STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. BUILDING _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	**438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079**

(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 Complaint NJ #: 155679; 156706; 161780; 165123; 166266; 168107; 168629 STANDARD SURVEY: 03/13/2024 CENSUS: 85 SAMPLE SIZE: 18 + 11 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=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		4/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/28/2024

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

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined the facility failed to maintain a comfortable and homelike environment for 3 resident rooms (room numbers NJ Exec [redacted] and NJ Exec [redacted] on the NJ Exec [redacted] unit of the facility. The evidence of this deficient practice includes: 1. During the initial tour of the unit on 03/04/24 at 11:32 AM, in Room NJ Exec [redacted] the surveyor observed the side table missing the middle drawer handle, the walls behind and next to the bed with gouges, the opposite wall with scratches and missing paint, the closets with scratches and missing laminate on the edges exposing the raw edge, and the closet drawer handle hanging perpendicular to the drawer. In the bathroom, the surveyor observed a brown discolored ceiling tile, a black bucket under the bathroom sink with	F 584	In room NJ Exec [redacted] the side table missing the middle drawer handle was replaced. The walls behind and next to the bed with gouges and the opposite wall with scratches and missing paint were spackled, sanded and painted. The stained ceiling tile was replaced. The sink was repaired, and the bucket removed. Closet doors replaced. In room NJ Exec [redacted] the broken window blind was replaced. The wall with the scratches and spackled area was sanded and painted. The dresser was replaced. The spackled area on the bathroom wall was replaced with tile. In room NJ Exec [redacted] the peeling wallpaper was reglued and will be removed and walls painted. All residents have the potential to be affected.	

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F 584	Continued From page 2 water in it, and water on the floor under the sink. 2. On 03/04/24 at 11:40 AM, in Room [NJ Exec O] the surveyor observed that the bottom of the window blind was broken in half. The resident stated that the blind did not raise up and down and [NJ Exec Ord] There were scratches and missing paint on the wall under the window, the laminated edge of the dresser was missing and exposed the raw edge, and there was a large, spackled area on the bathroom wall. 3. On 03/05/24 at 10:18 AM, in Room [NJ Exec O] the surveyor observed the bottom edge of the window blind broken in half and hanging from blind. At that time, there was a U.S. FOIA (b) (6)) in the room. The surveyor interviewed the [U.S. FOIA] about the window blind and the [U.S. FOIA] acknowledged that the window blind was broken and stated, "it's been broken a while." The [U.S. FOIA] stated that if she had found something broken and needed repair in a resident's room that she would have told maintenance by recording the request in the maintenance binder or that she would have verbally told maintenance and then it would have been completed. The surveyor inquired about the walls, furniture and bathroom observations and the [U.S. FOIA] acknowledged that the room should not look like that and was not considered homelike, stating, "personally, no, it sucks." 4. On 03/05/24 at 12:46 PM, in Room [NJ Exec O] the surveyor observed discolored wallpaper that was peeling from three of the walls in the room. On 03/05/24 at 12:49 PM, the surveyor interviewed the U.S. FOIA (b) (6)) of	F 584	All staff were in-serviced by the staff development/designee on the “Reporting Maintenance Concerns Policy”, documenting repairs needed in the appropriate maintenance book for follow-up by the Maintenance Department. The Maintenance staff were in-serviced by the Administrator on checking the maintenance books daily, documenting and signing off once a repair is completed within a timely manner. The Maintenance Director/Designee will conduct random weekly audits on 3 maintenance books to ensure repairs are being made in a timely manner, documented, and signed off once completed X6 months. The Maintenance Director/Designee will check 5 random rooms weekly X6 months to ensure that all repairs and maintenance needs are addressed. All findings from the audits will be reported and reviewed by the Maintenance Director/Designee at the next quarterly QAPI meeting for the next 3 quarters.	

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F 584	Continued From page 3	F 584		

the [NJ Exec O] unit who stated that if she had found something broken or that needed repair in a resident's room that she would write the room location and the issue in the maintenance book at the nurse's station. The [U.S. FOIA] stated that maintenance comes on the unit daily and checks the maintenance book and that if she wrote in the book and it was still not fixed that she would have gone to the maintenance department or called him to communicate the issue. The surveyor and the [U.S. FOIA] toured Rooms [NJ Exec O] [NJ Exec O] and [NJ Exec] together and discussed the surveyor's findings. The [U.S. FOIA] stated that it was important for safety that the toured rooms were homelike and that she would call maintenance to address the issues. The surveyor and the [U.S. FOIA] reviewed the unit's maintenance book together. The Maintenance Request form revealed sections for Location of Repair Requested, Your Name and Shift, Date, Description of Problem, Repaired by, Date, and Resolution. The [U.S. FOIA] stated that after finding an issue on the unit that the nurse would record on the maintenance request the room number, their name and date, and the issue to be resolved. She then stated that when maintenance reviewed the log that they would have signed and dated and gave a description of what was done.

The surveyor reviewed the Maintenance Request form. On one page there was an entry for Room [NJ Exec O] on 01/25/24 that was filled in completely; an entry for the Med Room on 01/25/24 that was filled in completely; an entry for Location of Repair Requested: Room [NJ Exec] (bathroom), Your Name and Shift: [[U.S. FOIA (b)] name] 7-3, Date 01/26/24, Description of Problem: Sink is leaking, water all over the floor, Repaired by: no entry, Date: no entry, Resolution: no entry; and an entry for Room [NJ Exec O] on 01/26/24 that was filled in

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F 584	Continued From page 4 completely except for Date of repair. On 03/05/24 at 01:12 PM, the surveyor interviewed the [NJ Exec] U.S. FOIA (b) (6)) who stated that the process for finding something not working or broken on the unit was to have it recorded on the maintenance log and then maintenance would have checked the log periodically throughout the day. The [U.S. FOIA (b) (6)] stated that if the issue required immediate attention, that staff would log it and then call maintenance immediately or page them overhead or they could have told maintenance if they were seen on the unit. The surveyor and the [U.S. FOIA (b) (6)] toured Rooms [NJ Exec] [NJ Exec] and [NJ Exec] together and discussed the surveyor's findings. The [U.S. FOIA (b) (6)] acknowledged that the rooms were not homelike and stated, "I wouldn't want my home looking like that." The [U.S. FOIA (b) (6)] stated that if she notified maintenance of an issue and it was not fixed that she would have gone up the chain of command and made her direct supervisor know about the issue. The surveyor and the [U.S. FOIA (b) (6)] reviewed the unit's maintenance book together. The [U.S. FOIA (b) (6)] acknowledged that the repair request marked Room [NJ Exec] (bathroom), dated 01/26/24, Description of Problem: "Sink is leaking, water all over the floor," had blank spots under "Repaired by", "Date", and "Resolution." She stated that the staff would write in their findings and request for repair then the maintenance man would have fixed the issue then signed when it was done. The surveyor inquired as to the blank spots on the entry for Room [NJ Exec] on 01/26/24 and what it meant when Repaired by, Date, and Resolution were unsigned. The [U.S. FOIA (b) (6)] stated, "That looks like that was completely skipped over." On 03/05/24 at 01:21 PM, the surveyor	F 584		

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F 584	Continued From page 5	F 584		

interviewed the U.S. FOIA (b) (6)) who stated that the process a resident had something in their room that needed repair or was broken was that the nurse would report it to maintenance by recording it on the maintenance log. The U.S. FOIA stated that the maintenance man was on the unit daily and would check the log and then would have repaired the issues and when done he would sign off on the maintenance log. The U.S. FOIA stated that the staff would also interrupt the maintenance man to inform him of issues verbally and that he would stop and do whatever was needed. She stated, "He never says no and is always available." Adding, "We are all guilty of stopping him in the middle of things and should have wrote it down." The surveyor reviewed with the U.S. FOIA photos of rooms NJ Exec NJ Exec and NJ Exec The U.S. FOIA acknowledged that the resident rooms should not have appeared that way and that the rooms should have looked more like someone's home. The surveyor and the U.S. FOIA reviewed the maintenance book together. The U.S. FOIA acknowledged the entry for Location of Repair Requested: Room NJ Exec (bathroom), Your Name and Shift: [CNA's name] 7-3, Date 01/26/24, Description of Problem: Sink is leaking, water all over the floor, Repaired by: no entry, Date: no entry, Resolution: no entry, and acknowledged the entry's blank spots. The U.S. FOIA stated that staff wrote in their findings and request for repair then maintenance would sign the log when it was completed. The U.S. FOIA stated that if the log was not signed then it was not done, and that the maintenance man may have gotten interrupted.

