STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 ROUTE 73 , VOORHEES, New Jersey, 08043

(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
F0000	INITIAL COMMENTS Standard Survey 03/24/2026 Census: 115 Sample Size: 23 + 3 closed records Complaint Intake ID #: 2586209,2641710, 2699716, 2720787, 2793180, 398979, 398990, 398998, 398999 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long-Term Care Facilities. Deficiencies were cited for this survey.	F0000		04/07/2026
F0602 SS = E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and review of facility policy, it was determined that the facility failed to ensure that 1 of 4 residents (Resident #122) observed during the medication administration observation were given their medication. Specifically, Resident #122 did not have their medication NJ Ex Order 26, 4B1 available for administration in the medication cart and was given another unidentified resident's home medication of NJ Ex Order 26, 4B1 This deficient practice was identified by the following: On 3/18/2026 at 9:04 AM, during medication pass observation on the NJ Ex Orde floor nursing unit, the	F0602	Corrective Action Resident #122 was immediately assessed with NJ E effects noted. The physician and responsible party were notified of the medication variance. Orders were reviewed and verified for accuracy. The correct medication NJ Ex Order 26, 4B1 was obtained and made available for administration. The practice of using another resident's medication was immediately discontinued. The involved staff member received immediate re-education by the NJ Ex Order 26, 4B1 and was removed from medication pass pending competency validation. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. They can be identified by their electronic medical record. Systemic Change The facility reinforced a zero-tolerance policy for	04/10/2026

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 reverse for further 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.

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

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F0602 SS = E	Continued from page 1 surveyor observed a Licensed Practical Nurse (LPN #2) administer medications for Resident #122. The LPN was unable to locate Resident #122's medication, NJ Ex Order 26, 4B1) give NJ Ex Order 26, 4B1 he U. S. FOI stated that the medication should have been available in the medication cart, however she could not locate it. She explained that she could not obtain the medication from the back up medication dispensing machine because that medication was not stocked there. The U. S. FOI referred the issue to the U. S. FOIA (b) (2) A review of the Admission Record (an admission summary) indicated that Resident #122 was admitted to the facility with the diagnoses which included but were not limited to NJ Ex Order 26, 4B1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated NJ Ex Order 26, indicated that Resident #122 scored a NJ Ex Order 26, 4B1 on the Basic Interview for Mental Status (BIMS), which indicated that the resident was NJ Ex Order 26, 4B1. Further review of the MDS also indicated that the resident required NJ Ex Order 26, 4B1 A review of Resident #122's Medication Administration Record (MAR) indicated that the resident was admitted to the facility on NJ Ex Order 2. The surveyor observed nursing signatures on the MAR which indicated that some nurses documented that they administered the medication, some were documenting that the resident NJ Exec Order 2 the medication, and some nurses were documenting that the medication was not available. A Review of Resident #122's physician orders (PO) reflected the following orders: -PO dated NJ Ex Order 2 for the medication NJ Ex Order 26, 4B1 qIV NJ Ex Order 26, 4B1 -PO dated NJ Ex Order 2 for NJ Ex Order 26, 4B1 qIV NJ Ex Order 26, 4B1	F0602	Continued from page 1 medication borrowing, ensuring that medications labeled for one resident are never administered to another resident. An in-service education was provided to all licensed nurses by staff development on 3/18/2026 addressing: Five Rights of Medication Administration Prohibition of borrowing medication Proper escalation process when medications are unavailable Documentation requirements including progress notes and physician notification A medication escalation protocol was implemented by the U. S. FOIA (b) (2) immediately on NJ Ex Order 26, 4B1 to include: Nurse verifies MAR and availability (including NJ Exec Or /back-up) Immediate pharmacy notification for STAT delivery Physician notification for alternate orders Supervisor notification Escalation to DON → Medical Director if unresolved A Medication Admission Reconciliation Checklist with dual sign-off (nurse + supervisor) was implemented for all admissions/readmissions. DON/designee will review all new admission medication availability daily during morning clinical meeting. Quality Assurance The DON/designee will conduct audits Weekly x 12 weeks, Biweekly x 12 weeks and then Monthly x 6 months of: Medication availability	04/10/2026

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F0602 SS = E	Continued from page 2 -PO dated [redacted] for [redacted] give [redacted]. [redacted]. Discontinued on [redacted]. -PO dated [redacted] for [redacted] Give [redacted] Discontinued on [redacted]. -PO dated [redacted] for [redacted] give [redacted] for [redacted]. On 3/18/2026 at 9:37 AM, the surveyor interviewed the third floor [redacted] who stated that Resident #122 was a [redacted] patient who was admitted to the facility a [redacted]. The [redacted] explained the process the facility followed when medications were ordered. She explained that when medications were ordered on admission the physicians confirmed the medications orders, the medications were then entered into electronic medical records (EMR) and once confirmed, the medication orders were considered active and then the pharmacy delivered the medications. She stated that the medication [redacted] was ordered for Resident #122 on the [redacted], and that the resident should still have a supply of the medication [redacted] in the medication cart. The [redacted] reviewed the MAR with the surveyor and she stated that she was not sure how some nurses were documenting that they administered the medication, some nurses documented that the medication was not available, and some nurses documented that the resident refused the medication. She stated that the medication [redacted] was not available in the electronic back up medication machine and was not a stock medication. She revealed that the nurses who documented on the MAR that the medication was not available should have documented in the progress notes (PN) what they did about the unavailable medication or should have notified a supervisor. She added that if a resident was not receiving scheduled medication as ordered, they could have adverse effects. She stated that sometimes the [redacted] would supply the [redacted] and sometimes the facility provided it. She then added that if the resident's medication was to be provided by the [redacted], then someone should have called them to let them know that the medication was not there and then someone should have notified the supervisor so that they could have investigated where the medication was.	F0602	Continued from page 2 MAR documentation accuracy Physician notification and follow-up Pharmacy delivery timeliness Narcotic and high-risk medication reconciliation The DON will report findings of the above audits to the QAPI committee monthly and QAA committee quarterly. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	04/10/2026

