NJ 08069**

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K 363	Continued From page 3 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 interview, the facility failed to ensure corridor doors closed and latched in their frames in accordance with NFPA 101 Life Safety Code (2012 edition) 19.3.6.3. This deficient practice Had the potential to affect 16 residents. Findings include: Observations on 01/09/23 of bedroom corridor door [redacted] at 9:50 AM, bedroom [redacted] at 9:50 AM, bedroom [redacted] at 10:15 AM, bedroom [redacted] at 10:20 AM, bedroom [redacted] at 10:25 AM, bedroom [redacted] at 10:28 AM, bedroom [redacted] at 10:28 AM, bedroom [redacted] at 10:29 AM and bedroom [redacted] at 10:30 AM revealed the bedroom corridor doors failed to latch into the frame when closed. In an interview at the times of the observation, the Maintenance Director confirmed the corridor doors did not latch when closed. NJAC 8:39-31.1(c), 31.2(e)	K 363	Corrective Action: All the problematic doors were repaired by the Maintenance Director and Assistant and ensured to be latching properly Identification of Residents at Risk: The residents who reside in that corridor were at risk by not having a properly latching corridor door. These residents can be identified by reviewing the resident roster. Systemic Change: Maintenance Director or designee will conduct a monthly audit of corridor doors to ensure they are being inspected and in working condition and latching properly. Quality Assurance: A quarterly review of the audit will be conducted and documented by the Maintenance Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as	

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K 363	Continued From page 4	K 363	needed. The results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) sections 8.5.2.1 and 8.5.6.2. This deficient practice had the potential to affect all 114 residents. Findings include: An observation of the smoke wall near the vending machines on 01/09/23 at 11:05 AM	K 372	Corrective Action: All the areas identified as lacking the proper fire rated red fire caulk were redone with proper fire rated red fire caulk Identification of Residents at Risk: All residents on [redacted] and [redacted] Units who rely on these fire barriers were at risk due to not having the proper sealant. These residents can be identified by reviewing the resident roster. Systemic Change: The Maintenance Director has added to his monthly audits for one year a check of	2/8/23

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AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD** **CARNEYS POINT, NJ 08069**

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K 372	Continued From page 5 revealed six of six penetrations used non-rated foam on a dry wall smoke barrier. An observation of the smoke barrier wall near bedroom Ex Order on 01/09/23 at 11:05 AM revealed three holes of three-inch diameter without any material sealing the openings. An observation of the smoke barrier wall near Ex Order on 01/09/23 at 11:10 AM revealed non-rated foam in six areas covering holes and two seams of over two feet wide were not sealed. An observation of the smoke barrier wall near Ex Order on 01/09/23 at 11:15 AM revealed non-rated foam covering all holes on each side of the barrier. An observation of the smoke barrier wall near Ex Order on 01/09/23 at 11:15 AM revealed non-rated foam covering holes on both sides of the smoke barrier wall. An observation of the smoke barrier wall near bedroom Ex Order on 01/09/23 at 11:20 AM revealed non-rated foam covering three holes and one three-inch diameter hole with no seal. An observation of the smoke barrier wall near bedroom Ex Order on 01/09/23 at 11:20 AM revealed non-rated foam covering holes in the wall in three locations. On the opposite side, four holes and two seams were not sealed. In an interview at each observation, the Maintenance Director verified the use of the non-rated foam and penetrations observed in the smoke barrier walls. NJAC 8:39-31-1(c), 31.2(e)	K 372	all areas which require fire caulk, to ensure that no changes have been made requiring it to be redone. Quality Assurance: A quarterly review of the audit will be conducted and documented by the Maintenance Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. The results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	

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K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the written Fire Safety Plan provided for evacuation of a smoke compartment and an emergency phone call to the fire department in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.7.2.2. This deficient practice had the potential to affect 114 residents. Findings include: A review of the fire plan located in the "Disaster Manual" revealed the fire plan lacked reference to moving residents beyond the smoke compartment affected by fire to an unaffected smoke compartment and to call 911 in addition to the alarm transmission. An interview with the Administrator on 01/09/23 at 3:00 PM verified the plan did not address the	K 711	Corrective Action: The Disaster Manual was immediately updated to reflect the proper moving of the residents beyond the smoke barrier as well as an additional 911 call. Changes were approved by the inspector. Identification of Residents at Risk: Any resident in an area requiring an evacuation or emergency response were at risk due to not having the proper wording in the disaster plan. These residents can be identified by reviewing the resident roster. Systemic Change: The Administrator will maintain a quarterly review with the Maintenance Director reviewing the fire plan in the Disaster Manual to ensure they are in compliance.	2/8/23

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K 711	Continued From page 7 above areas. NJAC 8:39-31.2(e)	K 711	Quality Assurance: The results of the quarterly audit will be reported to the Quality Assurance committee at their quarterly meeting for one year. Any concerns/recommendations will be made at that time and addressed as needed.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315237 Y1	A. Building 02 - SOUTHGATE B. Wing Y2	2/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

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Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0341	02/08/2023	LSC K0363	02/08/2023	LSC K0372	02/08/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0711	02/08/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
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