On 03/05/24 at 01:33 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that there was him and one

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F 584	Continued From page 6	F 584		

other maintenance man for the facility. He stated that the process when a resident's room needed repairs was that there was a book at each nurse's station and that the staff would write in the book or they would have told him and he would address the issue. The [U.S. FOI] stated that the staff would write the resident's room number, the issue, and the date it occurred in the book and that he would have tried to respond immediately to resolve the issue. The surveyor inquired as to what his responsibility with the maintenance book was and he stated that the staff would sign off on the repair that was made and that if it was not signed off that it usually meant it wasn't looked at yet, or that staff may have caught him in the hallway and told him about the issue and that he did not look at the book. The [U.S. FOI] stated that usually things would have gotten done as soon as they brought them up. The [U.S. FOI] acknowledged that he was responsible for any broken drawer handles, peeled wallpaper, broken blinds, cracked furniture and leaking sinks and stated, "Everything is my responsibility. I do it on priority of the task. We are redoing rooms one at a time." The surveyor inquired as to what redoing meant and the [U.S. FOI] stated that it depended on the room, if wallpaper needed to be taken down that they would have taken it down and painted the walls, stating, "rehab it like a house flip." The surveyor reviewed with the [U.S. FOI] pictures of Rooms [NJ Exec O] [NJ Exec O] and [NJ Exec O] The [U.S. FOI] acknowledged all of the issues that needed repair and stated, "We didn't have everything done, they need to be resolved." The [U.S. FOI] stated that it was important to make the resident's rooms homelike for dignity, adding, "This is their home where they stay, we want it to be nice as possible." The surveyor and the [U.S. FOI] reviewed the maintenance log together. The [U.S. FOI] stated that staff would write their concerns and

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F 584	Continued From page 7	F 584		

when maintenance repaired it that they would sign it too. The [U.S. FOI] acknowledged the entry for Location of Repair Requested: Room [NJ Exec] (bathroom), Your Name and Shift: [CNA's name] 7-3, Date 01/26/24, Description of Problem: Sink is leaking, water all over the floor, Repaired by: no entry, Date: no entry, Resolution: no entry, and when the surveyor inquired about the empty blank spaces the [U.S. FOI] stated, "It slipped by me. I don't know what happened." The surveyor requested any other communication in regard to maintenance issues and the [U.S. FOI] stated that there was no other repair information and he acknowledged that the bathroom sink in Room [NJ Exec] was not fixed. The [U.S. FOI] stated, "It wasn't done, it's still leaking now, we are aware of it."

A review of the undated facility policy, "Reporting Maintenance Concerns," revealed, Policy Interpretation and Implementation: The maintenance book is checked daily and signed as the work is completed.

A review of the undated facility policy, "Maintenance Repairs," revealed, Policy Interpretation and Implementation: The maintenance book is checked daily and signed as the work is completed.

A review of the facility provided Director of Maintenance job description revealed, Personnel Functions: Make daily rounds to assure that maintenance personnel are performing required duties and to assure that appropriate maintenance procedures are being rendered to meet the needs of the facility. Equipment and Supply Functions: Make periodic rounds to check equipment and to assure that necessary equipment is available and working properly.

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F 584	Continued From page 8	F 584		
F 658 SS=D	NJAC 8:39-4.1(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 review of electronic medical records and other pertinent facility documentation, it was determined that the facility failed to follow professional standards of clinical practice with respect to obtaining a diagnosis for the use of an NJ Exec Order 26.4b1 medication for 1 of 1 residents (Resident #184) reviewed for NJ Exec Order 26.4b1 This deficient practice was evidenced by the following: 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."	F 658	Resident #184 was educated ad regards to why he was receiving the NJ Exec Order 26.4b The diagnosis for the NJ Exec Order 26.4b was clarified with the physician and diagnosis obtained. The identified nurse that obtained the NJ Exec Order 26.4b order was counseled and received 1: 1 in-service by DON on complete orders to include diagnosis. The US FOIA (b)(6) was in-serviced by DON to verify that all NJ Exec Order 26.4b orders have a diagnosis during her assessment for infection control. All residents receiving antibiotics have the potential to be affected by this deficient practice. An audit was completed by Don/ designee on all residents with antibiotic orders to ensure all had appropriate diagnosis for the course of treatment. All staff were in-serviced by staff development to verify and to ascertain that all physician orders for antibiotics have a diagnosis. All residents on antibiotics will be	4/30/24

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F 658	Continued From page 9 According to the Admission Record, Resident #184 was admitted to the facility in [redacted] The resident did not have a comprehensive Minimum Data Set (MDS) and was not due for the assessment at the time of the survey. The admission assessment (AA) indicated that the resident was admitted to the facility with [redacted] and [redacted] The AA indicated that the resident had the diagnoses of [redacted] and that the resident had a [redacted] located in the [redacted]. On 03/04/24 at 10:47 AM, during tour, the surveyor observed that there was a sign on Resident 184's door indicating that the resident was o [redacted] The sign also indicated that to enter the room you must wear a protective gown and gloves. The surveyor observed an [redacted] and vile of medication were [redacted] that was next to the resident's bed. The [redacted] was labeled with the resident's name and the bag indicated that the medication, [redacted] was to [redacted] every 12 hours over [redacted]. The resident was interviewed at this time and stated that he/she did not [redacted] or [redacted] he/she had. Resident #184 stated that the nurse [redacted] last night on [redacted], but didn't think he/she [redacted]. On 03/04/24 11:17 AM, the surveyor interviewed the [redacted] who stated she was employed [redacted] The [redacted] stated that the facility provided her with competencies such as medication pass, abuse, infection control, and dementia training. She	F 658	reviewed at the morning clinical/communication meeting to insure there is a diagnosis for the antibiotic use. The Infection Preventionist will conduct weekly audits on all residents receiving antibiotics to verify that they have a diagnosis. The Infection Preventionist will review findings weekly with DON and quarterly with the QAPI committee over the next year.	

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stated that she was also provided with an orientation packet prior to employment. The [U.S. FOIA] stated that Resident #184 was on [NJ Exec Order 26.4b1] for an [NJ Exec Order 26.4b] but that she was not sure what type of [NJ Exec Order 26.] the resident had because it was not documented on the physician's order. She stated that it would have been important to know what [NJ Exec Order 26.4b1] the resident had and why the resident was being [NJ Exec Order 26.4b1]. The [U.S. FOIA] reviewed the [NJ Exec Order 26.4b1] with the surveyor who confirmed that there were no diagnoses associated with the [NJ Exec Order 26.4b1] order and she was not sure what type of [NJ Exec Order 26.] the resident had.

The surveyor reviewed the resident's Medication Administration Record (MAR), dated [NJ Exec Order 26.4b], which contained a physician's order for [NJ Exec Order 26.4b1] use [NJ Exec] 12 hours for [NJ Exec Order 26.4b] There were no diagnoses documented for the use of the [NJ Exec Order 26.4b1].

On 03/04/24 at 11:29 AM, the surveyor interviewed the [U.S. FOIA (b) (6)]) who stated that Resident #184 was ordered an [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b1]) in the [NJ Exec Orde] The [U.S. FOIA (b) (6)] also confirmed that the physicians order for the [NJ Exec Order 26.4b1] should have had a diagnosis associated with the use of the medication and that she would adjust the order to include a diagnosis.