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F0602 SS = E	Continued from page 3 The surveyor reviewed the PN with the [redacted] who confirmed that there were no PN documented when the resident [redacted] their scheduled dose of [redacted] and that there was no documentation to indicate what the nurses did when they identified that the medication was not available. On 3/19/2026 at 9:39 AM, the surveyor interviewed Resident #122 who was [redacted] and [redacted] The resident stated that they only took the medication, [redacted], about [redacted] since admission to the facility. The resident stated that they [redacted] the medication the rest of the time because the [redacted] told him/her that they did not need to take the medication as their [redacted] The resident stated that the facility continued to offer him/her the medication because they told him/her they had not received any orders to stop the medication. The resident stated that the nurse was in this morning with the medication and offered it to him/her, however he/she [redacted] it. The resident further added that during their stay, some nurses would sometimes bring in one pill and sometimes they would bring in [redacted] The resident stated," When I questioned the nurse, they would tell me this is what was ordered. Considering [redacted] I knew it was not the right dosage, so I would [redacted] to take the medications." On 3/19/2026 at 11:14 AM, the surveyor interviewed the [redacted] who stated that she investigated the reason Resident #122 did not have the medication [redacted] in the medication cart to be administered on [redacted] during the medication pass observation. The [redacted] stated that the delivery did not occur when the resident was first ordered the medication and based on her investigation staff were administering Resident #122's, another resident's [redacted] supply of medication that was discharged from the facility. She stated that the medication was from a bottle that the other resident had brought from [redacted] She stated that she was not sure whose medication it was because the name was blacked out on the bottle with marker. The [redacted] confirmed delivery of the [redacted] from the pharmacy. She also confirmed that the medication was not delivered from the pharmacy or [redacted] when ordered on admission. She stated that the facility performed [redacted] work to ensure that there were no concerns with Resident #122s [redacted]. She stated that [redacted] were done immediately and were within [redacted]. The surveyor reviewed those [redacted] and they were in fact within [redacted]. She stated that there was [redacted]	F0602		04/10/2026

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F0602 SS = E	Continued from page 4 [redacted] to Resident #122. The [redacted] provided the surveyor with the bottle of medication and stated that the facility [redacted] identified the medication that was in the bottle to be [redacted]. On 3/19/2026 at 12:04 PM, the surveyor telephoned the facility [redacted] who confirmed that she came to the facility on [redacted] and inspected the medication cart of the [redacted] floor and found a bottle of [redacted] with the resident's name blacked out on the bottle. The [redacted] further explained to the surveyor that she talked to the nurse who was assigned to the medication cart who stated that she had not used the medication. The [redacted] could not provide the surveyor with the nurse's name because she could not remember it. She stated that when she conducted medication review for the residents, she reviewed the orders and the MAR. The [redacted] stated that she reviewed Resident #122's medications on [redacted] because the resident was a new admission and she had seen that there was a '[redacted]' coded on the MAR. She stated that the code indicated that the resident was [redacted] The [redacted] stated at that time, my recommendation included changing the time of the medications to accommodate for [redacted] days and times. The [redacted] further stated that if the nurses were administering another resident's medication to Resident #122, there was a federal law that indicated that you cannot share medications that were not prescribed to you. She stated that the law protected people from taking other people's medications that were not prescribed to them. She continued to add that even though the nurse should not have been giving Resident #122 another resident's medication, at least it was the right medication and the right dose. On 3/19/2026 at 1:24 PM, the surveyor interviewed LPN #15 who admitted resident #122 to the facility. The [redacted] stated that she put medication orders in the system (EMR) and then the medications would be delivered. She stated that she was not sure why the medication was not delivered from the pharmacy and was not sure i[redacted] provided the medication or the pharmacy provided the medication. On 3/19/2026 at 1:46 PM, the surveyor telephone interviewed the [redacted] from the facility pharmacy who stated that for residents who were on [redacted] and had insurance, insurance would not pay for the medication through the facility pharmacy. She further explained that the [redacted] provided the medication and that insurance would cover the medications when it was obtained through the	F0602		04/10/2026

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F0602 SS = E	Continued from page 5 NJ Ex Order 26, 4B1 She stated that the only reason why the facility pharmacy sent the medication NJ Ex Order 26, 4B1 on NJ Ex Order 26 was because the facility agreed to pay for the medication. On 3/23/2026 at 8:53 AM, the surveyor interviewed a U. S. FOIA (b) (2) from the resident's NJ Ex Order 26 , and she explained that the residents' medications were bundled in NJ Ex Order 26, 4B1 and then the medication would be mailed to the facility. She stated that the U. S. FOIA (b) (2) and the U. S. FOIA (b) (2) were responsible for ordering the NJ Ex Order 26, 4B1 for the resident. She stated that she was not sure why the medication was not delivered to the resident and stated that the surveyor would need to speak to the U. S. FOIA (b) (2) of the NJ Ex Order 26, 4B1. On 3/23/2026 at 9:07 AM, the surveyor telephone interviewed LPN #8 who documented on the MAR on NJ Ex Order 26, 4B1 (8:00 PM) that she had administered NJ Ex Order 26, 4B1 to Resident #122. The U. S. FOIA stated that if the medication was not available, she would have borrowed it from another resident. She stated that this medication usually came in from the family, however, she did not notify the family that the resident did not have the medication. She also confirmed that she did not notify the pharmacy or the nursing supervisor that the medication was not available. She stated that when she realized that the medication was not available in the medication cart, she went to another unit to borrow another resident's medication. She stated that she was not educated regarding borrowing medications from other residents. On 3/23/2026 at 10:24 AM, the U. S. FOIA provided the surveyor with the following nurse statements: A review of an untimed written statement from LPN # 4 dated NJ Ex Order 26 , indicated that she administered Resident #122 the medication off the medication cart but she did not remember if it was given from a NJ Exec Ord supply or a bingo card (a card with medications sealed beneath blister packaging). A review of the untimed written statement from LPN #5 dated NJ Ex Order 26, , indicated that she administered Resident #122 the medication off the medication cart but did not remember if it was given from a NJ Exec Ord supply or a bingo card. A review of the untimed written statement from LPN #6 dated NJ Ex Order 26 , indicated that she administered Resident #122 NJ Ex Order 26, 4B1 out of a bottle that was in the medication cart. She indicated that the U.S. F was in and removed all expired medications,	F0602		04/10/2026