On 03/05/24 09:55 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who explained the

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AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

(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 658	Continued From page 11 policy for residents admitted with a [NJ Exec Order 26.4b1]. The [U.S. FOIA (b) (6)] explained to the surveyor that when a resident was admitted to the facility with a [NJ Exec Order 26.4b1], the nurse assessed resident's [NJ Exec Order 26.4b1] and checked for NJ Exec Order 26.4b1 with [NJ Exec Order 26.4b1] to make sure the [NJ Exec Order 26.4b1] was functional. She stated that the nurse was also responsible to make sure is a [NJ Exec Order 26.4b1] was on the end of the [NJ Exec Order 26.4b1]. The [U.S. FOIA (b) (6)] further explained that physician orders should be obtained to [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] and sometimes [NJ Exec Order 26.4b1] depending on what the physician ordered. The [U.S. FOIA (b) (6)] also stated that diagnoses for the [NJ Exec Order 26.4b1] and what the resident was on the [NJ Exec Order 26.4b1] for should be included in the [NJ Exec Order 26.4b1] order. On 03/12/24 at 01:39 PM, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed that the physician's order for the use of the [NJ Exec Order 26.4b1] should have had a diagnosis associated with the use of the medication. The facility's undated policy titled, "Medication and Treatment Orders" indicated that orders for medications and treatments will be consistent with principles of safe and effective order writing. The policy reflected that orders for medications must include clinical condition or symptoms for which the medication is prescribed. NJAC 8:39-27.1	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		4/30/24

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F 689	Continued From page 12 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint # 155679, 165123, and 168629 Based on interviews, review of electronic medical records, and review of other pertinent facility documents, it was determined that the facility failed to a.) obtain a physician order for the treatment of a NJ Exec Order 26.4b that was obtained during a NJ Exec and b.) update a resident's Care Plan (CP) with NJ Exec Order 26.4b1 interventions after the resident NJ Exec on NJ Exec Order 26.4b This was deficient practice was identified for 1 of 5 residents (Resident #334) reviewed for accidents and was evidenced by the following: According to the Admission Record (AR), Resident #334 was admitted to the facility with the diagnoses that included, but were not limited to, NJ Exec Order 26.4b1 [redacted] The admission Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated NJ Exec Order 26.4, reflected that the resident was NJ Exec Order 26.4b1 and had a history of NJ Exec prior to admission to the facility. The resident NJ Exec Order 26.4b1 as he/she was not currently a resident in the facility.	F 689	The resident no longer resides at the facility. The identified personnel directly involved in the incident/ accident was counseled and received 1:1 in-servicing by staff development regarding obtaining treatment order and updating the care plan immediately. All residents with incident/accidents have the potential to be affected by this deficient practice. All nursing staff were in-serviced by staff development/designee to obtain a physician's order for treatments if resident sustains an injury related to an incident (even if it's just a one-time order for initial first aid) All nursing staff were in-serviced by staff development/designee to ensure that all incident/accident interventions are added to the care plan immediately. The nursing management team were in-serviced to review all accident/incident reports daily in clinical meeting to ensure incident/accident reports are completed thoroughly, treatment orders obtained if necessary and care plan updated immediately. The nursing management team will review the incident/accident reports daily upon occurrence for accuracy and completion,	

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F 689	Continued From page 13 On 03/03/24 at 11:48 AM, the surveyor reviewed the facility's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 report, dated NJ Exec Order 26.4b, which revealed the following information: According to the Incident Report (IR), dated NJ Exec Order 26.4b at 09:07 AM, Resident #334 had an NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 of the bed. The resident indicated that he/she was NJ Exec Order 26.4b1 . The resident indicated that he/she was not NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 . The documentation indicated that the resident had NJ Exec Order 26.4b1 The IR indicated that physician (PCP) and responsible party (RP) were notified, and that the resident was currently on NJ Exec Order 26.4b caseload. The IR indicated that the resident was educated to NJ Exec Order 26.4b1 and that the resident's CP was updated. According to the NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b at 09:07 AM, Resident #334 was NJ Exec Order 26.4b1 and developed a NJ Exec Order 26.4b to the NJ Exec Order 26.4b1 which was NJ Exec Order 26.4b with NJ Exec Order 26.4b and was NJ Exec Order 26.4b1 . The NJ Exec also indicated that the resident's CP was updated to include additional interventions to NJ Exec Order 26.4b1 . The surveyor reviewed Resident #334's CP and there was no documentation that the resident's CP was updated to reflect a new intervention to prevent NJ Exec Order 26.4b1 after Resident #334 NJ Exe on NJNJ Exec Order 26.	F 689	the findings will be reviewed with administrator weekly and a QAPI regarding incident/accident reports has been initiated to report the findings of the daily audit of incident/accident reports monthly to the QA committee and quarterly to the QAPI committee. Risk management will review incident/accident reports weekly for compliance, risk management will submit report to DON/Administrator weekly and findings will be shared monthly with QA committee and quarterly with QAPI committee over the next year.	

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F 689	Continued From page 14	F 689		

The surveyor reviewed the Nursing Progress Notes (NPN) in the Electronic Medical Record (EMR) and there was no documentation pertaining to the events of the [redacted] that occurred on [redacted] at 09:07 AM.

The surveyor reviewed the Physician Order Summary Report (POSR), dated [redacted], and there was no documentation that the facility had ordered a treatment for Resident #334's [redacted] that occurred on [redacted].

The surveyor reviewed the Treatment Administration Record (TAR), dated [redacted], and there was no documentation that the facility obtained a treatment for Resident #334's [redacted] that occurred on [redacted]

On 03/07/24 11:29 AM, the surveyor interviewed the [redacted]) who stated she had been employed in the facility since [redacted]. The [redacted] explained the process of an [redacted] to the surveyor. She stated that she would notify the supervisor that the resident [redacted] and the supervisor would conduct a full assessment of the resident to include a full set of vital signs (VS), [redacted], ask the resident if they had [redacted] and [redacted] would be done. If the resident had [redacted] or [redacted], then a treatment order would be obtained from the physician.

On 03/07/24 at 11:37 AM, the surveyor interviewed the [redacted]) who stated that if she [redacted] and the [redacted], she would immediately call the nurse. She further added

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F 689	Continued From page 15	F 689		

that the nurse would assess the resident and complete any necessary documentation. She added that the only form that she would have to complete would be a statement form.

On 03/07/24 at 11:40 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who explained the process the facility conducted if a resident had an NJ Exec Order 26.4b1. The U.S. FOIA (b) (6) stated that if a NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, the supervisor would be notified, the resident would be assessed for NJ Exec Orde and vital signs obtained, which would include asking the resident if they NJ Exec Order 26.4. She stated that if the resident had an NJ Exec Order 26.4b1, the facility required that the resident be assessed NJ Exec Order 26.4b1 She continued to explain the nurse would assess the resident's NJ Ex Orde and if the resident was NJ Exec Order 26 the resident would get NJ Exec Order 26 and treatments would be ordered by the physician. She added that the nurse would also notify the family and the RP. The nurse would be required to complete an incident report, initiate the investigation, and would get statements. The U.S. FOIA would complete the investigation. She further added that the nurse would be responsible to document the NJ Exe in the EMR, assesses the resident, update the care plan with interventions to NJ Exec Order 26.4b1, and document the notifications of family and physician in the progress note.

On 03/07/24 11:54 AM, the surveyor interviewed the U.S. FOIA (b) (6)) that was caring for Resident #334 on NJ Exec Order 26.4b at the time the resident NJ Exec The RN stated that she did not remember the incident and did not remember documenting the NJ Exe in the progress notes (PN).

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F 689	Continued From page 16	F 689		

On 03/07/24 at 01:05 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who confirmed that there was no documentation or nursing PN located in the EMR pertaining to Resident #334 NJ Exec Ord or NJ Exec Order 26.4b. The U.S. FOIA further confirmed that there were also no treatment orders obtained to the resident's NJ Exec O for the NJ Exec Order 26.4b1 of NJ Exec Order 26.4b.

On 03/12/24 at 10:32 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who reviewed Resident #334's CP and physician's orders in the presence of the surveyor and confirmed that the CP was not updated to include new interventions to prevent further reoccurrence of NJ Exec O on NJ Exec Order 26.4b and that it NJ Exec O was performed to the NJ Exec Order 26.4b1, a one-time treatment order should have been obtained from the physician.

On 03/12/24 at 10:40 AM, the surveyor interviewed the U.S. FOIA regarding Resident #334's NJ Exe of NJ Exec Order 26.4b at 09:07 AM, and the U.S. FOIA confirmed that a treatment order should have been obtained for the NJ Exec Order 26.4 that the resident obtained during the NJ Exe and she also confirmed that the resident's CP was not updated with new interventions after the resident NJ Ex on NJ Exec Order 26.4b. The U.S. FOIA stated that it was important to update the CP with new interventions to prevent further reoccurrence of NJ Exec O

The facility policy titled, "Incidents and Accidents," with a revised date of February 2023, indicated that the purpose of incident reports included: Assuring that appropriate and immediate interventions were implemented and corrective action were taken to prevent reoccurrence and improve the management of resident care, first

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F 689	Continued From page 17 aid would be given for minor injuries such as cuts and abrasions, the nurse would contact the resident's practitioner to report any injuries and obtain orders. The policy also indicated that documentation would include date, time, nature of incident, location, initial findings, immediate interventions, notifications, and orders obtained for follow-up interventions. The facility policy titled "Wound Treatment and Management," dated 2019, indicated that wound treatments will be provided in accordance with physician orders, including cleansing method, type of dressing, frequency of dressing changes. The policy indicated that indicated that in the absence of treatment orders, the licensed nurse would notify the physician and obtain treatment orders. The policy also indicated that treatment would be documented in the Treatment Administration Record (TAR) in the electronic health record. The facility policy, with revised date of 10/17/23, titled, "Comprehensive Care Plan" indicated that the facility would develop and implement a comprehensive person-centered CP for each resident and that resident specific interventions would reflect the resident's needs and preferences. The policy also indicated that qualified staff responsible for carrying out interventions specified in the CP would be notified of their roles and responsibilities for carrying out interventions when changes were made. NJAC 8:3.9-27.1(a)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		4/30/24

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F 690	Continued From page 18 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) ensure an	F 690	Resident #67's [redacted] was changed and replaced with a [redacted].	

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F 690	Continued From page 19 NJ Exec Order 26.4b1 did not touch the floor and b.) ensure the NJ Exec Order 26.4b1 was kept below the level of the NJ Exec Order 26 for 1 of 3 residents (Resident #67) reviewed for NJ Exec Order 26.4b1. This deficient practice was evidenced by the following: On 03/04/24 at 9:58 AM, the surveyor observed Resident #67 lying in bed. The resident had a NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 to the NJ Exec O The bottom of the NJ Exec Order 26.4b1 was touching the floor. According to the Admission Record, Resident #67 had diagnoses which included, but were not limited to, NJ Exec Order 26.4b1. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b, included the resident had a Brief Interview for Mental Status score of 'NJ Exec O' which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS included the resident had an NJ Exec Order 26.4b1 Review of the Order Summary Report, as of NJ Exec Order 26.4b included a physician's order to change the NJ Exec Order 26.4b1 weekly and as needed, dated NJ Exec Order 26.4b1. Review of the Care Plan, initiated NJ Exec Order 26.4b included a focus that Resident #67 had an NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1 and an intervention to keep the NJ Exec Order 26.4b1 below the resident's NJ Exec Order 26.	F 690	Resident #67's NJ Exec Order 26.4b1 was placed NJ Exec Orde the NJ Exec O of NJ Exec Order 26.4b1. The facility utilized an NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 into the NJ Exec Order 26 The identified CNA immediately received education regarding the NJ Exec being left at the NJ Exec Order 26.4b1 and the proper procedure. All residents with a Foley catheter have the potential to be affected by this deficient practice. All nurses and CNAs were in-serviced by staff development/designee regarding Foley catheter care, location of drainage bag without touching the floor and maintaining drainage bag below bladder level. All ancillary staff were in-serviced by staff development/designee to ensure that Foley drainage bags are not in contact with the floor, that they are located below the bladder level and to report findings to nursing personnel for immediate correction. The infection preventionist will conduct 5 random observations and competencies weekly for 6 months then 5 observations and competencies monthly for the remainder of year of CNA's regarding Foley catheter care, placement of drainage bag being below bladder level and not allowing drainage bag to contact the floor. The Infection Preventionist findings will be reviewed with DON weekly and reported to the QAPI committee quarterly over the next year. The unit managers will monitor daily for Foley drainage bag placement on their	

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F 690	Continued From page 20 On 03/05/24 at 9:52 AM, the surveyor knocked on Resident #67's door, but the U.S. FOIA (b) (6) stated she was performing care on Resident #67 and asked the surveyor to come back later. At 10:35 AM, the surveyor observed Resident #67 lying down flat in bed, fully dressed, with his/her NJ Exec Order 26.4b1 to his/her NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was with the resident's not NJ Exec Order 26.4b1 of the At 10:36 AM, the surveyor observed Resident #67's U.S. FOIA in the hallway using the U.S. FOIA kiosk. The surveyor waited in the hallway for the U.S. FOIA to become available. At 10:42 AM, the surveyor observed the U.S. FOIA walk away from the kiosk. At that time, the surveyor interviewed the U.S. FOIA regarding care. The U.S. FOIA stated that for residents with she ensures the NJ Exec Order 26.4b1 is and not touching the floor to " At 10:44 AM, the surveyor accompanied the U.S. FOIA to Resident #67's room. The U.S. FOIA acknowledged the NJ Exec Order 26.4b1 was not the resident's and that the U.S. FOIA was waiting for the NJ Exec Order 26.4b1 staff to get the resident out of bed. The U.S. FOIA then left the room to get a NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 so that it could be NJ Exec Order 26.4b1 the resident's The surveyor waited in the resident's room.	F 690	units and report findings weekly to the Infection Preventionist and the Infection Preventionist will report Quarterly to the QAPI committee over the next year.	

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F 690	Continued From page 21	F 690		

At 10:47 AM, the U.S. FOIA (b) (6) entered the resident's room, put on gloves, removed the NJ Exec Order 26.4b1 from the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 to the bedframe NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1

During an interview with the surveyor on 03/05/24 at 10:52 AM, the U.S. FOIA (b) (6) stated that the U.S. FOIA s should secure the NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 to allow the NJ Exec Order 26.4b1 ," and NJ Exec Order 26.4b1 the resident. The U.S. FOIA (b) (6) further stated the NJ Exec Order 26.4b1 should not touch the floor for, "sanitation reasons."

During an interview with the surveyor on 03/05/23 at 10:58 AM, the U.S. FOIA (b) (6)) stated the U.S. FOIA (b) should NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 of the resident's NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 should not touch the floor for NJ Exec Order 26.4b1 control reasons. At that time, the surveyor informed the U.S. FOIA (b) (6) of the observations made on 03/04/24 and 03/05/24. The U.S. FOIA (b) (6) stated that after the U.S. FOIA (b) (6) performed care, she should have NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 to the side of the bed, NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1 and not touching the floor.

Review of the facility's Catheter Care policy, dated 11/2023, included, "It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care," and, "Ensure drainage bag is located below the level of the bladder to discourage backflow of urine." The policy did not indicate if the drainage bag should be kept off the floor.