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F0602 SS = E	Continued from page 6 discharged medications and a bottle of [NJ Ex Order 26, 4B1] out of the cart because the name on the medication was blacked out. She stated that she was assigned to that medication cart on [NJ Exec Order 2] on the 7:00 AM to 3:00 PM shift. A review of the untimed written statement from LPN #8 dated [NJ Ex Order 26, 4] , indicated that she administered Resident #122 [NJ Ex Order 26, 4B1] from a [NJ Exec Or] supply that was in the medication cart. A review of the untimed written statement from LPN #9 dated [NJ Ex Order 26, 4] , indicated that Resident #122 [NJ Exec Order 2] the medication and the [NJ Exec Orde] was documented. A review of the untimed written statement from LPN #10 dated [NJ Ex Order 26, 4B] indicated that she administered Resident #122 [NJ Ex Order 26, 4B1] from a [NJ Exec Or] supply that was in the medication cart. A review of the untimed written statement from LPN #11 dated [NJ Ex Order 26,] indicated that she administered Resident #122 [NJ Ex Order 26, 4B1] from a [NJ Exec Or] supply that was in the medication cart. A review of the untimed written statement from LPN #12 dated [NJ Ex Order 26, 4] indicated that on [NJ Exec Order 2] and [NJ Exec Order 2] she administered Resident #122 [NJ Ex Order 26, 4B1] the morning and noon doses out of a [NJ Exec Ord] supply of [NJ Ex Order 26, 4B1] A review of the untimed written statement from LPN #13 dated [NJ Ex Order 26] , indicated that she administered Resident #122 [NJ Ex Order 26, 4B1] from a [NJ Exec Or] supply that was in the medication cart. On 3/23/2026 at 10:57 AM, the surveyor conducted a telephone interview with the [NJ Ex Order 26] [U. S. FOIA (b)] who stated that the resident's medication was ordered by the [NJ Ex Order 26, 4B1] from a pharmacy in [NJ Exec Order 2] The [U. S. FO] stated that it took a [NJ Exec Order 26.4b1] for the medication to be mailed. The [U. S. FOIA (b)] could not provide any additional information as to who was responsible for ensuring that the resident had the medication while a resident in the facility. On 3/23/2026 at 11:01 AM, the surveyor conducted a telephone interview with the [NJ Ex Order 26, 4B1] [U. S. FOIA (b) (2)] who could not provide information regarding who was responsible to ensure that the resident received a medication that was ordered though the [NJ Ex Order 26, 4B1] On 3/23/2026 at 11:10 AM, the surveyor conducted	F0602		04/10/2026

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F0602 SS = E	Continued from page 7 a telephone interview with the facility's [NJ Ex Order 26,4] [redacted] who stated he would have to call the [NJ Ex Order 26, 4B1] to find out where the medication was or how to get the medication. He stated that there should have been better communication between the facility and the [NJ Ex Order 26, 4B1] to assure that the medication was available for the resident. On 3/23/2026 at 11:25 AM, the surveyor interviewed the resident's primary care physician who stated that the [U. S. FOIA (b) (2)] and the [U. S. FOIA] should have policies regarding medications that came from the [NJ Ex Order 26, 4B1]. She stated that she could not recall being notified by the facility staff that the resident did not have the medication [U. S. FOIA (b) (2)] in the facility. She stated that it should have been communicated to the [U. S. FOIA] and administration by the nurses so that the issue could have been resolved. On 3/24/2026 at 9:50 AM, the surveyor interviewed the [U. S. FOIA] who explained that during her investigation into why Resident #122's medication was not available, the [NJ Ex Order 26, 4B1] did not order the resident's medication, however the nursing staff upon recognizing that the medication was not available, should have followed the medication procurement policy and notified the physician, contacted the pharmacy, supervisor, [U. S. FOIA] and/or [U. S. FOIA (b) (2)]. A review of the facility undated policy titled, "Abuse, Neglect and Exploitation" indicated that misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings, money without the resident's consent. NJAC 8:39-4.1(a)5	F0602		04/10/2026
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing,	F0755	Corrective Action Resident #122 was immediately assessed; [NJ Ex] [redacted] noted. The physician and responsible party were notified. The medication [NJ Ex Order 26, 4B1] was obtained and made available for administration. Clarification was obtained regarding source of medication (facility vs. [NJ Exec Order 2] provider).	04/10/2026

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F0755 SS = E	Continued from page 8 and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Complaint # 2699716, #398990 Based on observation, interview, and review of medical records it was determined that the facility failed to establish a system to ensure that residents on [NJ Ex Order 26] received their medications according to physician orders. This deficient practice was identified during the medication pass administration observation for 1 or 4 residents (Resident #122), observed and was evidenced by the following: On 3/18/2026 at 9:04 AM, during medication pass observation on the third floor, the surveyor observed a [U. S. FOIA (b) (2)] administer medications for Resident #122. The [U. S. FOIA] was unable to locate Resident #122's medication, [NJ Ex Order 26, 4B1] give [NJ Ex Order 26, 4B1] The [U. S. FOIA] stated that the medication should be available in the medication cart, however she could not locate it. She explained that she could not obtain the medication in the back up medication dispensing machine because that medication was not stocked there. The [U. S. FOIA] referred the issue to th [U. S. FOIA (b) (2)] A review of the Admission Record (admission summary) indicated that Resident #122 was admitted to the facility with the diagnoses which included but	F0755	Continued from page 8 The practice of administering medication from another resident's supply was immediately discontinued. Staff involved were immediately re-educated by the Director of Nursing on 9/18/2026 and removed from medication pass until competency validation was completed. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice, this can be identified by reviewing the resident's medical records. Systemic Change The facility implemented a Dialysis Medication Management Process: Clear designation of responsibility for medications (facility vs dialysis provider) Verification upon admission and at each dialysis visit A Medication Availability Verification Process was implemented: Nurse verifies medication availability at start of shift and prior to administration Missing medications are escalated immediately A Medication Escalation Protocol was reinforced: Verify MAR and medication cart Check backup supply [NJ Exec Or]	04/10/2026