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F 690	Continued From page 22 NJAC 8:39 - 27.1(a)	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to label and dispose of medications in accordance with accepted professional principles for 1 of 1 residents (Resident #184) reviewed for [NJ Exec Order 26.4b] [redacted]	F 761	Resident #184 was educated on why he was receiving the [NJ Exec Order 26.4b] The [NJ Exec Order 26.4b] [NJ Exec] was removed and discarded accordingly. All residents receiving IV therapy have the potential to be affected by this deficient practice.	4/30/24

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AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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F 761	Continued From page 23 This deficient practice was evidenced by the following: According to the Admission Record, Resident #184 was admitted to the facility in [NJ Exec Order 26.4b] [redacted] The resident did not have a comprehensive Minimum Data Set (MDS) completed at this time. The admission assessment (AA) indicated that Resident #184 was admitted to the facility with [NJ Exec Order 26.4b1] [redacted] and [NJ Exec Order 26.4b1] The AA indicated that the resident had the diagnoses of [NJ Exec Order 26] and that the resident had a [NJ Exec Order 26.4b1] [redacted] On 03/04/24 at 10:47 AM, during tour, the surveyor observed a sign posted on the resident's door indicating that the resident was on [NJ Exec Order 26.4b1] [redacted] The sign also indicated that to enter the room you must wear a protective gown and gloves. The surveyor observed an [NJ Exec Order 26.4b1] [redacted] and vile of medication [NJ Exec Order 26] on the [NJ Exec Order] that was next to the resident's bed. The [NJ Exec Order] was labeled with the resident's name and the bag indicated that the medication [NJ Exec Order 26.4b1] [redacted] was to [NJ Exec Order] every 12 hours over [NJ Exec Order 26.4b1]. There was no date or labeling on the [NJ Exec Order 26.4b]. The resident was interviewed at this time and stated that he/she did not know why he/she was on the medication or what [NJ Exec Order 26.4] he/she had. Resident #184 stated that the nurse [NJ Exec Order 26.4b1] last night on [NJ Exec Order], but didn't think he/she received any of the medication. Review of the physician Order Summary Report	F 761	The identified nurse that [NJ Exec Or] the [NJ E] was given 1:1 in-service on labeling, dating the [NJ Exec Order] and [NJ Exec Orde] when [NJ Exec Order 26] the [NJ Exec O] The identified nurse was also in-serviced on disposing of medications whenever she is not able to administer the medication and it's not to be left in the room. All nursing staff were in-serviced on labeling and dating IV bags and tubing upon administration of the medication and to remove any medications that they are not able to be administered. The Unit Managers will verify during daily rounds that all IV bags and tubing's are signed and dated upon administration. The Unit Managers will make any corrections necessary as needed. The Unit Mangers will report findings weekly to the DON and quarterly to the QAPI committee for the next year.	

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(OSR), dated NJ Exec Order 26.4b reflected a physician's order for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 12 hours for NJ Exec Order 26.4b

Review of the resident's Medication Administration Record (MAR) indicated that the NJ Exec Order 26.4b1 every 12 hours was to be administered at 09:00 am and 2100 hours (09:00 pm). The MAR also indicated that on NJ Exec Order 26.4b at 2100 hours (9:00 pm) the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b

On 03/04/24 11:17 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated she was employed NJ Ex Order 26.4b1 The U.S. FOIA stated that the facility provided her with competencies such as medication pass, abuse, infection control, and dementia training. She stated that she was also provided with an orientation packet prior to employment. The U.S. FOIA stated that Resident #184 was on NJ Exec Order 26.4b1 for an NJ Exec Order 26.4b but was not sure what type of NJ Exec Order 26.4 the resident had because it was not documented on the physician's order. She stated that it would have been important to know what type of NJ Exec Order 26.4 the resident the resident had and why the resident was being treated with NJ E . She stated that when she came in to work that morning, she was given report by the 11:00 pm-7:00 am nurse who told her that the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26 the night prior, and the resident NJ Exec Order 26.4b1 the dose of medication that was ordered to be given at 9:00 pm. She stated that the NJ Exec Order 26.4b1 that was NJ Exec Order 26 on the NJ Exec Order 2 must have been from the 9:00 pm dose that was ordered to be given NJ Exec Order 26.4b at 9:00 PM. The U.S. FOIA further stated that the 11:00 pm-7:00 am nurse should have

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discarded the medication when she realized the resident's [NJ Exec Order 26.4b] was [NJ Exec Order 26] and that she could not administer the medication at that time.

On 03/04/24 at 11:29 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated that Resident #184 was ordered an [NJ Exec Order 26.4b1] [redacted]. She explained that the nurse had documented on [NJ Exec Order 26.4b] at 22:49 (10:49 PM) that the [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4] notified the [U.S. FOIA (b) (6)]), and called the [NJ Exec Order 26.4b1] company to come to the facility to [NJ Exec Order 26.4b1]. The [U.S. FOIA (b) (6)] stated that she heard that the resident did not get the 9:00 pm [NJ Exec Order 26.4b1] on [NJNJ Exec Order 26] The surveyor explained to the [U.S. FOIA (b) (6)] that the resident's [NJ Exec Order 26.4b1] was still [NJ Exec Order 26] on the [NJ Exec Order 2] since the [NJ Exec Order 26.4b1] and the [U.S. FOIA (b) (6)] stated that the medication that was [NJ Exec Order 26] on the [NJ Exec Order 2] should have been discarded when the nurse was not able to administer the medication. The [U.S. FOIA (b) (6)] went to the resident's room with the surveyor and confirmed that the [NJ Exec Order 26.4b1] and [NJ Exec Orde] was not dated or timed, so she was not sure how long the medication or [NJ Exec Orde] had been [NJ Exec Order 26.4] The [U.S. FOIA (b) (6)] then stated that the [NJ Exec Order 26.4b1] that was [NJ Exec Order 26] on the [NJ Ex] [NJ Exec O] should have been discarded.

On 03/05/24 09:55 AM, the surveyor interviewed the [U.S. FOIA (b) (6)]) who explained the policy for residents admitted with a [NJ Exec Order 26.4b1]. The [U.S. FOIA (b) (6)] explained to the surveyor that when a resident was admitted to the facility with a [NJ Exec Orde]

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NJ Exec O the nurse assessed the resident's NJ Exec Order 26.4b1 to check for NJ Exec Order 26 by NJ Exec Order 26.4b1 with NJ Exec O to make sure the NJ Exec was functional. She stated that the nurse was also responsible to make sure is a NJ Exec was on the NJ Exec of the NJ Exec Order 26.4b1 She stated that physician orders should be obtained to NJ Exec O with NJ Exec Order 26.4b1 and sometimes NJ Exec Order 26.4b1 depending on what the physician ordered. The U.S. FOIA explained that if the NJ Exec Orde was NJ Exec Order 26 the nurse should call the MD and then call the NJ Exec Order 26.4b services to come NJ Exec Order the NJ Exec Order C She stated that the NJ Exec Order 26.4b was NJ Exec Order 26.4b1 on NJ Exec Order 26.4, in the afternoon, and the resident received the dose of NJ Exec Order 26.4 that the resident missed at 9:00 AM. The U.S. FOIA confirmed that the NJ Exec Order 26.4b1 that was NJ Exec Order 26 at the resident's bedside should have been labeled and NJ Exec Orde dated and should have been discarded if the nurse was not going to administer the medication.

On 03/12/24 at 01:39 PM, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed that the NJ Ex medication should have been disposed of after the nurse realized that the NJ Exec Order 26.4b1 was not functional and that she was unable to administer the medication.

The facility policy facility policy titled, "Discarding and Destroying Medications" indicated that medications that cannot be returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by residents, and/or medications left by residents upon discharge) are to be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and

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F 761	Continued From page 27 controlled substances. The facility policy, dated 2022, titled, "Intravenous Therapy" indicated that IV tubing was to be changed every 96 hours or sooner if contamination or integrity of system is compromised. There was no documentation on the facility policy on labeling and dating of IV tubing. The facility provided the surveyor with a Nursing Inservice form, dated 03/05/24, which indicated that the nursing staff were educated on the following: "Be sure to date IV bag and tubing. Tubing was good for 24 hours. If unable to administer antibiotic medication, remove from the residents room." N.J.A.C. 8:39-29.4(h)	F 761		
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.	F 812		4/30/24

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F 812	Continued From page 28 §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.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was observed and evidenced by the following: On 03/04/24 from 09:54 to 11:03 AM, the surveyor toured the kitchen in the presence of the U.S. FOIA (b) (6) and observed the following: 1. On a metal rack in the walk-in refrigerator, there were two boxes marked raw chicken drumsticks that were resting on a parchment paper lined metal tray and the paper was marked "pull" with no date. The U.S. FO acknowledged there was no pull date and stated that it was important that expired food was not served, and that the box should have had a label with a pulled and use by date. 2. There was a box marked fresh leaf lettuce with a sticker dated 2/15/24. The lettuce was wilted, dry, had brown edges and there was black lettuce observed in the box. The U.S. FO stated that the sticker was dated when the lettuce was delivered and that it was good for 7 to 14 days. The U.S. FO acknowledged the wilted and black lettuce and stated that it was no longer fresh and removed	F 812	On 3/4/24 the Dietary Director immediately removed and discarded the two boxes of raw chicken with no pull date or use by date. On 3/4/2024 the box marked 2/15/2024 containing leaf lettuce with wilted, dry with brown edges was immediately discarded. The three stacked trays of undated, lidded cups of various liquids, each marked with liquid contents were discarded on 3/4/2024. On 3/4/2024 in the freezer the unlabeled and undated scalloped potatoes and 20 pounds of pork loins were immediately discarded. The dented can was discarded on 3/4/2024. The prep table and the slicer with tan debris observed on the base were immediately washed, rinsed, sanitized, and allowed to air dry on 3/4/2024. The white plastic cutting board with large brown circular stain was discarded on 3/4/2024. All residents who eat food from the kitchen have the potential to be affected. Beginning on 3/4/2024 Dietary Director started labeling and dating in-service with all dietary staff. Beginning on 3/4/2024 the dietary staff was in-serviced on dented can storage. The cleaning schedule was updated to ensure the slicer is cleaned after ever use and routinely more frequently. On	

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F 812	Continued From page 29 the box from the refrigerator. 3. There were three stacked trays of undated, lidded cups of various liquids, each marked with liquid contents. The [redacted] stated the cups of liquids were prepped for the day, but acknowledged that she was unsure how old they were and stated that they should have had the date they were prepped. 4. In the walk in freezer, there was one sealed, clear plastic bag that contained thin white ovals, with no label nor date. The [redacted] identified the food item as scalloped potatoes and acknowledged that the bag should have had a date that the food was received, the date it came out of the box and a use by date. The [redacted] discarded the bag of scalloped potatoes. 5. There were three 20 pound (lb) pork loins. One pork loin was manufacturer marked best by or freeze by with an unreadable date. The [redacted] acknowledged that she was unsure how old the undated pork loin was and stated that there was no label and that it should have had a label when it was received. One pork loin was manufacturer marked with the date 3/10/24, and there was a hole in the packaging with the meat opened and exposed to air. The [redacted] acknowledged the hole and stated that the hole should not have been there, that it was freezer burnt, and that it should not have been served. The [redacted] discarded the two pork loins. 6. On a rack in the dry storage area, there was one 108 ounce dented can of sweetened applesauce. The [redacted] acknowledged the dent and removed the can to the dented can section.	F 812	3/4/2024 an in-service began with all the dietary staff on how to properly follow cleaning procedures for the slicer following daily/weekly/monthly cleaning schedules. Audits for labeling and dating will be done by the Dietary Director/designee weekly for 4 weeks, and then monthly for 5 months. Dietary Director/Designee will complete a weekly audit for one year that all food items are properly labeled and dated according to policy. The findings of the audit will be shared with the QAPI committee quarterly. Audits for dented cans will be done by the Dietary Director/Designee weekly for 4 weeks, and then monthly for 5 months. Dietary Director/Designee will complete a weekly audit for one year to ensure that all cans are stored properly, and no dented cans are stored on shelves. The findings of the audit will be shared with the QA committee quarterly. Audits of the cleaning schedule will be done by the Dietary Director/Designee weekly for 4 weeks, and then monthly for 5 months. Dietary Director/Designee will complete a weekly audit of the daily/weekly/monthly cleaning log checking all areas of the kitchen for cleanliness. The findings of the audit will be shared with the QAPI committee quarterly. A quarterly review of all dietary audits will be conducted and documented by the Food Service Director. 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	

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F 812	Continued From page 30 7. On a metal prep table there was a slicer covered with a plastic bag. The [redacted] stated that once equipment was used that it was cleaned and sanitized then covered with a plastic bag. The [redacted] removed the bag and there was tan debris observed on the base, the slicer, and the blade arm. The [redacted] stated she did not know what the debris was as she removed the debris with her finger. She acknowledged that the debris should not have been there and stated that cleaned and sanitized equipment avoided cross contamination. 8. On a rack in the dry pots and pans area, there was a white cutting board with a large brown circular stain. The [redacted] acknowledged the stain and stated that it was important that the cutting boards were clean so germs and cross contamination were prevented. On 03/12/24 01:36 PM, the administrative team was made aware of the kitchen concerns. A review of the facility policy, "Food Receiving and Storage," reviewed and updated-January 2024, revealed, Policy Interpretation and Implementation: Dented cans will be stored in a designated area and returned to vendor. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date). The freezer must keep frozen foods solid. Wrappers of frozen foods must stay intact until thawing. A review of the facility policy, "Sanitation," reviewed and updated January 2024, revealed, Policy Interpretation and Implementation: All utensils, counters, shelves and equipment shall be kept clean ...All equipment, food contact surfaces and utensils shall be washed to remove	F 812	Assurance committee for one year.	

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F 812	Continued From page 31 or completely loosen soils ...Cutting boards will be washed and sanitized between uses. Manual washing and sanitizing will employ a three-step process for washing, rinsing, and sanitizing. Scrape food particles ... A review of the facility policy, "Food Preparation and Service," reviewed and updated-January 2024, revealed, Policy Interpretation and Implementation: Appropriate measures are used to prevent cross contamination. These include: Cleaning and sanitizing work surfaces (including cutting boards) and food-contact equipment between uses ... NJAC 8:39-17.2(g)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		4/30/24

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§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

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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 842	Continued From page 33 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint NJ# 168629 Based on interview and review of medical records and other facility documents, it was determined that the facility failed to maintain an accurately documented and complete medical record for 1 of 22 reviewed (Resident #334). This deficient practice was evidenced by the following: According to the Admission Record (AR), Resident #334 was admitted to the facility with diagnoses that included, but were not limited to [redacted] The admission Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated [redacted], reflected that the resident was [redacted] and had a history of [redacted] prior to admission to the facility. The resident was [redacted] as he/she was not currently a resident in the facility. On 03/03/24 at 11:48 AM, the surveyor reviewed the facility's [redacted] investigation and [redacted] incident report, dated [redacted], which revealed the	F 842	Resident #334 no longer resides at the facility. All residents with incident/accidents have the potential to be affected by this deficient practice. The identified staff directly involved in the incident/accident for this resident was counseled and received 1:1 in-servicing by DON regarding documenting a progress note related to the incident in the Electronic Medical Records. All nursing staff were in-serviced by staff development on completing a progress note for all incident/ accidents in the Electronic Medical Records. The nursing management team will review all incidents/accidents daily that occurred the previous day during the next days clinical meeting. The team will ascertain that the incident/accident has been documented correctly in the progress notes section in the Electronic Medical Records. The findings will be reviewed weekly with the Administrator and at the quarterly QAPI meeting over the next year. Risk management will review incident/accident reports weekly for compliance, risk management will submit reports to DON/Administrator weekly and findings will be shared monthly with QA	

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F 842	Continued From page 34 following information: According to the Incident Report (IR), dated [NJ Exec Order 26.4b] at 09:07 AM, Resident #334 had an [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] of the bed. The resident indicated that he/she [NJ Exec Order 26.4b1] The resident indicated that he/she was not [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4b1]. The documentation indicated that the resident had [NJ Exec Order 26.4b1] on the [NJ Exec Order 26.4b1] during the [NJ Ex] and that physician (PCP) and responsible party (RP) were notified. The IR also reflected that Resident #334 was currently on [NJ Exec Order 26.4b] caseload and was educated to utilize the [NJ Ex Order 26] during [NJ Exec Order 26.4b1] The surveyor reviewed the Nursing Progress Notes (NPN) in the Electronic Medical Record (EMR) and there was no documentation pertaining to the events of the [NJ Ex] that occurred on [NJ Exec Order 26.4] at 09:07 AM. On 03/07/24 11:29 AM, the surveyor interviewed the [U.S. FOIA (b) (6)]) stated she had been employed in the facility since [NJ Exec Order 26] . The [U.S. FOIA] explained the process of an [NJ Exec Order 26.4b1] to the surveyor. She stated that she would notify the supervisor that the resident [NJ Ex] and that supervisor would conduct a full assessment of the resident which included a full set of vital signs (VS), [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1], assess for [NJ Exec O] and [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] would be done. She stated that all [NJ Exec Order 26.4b1] required [NJ Exec Order 26.4b1] in case the resident [NJ Exec Order 26.4b1]. She continued to explain that the nurse would	F 842	committee and quarterly with QAPI committee meetings over the next year.	