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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
F0755 SS = E	Continued from page 9 were not limited NJ Ex Order 26, 4B1 A review of the comprehensive Minimum Data Set (MDS), (an assessment that facilitates a resident's care) dated NJ Ex Order 26, indicated that Resident #122 scored NJ Ex Order 26, 4B1 on the Basic Interview for Mental Status (BIMS), which indicated the resident was NJ Ex Order 26, 4B1. Further review of the MDS indicated that the resident required NJ Ex Order 26, 4B1 and was on NJ Ex Order 26, 4B1. A review of Resident #122's Medication Administration Record (MAR) indicated that the resident was admitted to the facility on NJ Ex Order 2. The surveyor observed nursing signatures on the MAR that indicated some nurses documented that they administered the medication, some were documenting that the resident NJ Exec Order 2 the medication, and some nurses were documenting that the medication was not available. A review of Resident #122's physician orders (PO) reflected the following orders: -PO dated NJ Ex Order 26 for the medication NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 -PO dated NJ Ex Order 26 for NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 and discontinued NJ Ex Order 26, 4B1 -PO dated NJ Ex Order 26 for NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 Discontinued on NJ Ex Order 26, 4B1 -PO dated NJ Ex Order 26, 4 for NJ Ex Order 26, 4B1 Giv NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1. Discontinued on NJ Ex Order 26, 4B1 -PO dated NJ Ex Order 26, for NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1. On 3/18/2026 at 9:37 AM, the surveyor interviewed the NJ Ex Order 26, 4B for the NJ Ex Orde floor who stated that Resident #122 was a NJ Ex Order 26 patient who was admitted to the facility a NJ Ex Order 26, 4B1. The	F0755	Continued from page 9 Notifying pharmacy for STAT delivery Notify physician for alternate orders Notify supervisor Escalate to DON → Medical Director if unresolved A Medication Admission Reconciliation Tool (dual sign-off) was implemented for all admissions/readmissions. The consultant pharmacist was re-educated and will: Review medication availability Review of dialysis-related medications Ensure reconciliation processes are followed An in-service education was conducted by staff development coordinator for licensed nurses on 3/18/2026 regarding: Pharmacy services requirements Prohibition of borrowing medication Dialysis medication coordination Documentation requirements Quality Assurance The DON/designee will audit the following areas, Weekly x 12 weeks, Biweekly x 12 weeks and then Monthly x 6 months: Medication availability	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

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F0755 SS = E	Continued from page 10 U.S. FOIA (b)(6) explained the process the facility followed when medications were ordered. She explained that when medications were ordered on admission the physicians confirmed the medications orders, medications were then entered into electronic medical records (EMR) and once confirmed, the medications were considered active and then the pharmacy delivered the medications. She stated that the medication NJ Ex Order 26, 4B1 was ordered for Resident #122 on the NJ Exec Order, and the resident should still have a supply of the medication NJ Ex Order 26, 4B1 in the medication cart. The U. S. FOIA (b) (2) reviewed the MAR with the surveyor the U. S. FOIA (b) (2) stated that she was not sure how some nurses were documenting that they administered the medication, some nurses documented that the medication was not available, and some nurses documented that the resident refused the medication. She stated that the medication NJ Ex Order 26, 4B1 was not available in the electronic back up medication machine and was not a stock medication. She revealed that the nurses who documented on the MAR that the medication was not available should have documented in the progress notes what they did about the unavailable medication or should have notified a supervisor. She added that if a resident was not receiving the scheduled medication as ordered, they could have an adverse effect. She stated that sometimes the NJ Ex Order 26, 4B1 would supply the NJ Ex Order 26, 4B1 and sometimes the facility provided it. She then added that if the resident's medication was to be provided by the NJ Ex Order 26, 4B1, then someone should have called them to let them know that the medication was not there and then someone should have notified the supervisor so that they could have investigated where the medication was. The surveyor reviewed the progress notes (PN) with the U. S. FOIA (b) (2) who confirmed that there were no PN documented when the resident NJ Exec Order 2 and that there was no documentation to indicate what the nurses did when they identified that the medication was not available. On 3/19/2026 at 9:39 AM, the surveyor interviewed Resident #122 who was NJ Exec O and NJ Exec Order 26. The resident stated that they only took the medication NJ Ex Order 26, 4B1 about NJ Ex Orde times since admission to the facility. Resident #122 stated that they NJ Exec Order 2 the medication the rest of the time. NJ Ex explained that the U. S. FOIA (b) (2) told him/her that he/she did not need to take the medication as their NJ Ex Order 26, 4B1 were NJ Exec Order 26.4b1. The resident stated that the facility continued to offer him/her the medication because they told him/her they had not received any orders to stop the	F0755	Continued from page 10 MAR documentation consistency Dialysis medication coordination Pharmacy delivery timeliness Documentation of escalation and physician notification Results of audits of new admissions will be reported by DON to through QAP committee monthly for 12 months and QA committee for four quarters. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	04/10/2026

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F0755 SS = E	Continued from page 11 medication. The resident stated that the nurse was in this morning with the medication and offered it to him/her, however they [NJ Exec Order 2] it. The resident further added that during the resident's stay, some nurses would sometimes bring in [NJ Exec Order] and sometimes they would bring in [NJ Ex Order 26, 4B1] of the [NJ Ex Order 26, 4B1] The resident further stated, "When I questioned the nurse, they would tell me this is what was ordered. Considering NJ Exec Order 26.4b1, I knew it was not the right dosage so I would [Orde] to take the medications." On 3/19/2026 at 11:14 AM, the surveyor interviewed the [U. S. FOIA (b) (2)] who stated that she investigated the reason Resident #122 did not have the medication [NJ Ex Order 26, 4B1] in the medication cart to be administered on [NJ Exec Order 2] during the medication pass observation. The [U. S. FOIA] stated that the delivery did not occur when the resident was first ordered the medication. She confirmed delivery of the [NJ Ex Order 26, 4B1] on [NJ Exec Order 2] from the pharmacy after surveyor inquiry. The [U. S. FOIA] also confirmed that the medication was not delivered from the pharmacy or [NJ Ex Order 26] when ordered on admission. She stated that the facility performed [NJ Exec Order 26.4b] work to ensure that there were no concerns with Resident #122s [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] levels. She stated that labs were done immediately and were within [NJ Ex Order 26] . The surveyor reviewed those [NJ Exec O] and they were in fact within [NJ Ex Order 26, 4B1]. She stated that there was [NJ Exec Order 2] to Resident #122. On 3/19/2026 at 12:04 PM, the surveyor telephoned the facility [U. S. FOIA (b) (2)] who confirmed that she came to the facility on [NJ Ex Order 26] and inspected the medication cart on the [NJ Ex Or] floor and found a bottle of NJ Ex Order 26, 4B1 with the name blacked out on the bottle. The [U. S. FO] interviewed explained to the surveyor that she talked to the nurse on the cart who stated that she hadn't used the medication. The [U. S. F] could not provide the surveyor with the nurse's name because she could not remember it. She stated that when she conducted medication reviews for the residents, she reviewed the orders and the MAR. The [U. S. F] stated that she reviewed Resident #122's medications on [NJ Ex Order 2] because the resident was a new admission and she had seen that there was a "[NJ E] coded on the MAR. She stated that the code indicated that the resident was out of the facility. The [U. S. F] stated at that time, my recommendation included changing the time of the medications to accommodate for [NJ Ex Order 26] days and times. The [U. S. F] further stated that if the nurses were administering another resident's medication to Resident #122, it was a federal law that indicated that you cannot share medications	F0755		04/10/2026

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F0755 SS = E	Continued from page 12 that were not prescribed to you. She stated that the law protected people from taking other people's medications that were not prescribed to them. She continued to add that even though the nurse should not have been giving Resident #122 another resident's medication, at least it was the right medication and the right dose. On 3/19/2026 at 1:24 PM, the surveyor interviewed the [U. S. FOIA] that admitted resident #122 to the facility. The [U. S. FOIA] stated that she put medication orders in the system (EMR) and then the medications would be delivered. She stated that she was not sure why the medication was not delivered from the pharmacy and was not sure that [NJ Ex Order 26,] provided the medication or the pharmacy provided the medication. On 3/19/2026 at 1:46 PM, the surveyor conducted a telephone interview with the [U. S. FOIA (b) (2)] from the facility pharmacy who stated that residents who were on [NJ Ex Order 26,] and had insurance, insurance would not pay for the medication through the facility pharmacy. She further explained that the [NJ Ex Order 26] provided the medication and that insurance would cover the medications when they were obtained through the [NJ Ex Order 26, 4B1] She stated that the only reason why the facility pharmacy sent the medication [NJ Ex Order 26, 4B1] on [NJ Ex Order 26,] was because the facility agreed to pay for the medication. On 3/23/2026 at 8:53 AM, the surveyor interviewed a [U. S. FOIA (b) (2)] from the resident's [NJ Ex Order 26] , and she explained that the residents' medications were bundled in [NJ Exec Order 26.4b1] and then the medication would be mailed to the facility. She stated that the [U. S. FOIA (b) (2)] and the [U. S. FOIA (b) (2)] would be responsible for ordering the [NJ Ex Order 26 4B1] for the resident. She stated that she was not sure why the medication was not delivered to the resident and further stated that the surveyor would need to speak to the [U. S. FOIA (b) (2)] of the [NJ Ex Order 26, 4B1] On 3/23/2026 at 10:57 AM, the surveyor conducted a telephone interview with the [NJ Ex Order 26] [U. S. FOIA (b)] who stated that the resident's medication was ordered by the [NJ Ex Order 26, 4B1] from a pharmacy in [NJ Exec Order 2] The [U. S. F] stated that it took a [NJ Exec Order 26.4b1] for the medication to be mailed. The [U. S.] could not provide any additional information as to who was responsible for ensuring that the resident had the medication while a resident in the facility. On 3/23/2026 at 11:01 AM, the surveyor conducted	F0755		04/10/2026

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F0755 SS = E	Continued from page 13 a telephone interview with the [NJ Ex Order 26, 4B1] [U. S. FOIA (b) (2)] who could not provide information regarding who was responsible to ensure that the resident received a medication that was ordered though the [NJ Ex Order 26, 4B1]. On 3/23/2026 at 11:10 AM, the surveyor conducted a telephone interview with the facility [U. S. FOIA (b) (2)] who stated he would have to call the [NJ Ex Order 26, 4B1] to find out where the medication was or how to get the medication. He stated that there should have been better communication between the facility and the [NJ Ex Order 26, 4B1] to assure that the medication was available for the resident. On 3/23/2026 at 11:25 AM, the surveyor interviewed the resident's primary care physician who stated that the [U. S. FOIA (b) (2)] and the [U. S. FOIA] should have policies regarding medications coming from the [NJ Ex Order 26, 4B1]. She stated that she could not recall being notified by the facility staff that the resident did not have the medication [NJ Ex Order 26, 4B1] in the facility. She stated that it should have been communicated to the [U. S. FOIA] and administration by the nurses so that the issue could have been resolved. On 3/24/2026 at 9:50 AM, the surveyor interviewed the [U. S. FOIA] who explained that during her investigation into why Resident #122's medication was not available, the [NJ Ex Order 26, 4B1] did not order the resident's medication, however, the nursing staff upon recognizing that the medication was not available, should have followed the medication procurement policy and notified the physician, contacted the pharmacy, [U. S. FOIA (b) (2)] and/or [U. S. FOIA (b) (2)] A review of the facility policy dated 1/2025 and titled, "Medication Procurement Policy" indicated that the facility was committed to ensuring that all residents receive their prescribed medications as ordered by their physician. Medications must be available in the facility when needed and alternate physician-approved medications must be provided if the medication ordered was unavailable. To ensure that all physician-ordered medications are received, available, and administered to residents in a timely, safe and accurate manner and to prevent delays that could result in unmanaged pain or other adverse outcomes. This policy applies to all licensed nursing staff, nursing supervisors, pharmacy personnel, and any other staff involved in ordering, receipt, and administration of medications. NJAC 8:39-29.2	F0755		04/10/2026

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F0658 SS = D	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, interviews, record review and review of facility provided documents, it was determined that the facility failed to obtain a physician's order (PO) for a NJ Exec Order 26.4b1 [redacted] for 1 of 1 resident (Resident #9) reviewed for supportive devices. 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 registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 3/17/26 at 11:21 AM, during the initial tour of the facility, the surveyor observed Resident #9 sitting in a wheelchair with a NJ Ex Order 26, 4B1 [redacted] NJ Ex Order 26, 4 [redacted].	F0658	Corrective Action Resident #9 was immediately assessed, and the use of the NJ Exec Order 26.4b1 was reviewed. The attending physician was notified immediately, and a physician order was obtained for the NJ Exec Orde [redacted], including parameters for use (application, removal, and NJ Exec Order 2 instructions). The comprehensive care plan was updated to reflect the use of the NJ Exec Order 26.4b1, including safety precautions and staff instructions. Nursing staff were immediately re-educated on the requirement that all NJ Exec Order 26.4b devices must have a physician order prior to use. Identification of At-Risk Resident All residents have the potential to be affected by this deficient practice. These residents can be identified by their medical record. Systemic Change The Director of Nursing reinforced the facility policy requiring that no supportive device may be applied or utilized without a physician order. An in-service was provided by staff development coordinator to licensed nurses and therapy staff on 4/6/2026 regarding: Requirement for physician orders for all devices Differentiation between therapy recommendations vs. physician orders Documentation requirements in EMR Care plan integration A standardized process was implemented by the U. S. FOIA (b) (2) on 4/6/2026 regarding: Any new device initiated by therapy must be	04/10/2026