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write an incident note (progress note) in the Electronic Medical Record (EMR), fill out incident report form, and obtain statements from the person that found the resident, the U.S. FOIA (b) (6), and the U.S. FOIA (b) (6). She further added that the U.S. FOIA (b) (6) assigned to that resident would document the NJ Exec in the progress notes.

On 03/07/24 at 11:37 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that if she NJ Exec Order a resident NJ Exec Order NJ Exec O and the NJ Exec Order 26.4b1, she would immediately call the nurse. She further added that the nurse would assess the resident and complete any necessary documentation. She added that the only form that she would have to complete would be a statement form.

On 03/07/24 at 11:40 AM, the surveyor interviewed the U.S. FOIA (b) (6) who explained the process the facility conducted if a resident had an NJ Exec Order 26.4b1. The U.S. FOIA (b) (6) stated that if a resident NJ Exec NJ Exec Order 26.4b1, the supervisor would be notified, the resident would be assessed, and VS would be taken, including NJ Exec O If the resident had an NJ Exec Order 26.4b1, the facility required that the resident be assessed NJ Exec Order 26.4b1 She continued to explain the nurse would assess the resident's NJ Exec Ord and if the resident was NJ Exec Order 26 the resident would get NJ Exec Order 26 and treatments would be ordered by the physician. She added that the nurse would also notify the family and the RP, complete an incident report, initiate the investigation and get statements from staff. She further added that the U.S. FOIA (b) (6)) would complete the investigation. She stated that it would be the

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nurses responsiblity to document the [redacted] in the EMR, assesses the resident, update the care plan with interventions to prevent [redacted] and document the notifications of family and MD in the progress note. She verified that it would be important to document in the progress any changes in condition that occurred with residents so that there was accurate communication between disciplines. She further stated it was also important to keep accurate documentation in the progress notes because the progress notes were a legal document. The [redacted] reviewed Resident #334's progress notes and confirmed that there was no documentation regarding Resident #334 [redacted] of [redacted]

On 03/07/24 11:54 AM, the surveyor interviewed [redacted] that was caring for Resident #334 on [redacted] at the time the resident [redacted] The [redacted] stated that she did not remember the incident and did not remember documenting the [redacted] in the progress notes.

On 03/07/24 at 12:00 PM, the surveyor interviewed the [redacted]) and she confirmed the nurses were responsible to complete progress notes to include what happened at the time the [redacted] assessment, [redacted] notification of family and doctor, and [redacted] of the resident. She stated that the resident's PN were required for any [redacted]. She stated that PN were a form of communication between disciplines, a legal document and assisted the writer in recollection of the events.

On 03/07/24 at 01:05 PM, the surveyor interviewed the [redacted]) who confirmed that there was no documentation or

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F 842	Continued From page 37 nursing progress notes located in the EMR pertaining to Resident #334's [NJ Exc] on [NJNJ Exec Order 26]. On 03/12/24 at 10:32 AM, the surveyor interviewed the [U.S. FOIA] who confirmed that that there was no documentation in the resident's progress notes regarding the resident's [NJ Exc] of [NJ Exec Order 26]. The facility policy, dated February 2019, titled, "Charting and Documentation" indicated that all services provided to the resident, progress notes toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective, complete, and accurate. NJAC 8:39-35.2 (d)6, 16(e)	F 842		
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	F 880		4/30/24

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F 880	Continued From page 38 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: (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.	F 880		

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F 880	Continued From page 39 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to follow appropriate infection control practices and perform hand hygiene as indicated during meal tray pass observed in the Main Dining area. The deficient practice was evidenced as follows: On 03/04/24 at 12:07 PM, the surveyor observed the following: The U.S. FOIA (b) (6)) was standing at Resident #19's table, and with her bare hands, she opened a packet of powder, emptied the powder into a cup of white liquid and mixed it with a spoon with her left hand. With her right hand she removed a phone from her pocket and touched the phone screen then placed it back into her pocket. The U.S. FOIA continued to stir the liquid with her left hand and added more powder from the packet with her right hand then continued to stir. The U.S. FOIA then moved the cup onto the resident's tray and placed the spoon on the tray.	F 880	The identified nurse was addressed immediately, and corrective measures implemented. The identified nurse received counseling and 1:1 training by DON regarding infection control practice and hand hygiene in the dining room. All residents who receive a meal tray have the potential to be affected by this deficient practice. All staff were in-serviced by staff development/designee on hand hygiene and infection control practice in the dining room. Infection Preventionist will conduct hand hygiene competency and validation on all employees. The Infection Preventionist will conduct 5 hand hygiene observations/competencies each week for 6 months and 5 observations/competencies monthly over the next year. Findings will be reviewed with staff and corrective actions implemented immediately and as needed.	

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F 880	Continued From page 40 The U.S. FOIA returned to the food cart area and placed her hands in her pockets. She then approached the food cart, removed a food tray, and placed it in front of Resident #68. The U.S. FOIA removed the plastic food lid and walked away. The U.S. FOIA stopped and spoke with Resident #46, then went to the piano area where she grasped an empty cup and a lid, placed the lid on the cup, then presented the cup to Resident #46. The U.S. FOIA then went back to the food cart area and placed her hands in her pockets. The U.S. FOIA approached the food cart and touched the first tray and the items on the tray; touched a second tray; touched a third tray, lifted the lid and pushed the tray back on the cart; touched a fourth tray, lifted the lid and moved items on the tray; lifted the lid of the fifth tray and lifted items on the tray then moved the tray back on the cart; touched the sixth tray and lifted to food lid; touched the seventh tray and lifted the food lid; touched the eighth tray and lifted the food lid then pushed the tray back on the cart. The U.S. FOIA then touched her nose as she stood waiting at the food cart. Another staff member handed the U.S. FOIA a food tray and she placed the tray in front of Resident #11. The U.S. FOIA walked to the side of the room and picked up a chair, which she placed next to the resident, then sat down. The U.S. FOIA removed the lid from the plate, opened the silverware and placed it on the tray, opened the resident's milk carton, removed the straw paper from the straw and then placed the straw into the milk carton. The U.S. FOIA grasped the spoon and fed the resident a bite of food. The U.S. FOIA held the milk carton up to the resident to drink then again grasped the spoon and fed the resident the rest of his/her meal tray. There was no hand hygiene (HH) observed during the observation.	F 880	The Infection Preventionist will report findings weekly to DON, Administrator and quarterly to QAPI committee over the next year.	