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F0658 SS = D	Continued from page 15 On 3/18/26 at 10:02 AM, the surveyor observed Resident #9 sitting in their room with a NJ Ex Order 26, 4B1 on their NJ Ex Order 2, NJ Ex Order 26, 4B1. Resident #9 stated they NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1 The resident stated a NJ Ex Order 26, 4B1 t". Resident #9 stated they had to NJ Ex Order 26, 4B1 The resident stated in NJ Ex Order 26, 4B1) they went to a follow up doctor's appointment where th NJ Ex Order 26, 4B1 with the hinges NJ Exec Order 26.4b1 for almost NJ Exec Order 2." Resident #9 stated the NJ Ex Order 26, 4B1 was taken off when they went to bed and put back on every morning, to be NJ Exec O when they NJ Exec Or or NJ Exec Order 2 Resident #9 added the NJ Ex Order 26, 4B1 was put on NJ Ex Order 26, 4B1, which was much easier than NJ Ex Order 26, 4B1. Resident #9 stated in early NJ Ex Order 26, 4B1 they went to another follow up doctor's appointment. At that appointment, the NJ Exec Orde were NJ Exec Order 26 The resident stated they were allowed to NJ Ex Order 26, 4B1, and NJ Ex Order 26, 4B1 to demonstrate to the surveyor. At this point, the surveyor observed Resident #9 NJ Exec on the NJ Ex Order 26, 4B1 by the NJ Ex Order 26, 4B1 on NJ Ex Order 26, 4B1 Resident #9 stated they were NJ Exec Or the NJ Ex Order 26, 4B1 and added they were adjusting the NJ Exec Order 2 because "it's important the NJ Exec Orde NJ Ex Order 26, 4B1 Depending on what I'm NJ Exec Order 26.4b1 sometimes." On 3/18/26 at 11:09 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who was assigned to Resident #9. LPN #1 stated Resident #9 wore a NJ Ex Order 26, 4B1" with "settings" on it. LPN #1 stated there should be a PO for "when to put it on, and where to put it." LPN #1, together with the surveyor, reviewed Resident #9's PO's in the electronic medical record (EMR). LPN #1 acknowledged she was not able to locate a PO for the resident to NJ Exec O the NJ Ex Order 26, 4B1. On 3/18/25 at 11:25 AM, the surveyor interviewed LPN/UM #1 who stated Resident #9 was at the facility after a NJ Ex Order 26, 4B1 LPN/UM #1 stated her expectation was that the nurses followed the residents' care plans	F0658	Continued from page 15 communicated to nursing and physician immediately Nursing must verify and obtain a physician order prior to implementation Unit Managers to verify orders during daily clinical review (morning meeting) Admission and readmission process updated by Director of Nursing to include: Device verification checklist (braces, splints, immobilizers, etc.) Confirmation of physician orders upon admission Quality Assurance The DON/designee will audit the following audits weekly x 12 weeks, Biweekly x 12 weeks and then Monthly x 6 months: Presence of physician orders for all supportive devices Care plan accuracy Documentation of use and compliance with orders DON or designee will report the findings of the above audits to the QAPI committee monthly and QAA committee quarterly for the next 12 months. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	04/10/2026

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F0658 SS = D	Continued from page 16 and orders. She stated Resident #9 should have an order for their device to make sure it was placed in the right location, and at the right settings. LPN/UM #1, together with the surveyor, reviewed the EMR for Resident #9. LPN/UM #1 acknowledged there was not a PO for the NJ Ex Order 26, 4B1 [redacted] On 3/18/26 at 12:03 PM, the surveyor interviewed the U. S. FOIA (b) (2) [redacted] who stated residents with NJ Exec Order 26.4b1 [redacted] should have physician orders including proper NJ Exec Order 26.4b [redacted] and NJ Ex [redacted]. The U. S. FOIA (b) (2) stated "it's the default" that a NJ Ex Order 26, 4B1 [redacted]. The [redacted], together with the surveyor, reviewed the EMR for Resident #9. The U. S. FOIA (b) (2) [redacted] acknowledged there was not a PO for the resident to NJ Exec O [redacted] the NJ Ex Order 26, 4B1 [redacted] The surveyor reviewed the EMR for Resident #9. A review of the Admission Record (an admission summary) reflected diagnoses which included but were not limited to; NJ Ex Order 26, 4B1 [redacted] A review of the most recent comprehensive Minimum Data Set (MDS, a standardized assessment tool) dated NJ Ex Order 2 [redacted], reflected a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 [redacted], which indicated the resident was NJ Ex Order 26, 4B1 [redacted]. A review of the individualized comprehensive care plan (ICCP) with last reviewed date of NJ Ex Order 26 [redacted] reflected focus areas including but not limited to; a NJ Ex Order 26, 4B1 [redacted] and a NJ Exec Order 26.4b1 [redacted] in activities of daily living related to NJ Ex Order 26, 4B1 [redacted] A review of the downloaded documents in the resident's EMR included a letter from [doctor's office name redacted] dated NJ Ex Order 2 [redacted] which reflected Resident #9 was seen in their office on NJ Ex Order 2 [redacted]... NJ Ex Order 26, 4B1 [redacted] A review of the progress notes included a general nurses note dated NJ Ex Order 26 [redacted] which reflected the resident had returned from [doctor's office name redacted]..."orders received NJ Ex Order 26, 4B1 [redacted]	F0658		04/10/2026

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F0658 SS = D	Continued from page 17 A review of the Order Summary Report (OSR) which included order status: active, completed, and discontinued reflected a PO for [NJ Ex Order 26, 4B1] dated [NJ Ex Order 2], but did not reflect a PO for the placement or use of the NJ Ex Order 26, 4B1 A review of the facility provided policy "Physician Orders" updated April 2024, reflected… "Medications, diets, therapy, or any other treatment may not be administered to the residents without the written approval from the attending physician." A review of the undated facility provided policy "Consulting Physician/Practitioner Orders" reflected, policy explanation and compliance guidelines including but not limited to: Consulting physician/practitioner orders are those provided to the facility by a physician/practitioner other than their resident's attending physician… For consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will: Call the attending physician to verify the order. Document the verification order by entering the order and the time, date, and signature on the physician order sheet… NJAC 8:39-11.2(b)	F0658		04/10/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of the medical record (MR) and review of other pertinent facility documents, it was determined that the facility failed to consistently ensure communication with a contracted [NJ Ex Order 26] facility according to facility policy and procedure. This deficient practice was evidenced for 1 of 1 resident (Resident #13) reviewed for	F0698	Corrective Action Resident #13's [NJ Ex Order 26,] communication binder was immediately reviewed and updated. Missing pre- and post-[NJ Exec Order 2] documentation was addressed to the extent possible through: Nursing assessment Review of [NJ Exec Order] center records (when available) The [NJ Exec Order] provider was contacted to re-establish communication expectations and ensure documentation exchange. Licensed nursing staff were immediately re-educated	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 ROUTE 73 , VOORHEES, New Jersey, 08043