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F 880	Continued From page 41 On 03/04/24 at 12:26 PM, the surveyor interviewed the [U.S. FOIA] who stated she was working on the [NJ Exempt] unit today and was assisting in the main dining room. The [U.S. FOIA] stated that when residents were served lunch in the dining area that it was the staff who brought the residents to the main dining area and got them set up, made sure their hands were cleaned and placed a clothing protector in place if needed. When the trays came out, the nurses checked the tray for accuracy-that the diet matched the ticket and meal slip matched the meal. The [U.S. FOIA] stated that they would ask the resident if they needed anything opened or if they needed help to be fed and that they passed meal trays to the whole table first before moving to the next table and added that if they were self-fed then the staff would supervise them. The [U.S. FOIA] stated that hand hygiene was done by staff in between resident contact and when trays were passed. When the surveyor inquired as to what resident contact was, the [U.S. FOIA] stated that if she had physical contact with a resident that she would then clean her hands before touching a tray and after trays were checked and passed out that she would then clean her hands. The surveyor informed the [U.S. FOIA] of the meal tray pass observation. The [U.S. FOIA] stated that she did perform HH correctly when she came out initially to dining room. The surveyor explained that the observation started during the interaction with Resident #19 and inquired as to whether she performed HH correctly during the observation period. The [U.S. FOIA] stated, "Honestly, I don't remember." The surveyor inquired as to whether HH should have been done during the meal tray pass observation and the [U.S. FOIA] stated, "yes." She further stated that it was important to perform HH correctly during meal tray pass to prevent passing infection.	F 880		

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F 880	Continued From page 42 On 03/04/24 at 12:36 PM, the surveyor interviewed the U.S. FOIA (b) (6)) of the NJ Exec unit who stated the process for the meal tray pass in the dining room was that the staff arrived in the main dining room once they overhead announced the meal was being served. She stated that there was a list of residents that ate in the dining room and that it was one nurse's responsibility to check the trays for accuracy. The U.S. FOIA (b) (6) stated that all residents were served at the entire table at the same time, and that some residents needed assistance to be fed. The staff member would then obtain the next tray and continue until all the trays were served. The surveyor inquired as to when HH should have been performed and the U.S. FOIA (b) (6) stated that HH was done when staff entered the dining room, in between serving the trays and before and after feedings. The U.S. FOIA (b) (6) was told of the LPN meal tray pass observation. The U.S. FOIA (b) (6) acknowledged that the U.S. FOIA did not perform HH correctly and that she should have done HH after she touched her phone, when she touched her nose, and before she sat down to feed the resident. The U.S. FOIA (b) (6) stated that it was important to perform HH correctly during meal tray pass to prevent cross contamination. On 03/04/24 at 12:45 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that HH was done for the staff and the residents prior to meal service and that after a tray was served that staff performed HH prior to obtaining another resident's tray. The surveyor informed the U.S. FOIA (b) (6) of the U.S. FOIA s meal tray pass observation. The U.S. FOIA (b) (6) acknowledged that HH was not performed correctly and stated that HH should have been performed after she	F 880		

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touched her phone, after she touched her nose, and before she sat down to feed the resident. The [redacted] stated that it was important to perform HH correctly during meal tray pass for the prevention of the transmission of flu, colds, and diseases.

On 03/04/24 at 12:55 PM, the surveyor interviewed the [redacted]) who stated that the process for meal tray pass in the dining room was that staff performed HH prior to meal tray service, the nurse looked at the meal ticket and handed the tray to staff nurse who would thicken any liquids. The residents were served by table, that no one ate until all trays were served, and that then the nurse would return to the food cart to obtain the next tray. The surveyor inquired as to when HH should have been performed for tray pass and the [redacted] stated that handwashing was done prior to entering the dining room or that hand sanitizer was available in the dining room. When the surveyor inquired if HH should have been performed at any other time, the [redacted] responded, "no." The surveyor informed the [redacted] of the [redacted] meal tray pass observation. The [redacted] acknowledged that the [redacted] did not perform HH correctly and stated that she should have used HH after she touched her nose, every time she touched her pocket or phone, any time she touched an inanimate source, and when she picked up the chair. The [redacted] stated it was important to perform HH correctly during meal tray pass, so germs were not passed.

On 03/12/24 at 01:36 PM, the administrative team was made aware of the main dining room meal tray pass observation.

A review of the undated facility policy,

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F 880	Continued From page 44 "Handwashing/Hand Hygiene," revealed, Policy Interpretation and Implementation: All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: After contact with objects ...in the immediate vicinity of the resident; Before and after assisting a resident with meals. A review of the facility provided Charge Nurse/Staff Nurse job description revealed, Duties and Responsibilities: Safety and Sanitation: Ensure that your assigned personnel follow established hand washing techniques in the administering of nursing care procedures. NJAC 8:39-19.4 (m)(n)	F 880		

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AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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S 000	Initial Comments Complaint # NJ: 168629 The facility was not in compliance with the standards in the New Jersey Administrative code, 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: Complaint NJ #: 168629 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 1 of 1 week of complaint staffing and 2 of 2 weeks of staffing prior to the recertification survey dated 03/13/24. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	The following corrective actions have been accomplished for the identified deficiency: 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. The facility will utilize agencies to fill open slots in the schedule as needed. Additional agencies have been contracted to attain the appropriate staff ratios for the facility census. New staff tracking program up and running to mainstream staffing efforts. All residents have the potential to be affected by the deficient practice.	4/30/24

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

Electronically Signed | 03/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061703	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) 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" for the following weeks provided by the facility revealed the following: 1.) For the week of Complaint staffing from 10/22/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -10/22/23 had 6 CNAs for 82 residents on the day shift, required at least 10 CNAs. -10/23/23 had 5 CNAs for 82 residents on the day shift, required at least 10 CNAs. -10/24/23 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs. -10/25/23 had 8 CNAs for 81 residents on the day	S 560	Advertisements/Job postings for CNAs have been posted on hiring platforms, social media websites as well as flyers posted and are monitored closely by the HR Director for immediate follow-up with interested candidates. Incentives are offered to CNAs to work extra shifts such as gift cards, bonuses, and raffles. Staffing agencies are being utilized to fill in any open shifts. Bonuses are also being offered to agency staff to pick up shifts. Hiring and recruitment efforts now include referral bonuses, sign-on bonuses, weekend bonuses amongst other incentives to quickly attract good staff. Tap Check payout system implemented for staff to receive daily pay as an incentive to attract and employ more staff. An autumn tracking system has been implemented for transparency with staff regarding open shifts and bonuses available. Overtime is made available to all current employees. The Staffing Coordinator or designee will review staffing levels daily to ensure that we have adequate staffing. Findings will be reported to the DON/Administrator daily and reviewed with the QAPI committee quarterly until substantial compliance is obtained. The Staffing Coordinator, DON and Administrator will review the staffing schedules weekly to monitor the staffing ratio on all shifts weekly x 90 days. The Staffing Coordinator will report findings to the QAPI committee on a quarterly basis x 4 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061703	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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S 560	Continued From page 2	S 560		

shift, required at least 10 CNAs.
-10/26/23 had 7 CNAs for 80 residents on the day shift, required at least 10 CNAs.
-10/28/23 had 6 CNAs for 78 residents on the day shift, required at least 10 CNAs.

2.) For the 2 weeks of staffing prior to survey from 02/18/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows:

-02/18/24 had 6 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-02/19/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-02/20/24 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-02/21/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-02/22/24 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-02/23/24 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs.
-02/24/24 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs.

-02/25/24 had 6 CNAs for 89 residents on the day shift, required at least 11 CNAs.
-02/26/24 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs.
-02/27/24 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs.
-02/29/24 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/02/24 had 7 CNAs for 84 residents on the day shift, required at least 10 CNAs.

During an interview with the surveyor on 03/07/24 at 10:47 AM, the Director of Nursing stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061703	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

(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 3 the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for 10 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. During an interview with the surveyor on 03/07/24 at 11:17 AM, the Staffing Coordinator stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for 10 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. Review of the facility's Staffing policy, undated, included, "One CNA to every eight residents for the day shift; One direct care staff member to every 10 residents for the evening shift; and One direct care staff member to every 14 residents for the night shift."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315058	A. Building B. Wing	5/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 04/30/2024	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 04/30/2024	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 3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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
315058 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0658	Correction	ID Prefix F0689	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	04/30/2024	LSC	04/30/2024	LSC	04/30/2024
ID Prefix F0690	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	04/30/2024	LSC	04/30/2024	LSC	04/30/2024
ID Prefix F0842	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	04/30/2024	LSC	04/30/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061703	A. Building B. Wing	5/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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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 04/30/2024	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	
3/13/2024	☐ 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
	315058	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	**438 SALEM-WOODSTOWN ROAD** **SALEM, NJ 08079**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by CertiSurv, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/08/2024 and Autumn Lake Healthcare at Salem County was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Autumn Lake Healthcare at Salem County is a 2-story with a partial basement Type II (111) construction that was built in the 1960. The facility resident rooms have hard-wired smoke detectors, corridors and spaces opened to the corridor. The facility has 4 smoke compartment zones.	K 000		

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

Electronically Signed | 03/28/2024

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