(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
F0698 SS = D	Continued from page 18 NJ Ex Order 26, This deficient practice was evidenced by the following: On 03/18/2026 at 9:04 AM, the surveyor observed Resident #13 seated in the wheelchair eating breakfast. Resident #13 offered NJ Exec Order 26.4b1 and told the surveyor that they attended for approximately NJ Ex Order 26, 4B1 On 3/18/2026 at 11:03 AM, the surveyor reviewed the medical record (MR) for Resident #13 which revealed the following: A review of the Admission Record, an admission summary, revealed that Resident #13 had the following but not limited to diagnoses: NJ Ex Order 26, 4B1 A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, 4B, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 which indicated the resident's NJ Ex Order 26, 4B1. Further review of the MDS revealed the resident received NJ Ex Order 26 services. A review of Resident #13's Individual Comprehensive Care Plan (ICP) included a focus area, dated NJ Ex Order 26, 4B that the resident required NJ Ex Order 26, 4B1 Interventions included: Monitor for NJ Ex O monitor/report to U. S. FOIA (b) (2)) s/sx (signs/symptoms) of NJ Exec Order 26 to NJ Exec Order 26.4B1: NJ Ex Order 26, 4B1 and monitor/report to MD s/sx of the following: NJ Ex Order 26, 4B1. A review of the Order Summary Report (OSR), dated as o NJ Ex Order 26, 4B1, included the following physician order dated NJ Ex Order 26, 4B1 for "Send communication book with resident on NJ Ex Order 26 days and check book upon return every day shift every Mon, Wed, Fri for NJ Ex Order 26 protocol." A review of Resident #13's NJ Ex Order 26, 4B1 communication binder on NJ Ex Order 26, 4B1 revealed the following: On NJ Exec Order 26.4B the facility failed to document NJ Ex Order 26, 4B1 information for Resident #13. On NJ Exec Order 26 the facility failed to document NJ Ex Order 26, 4B1 Information for Resident #13, which	F0698	Continued from page 18 by staff development coordinator on 3/23/2026 regarding: Required completion of pre- and post- NJ Exec Order 2 documentation Review of NJ Exec Order communication binder upon return Physician notification for abnormal findings Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. They can be identified by their medical records. Systemic Change The facility implemented a standardized dialysis communication process, including: Mandatory use of a dialysis communication binder/form for every dialysis visit Clear assignment of responsibility: Day shift nurse completes pre-dialysis documentation Receiving nurse (upon return): completes post-dialysis assessment and documentation A Dialysis Communication Checklist was implemented by the Director of Nursing to ensure: Vital signs documented pre/post Access site assessed Communication form sent and returned Changes in condition communicated to physicians/NP Unit Managers will verify NJ Exec Order 2 documentation during the daily morning clinical meeting by initialing the communication sheet as complete.	04/10/2026

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F0698 SS = D	Continued from page 19 included vital signs, physician name, medications administered prior to [NJ Ex Order 26, NJ Exec Order 26.4b1] sent, any additional information (changes in condition, physician order changes, new labs since last visit) and the nurse signature. In addition, no [NJ Ex Order 26, 4B1] information was documented. [NJ Exec Order 26.4b1] of the resident, date/time and vital signs. On [NJ Exec Order 26], the facility failed to document [NJ Ex Order 26, 4B1] information upon return to facility. On [NJ Ex Order 26, 4B1] the facility failed to receive documentation from the [NJ Ex Order 26, 4B1] and failed to document [NJ Ex Order 26, 4B1] information. On [NJ Ex Order 26, 4B] the facility failed to document [NJ Ex Order 26, 4B1] information and failed to document [NJ Ex Order 26, 4B1] information for Resident #13. On [NJ Exec Order 26.4b], the facility failed to receive documentation from the [NJ Ex Order 26] facility [NJ Ex Order 26, 4B1] and failed to document [NJ Ex Order 26, 4B1] information. On [NJ Exec Order 26.4b], the facility failed to document [NJ Ex Order 26, 4B1] information. On [NJ Ex Order 26, 4B1] the facility failed to document [NJ Ex Order 26, 4B1] information. On [NJ Exec Order 26.4b], the facility failed to document [NJ Ex Order 26, 4B1] information for Resident #13. On 03/19/2026 at 11:54 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) for the [NJ Ex Ord] Floor. The surveyor asked LPN/UM #1 to explain the purpose of the [NJ Ex Order 26,] Communication Form. LPN/UM #1 explained the communication sheet was to be filled out by the nurse assigned to the resident prior to leaving facility. The facility sends the communication book with the resident to [NJ Ex Order 26, NJ Ex Order 26,] staff was responsible for documenting pre and post [NJ Exec Order 2] and anything pertinent during treatment. LPN/UM #1 further explained that the communication form/book comes back with the resident, and the receiving nurse looks at the sheet and notes any new orders. Then, they assessed the [NJ Ex Order 26, 4B] site upon return and write a progress note. The surveyor then asked LPN/UM #1 if the receiving nurse was to fill out the [NJ Ex Order 26, 4B1] Information on the [NJ Ex Order 26] Communication Form upon return to the facility. LPN/UM #1 could not confirm that the facility receiving nurse was responsible for documenting the [NJ Ex Order 26, 4B1] information. She stated, I guess it could go either way ([NJ Ex Order 26] staff to fill out or facility staff.) She then stated that it was the facilities' responsibility to fill out the [NJ Ex Order 26, 4B1]	F0698	Continued from page 19 The [NJ Exec Order] provider was contacted and re-informed on expectations for timely return of communication documentation. An in-service was provided by staff development coordinator to licensed nurses on 3/23/2026 regarding: [NJ Exec Order 2] standards of care Documentation requirements Communication expectations with [NJ Exec Order 2] providers Care plan integration Quality Assurance The DON/designee will audit 100% of dialysis residents Weekly x 12 weeks, Biweekly x 12 weeks and then Monthly x 6 months for: Completion of pre-dialysis documentation Completion of post-dialysis documentation Presence of dialysis center communication Physician notification when indicated *The findings of the dialysis audits will be reported by the Director of Nursing to the QAPI committee monthly and the QAA committee quarterly for 12 months * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	04/10/2026

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F0698 SS = D	Continued from page 20 information. The surveyor then asked LPN/UM #1 what the process was if the [redacted] facility failed to document on the [redacted] Communication Form. LPN/UM #1 responded that If [redacted] failed to document any information under [redacted] information the nurse was to call the [redacted] facility and get any pertinent information. LPN/UM #1 further stated that on [redacted], the receiving [redacted] should have called the [redacted] facility to get the [redacted] information that was left blank. On 03/23/2026 at 2:11 PM, the survey team conducted an interview with facility administration which included the [redacted] the facility [redacted]. The surveyor asked the staff to explain the [redacted] communication form process. The [redacted] told the surveyor that the facility filled out the communication form and took vitals prior to [redacted]. The binder goes with the resident to [redacted] and pre and post [redacted] vital signs, any medications delivered, or medications ordered were to be documented by the [redacted] staff. The surveyor then asked what the facility should do if the [redacted] staff failed to document on the [redacted] communication form. The [redacted] stated that the staff should contact the [redacted] if the form comes back blank and gets the necessary information from [redacted]. The surveyor then asked the [redacted] if facility staff were required to document [redacted] information upon return to the facility. The [redacted] responded, the receiving nurse should check the MAR (Medication Administration Record) and TAR (Treatment Administration Record) upon return to the facility. They could also write a skilled documentation note. These items were located on the MAR and TAR and are documented upon return (referring to the items to be assessed under [redacted] information on the [redacted] Communication Form.) On 03/24/2026 at 9:56 AM, during a meeting with facility administration the [redacted] told the surveyor the following: The sending staff would be responsible for filling out the top portion of the communication [redacted] sheet. The [redacted] facility will be responsible for filling out the middle section of the [redacted] sheet ([redacted]/part 2). She then told the surveyor that the receiving facility nurse would be responsible for documenting part 3 [redacted] information) upon return to the facility as well as, documenting in the electronic medical record status post return to facility. The surveyor then asked if all three (3) sections of the [redacted] Communication Form were required to be completed and the [redacted] replied, "Yes, all 3 sections are to be completed on	F0698		04/10/2026

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F0698 SS = D	Continued from page 21 the communication sheet." A review of the facility provided and undated policy titled "Dialysis Care". revealed under Policy Statement: It is the policy of this facility to provide care to the resident with end stage renal disease who is receiving hemodialysis offsite. The purpose of this care is to provide comfort and quality of life for these residents. In addition, the following was observed under Policy Interpretation and Implementation: Initiate communication sheets which will be sent and received from the dialysis unit. The communication sheets will contain routine communication between the facility and dialysis unit. The dialysis unit will notify the facility by phone if there is any further information. This will be documented on the communication sheet. The communication sheets will be maintained on the unit. The surveyor reviewed the facility provided policy titled, "End Stage Renal Disease, Care of a Resident with", updated and reviewed June 2024. The following was revealed under Policy Interpretation and Implementation: Staff caring for residents with ESRD (end stage renal disease), including residents receiving dialysis care outside of the facility, shall be trained in the care and special needs of these residents. The policy also revealed the following: Initiate communication sheets which will be sent and received from the dialysis unit to have routine communication. The communication sheet will be kept on the unit and/or in resident medical record. NJAC 8:39-27.1(a)	F0698		04/10/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F0756	Corrective Action Resident #8's medication regimen was immediately reviewed. The U. S. FOIA (b) (2) recommendation was: Reviewed with the attending physician Addressed with appropriate action and documented in the medical record Documentation was updated to reflect: Physician review of the irregularity Clinical rationale and/or medication changes	04/10/2026

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F0756 SS = D	Continued from page 22 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of the Electronic Medical Record (EMR) and other facility documentation, the facility failed to follow through on recommendations made by the [U. S. FOIA (b) (2)]) during their medication review regimen (MRR) in a timely manner. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #8) and was evidenced by the following: During the initial tour of the facility on 3/17/26 at 12:10 PM, Resident #8 was receiving care and was unavailable for an interview. A review of the electronic medical record (EMR) on 3/18/26 at 1:50 PM revealed the following: According to the Admission Record, Resident #8 was admitted to the facility with diagnoses that included but was not limited to [NJ Ex Order 26, 4B1]	F0756	Continued from page 22 [U. S. FOIA (b) (2)] were re-educated by [NJ Ex Order 26, 4B1] on 4/6/2026 regarding timely follow-up and documentation of pharmacist recommendations. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice, this can be identified by reviewing the resident's medical records. Systemic Change The facility implemented a formal MRR (Medication Regimen Review) Tracking System: All pharmacist recommendations logged upon receipt Assigned to Unit Manager/DON for follow-up Timeframe requirements established: Routine recommendations: addressed within 24–72 hours Urgent recommendations: addressed immediately (same day) A Pharmacist Recommendation Tracking Log was implemented to include: Resident name Medication/irregularity Date received Date physician notified Action taken Date completed Unit Managers will review open recommendations during daily morning clinical meeting. An in-service education was conducted by staff	04/10/2026

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F0756 SS = D	Continued from page 23 NJ Ex Order 26, 4B1 A review of the comprehensive Minimum Data Set (MDS), an assessment tool that facilitates a resident's care dated NJ Ex Order 26, , revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1, reflecting NJ Ex Order 26, 4B1 A review of the Order Summary Report revealed the following physician orders (PO): A PO for NJ Ex Order 26, 4B1 if NJ Exec Order 26.4b1 or NJ Ex Order 26, 4B1. A PO for NJ Ex Order 26, 4B1 per day for NJ Ex Order 26, 4B1. A PO for NJ Ex Order 26, 4B1 NJ Exec one time a day for NJ Ex Order 26, 4B1. A PO for NJ Ex Order 26, 4B1 by mouth NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1. A review of the U. S. FOIA (b) (2) report dated NJ Exec Order 2 noted the following: NJ Ex Order 26, 4B1 is a NJ Ex Order 26, 4B1 and should be administered within NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1." A further review revealed, NJ Ex Order 26, 4B1 recommended NJ Ex Order 26, 4B1 when given for NJ Ex Order 26, 4B1. Please review current time of administration." NJ Ex Order 26, 4 should be administered NJ Ex Order 26, 4B1 . NJ Ex Order 26, 4B1. If the resident is unable to NJ Ex Order 26, 4B1 NJ Ex Order , consider changing to NJ Ex Order 26, 4, which can be opened if needed for administration. Alternatively, the physician can update the order to include 'may open for administration.'" NJ Ex Order 26, 4B1 If the resident is unable to NJ Ex Order 26, 4B1, contact the physician to change to NJ Ex Order 26, 4B1 or to another medication." There was no evidence in the medical record that the facility followed up with the CP's recommendations. On 3/23/26 at 10:51 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that the	F0756	Continued from page 23 development coordinator for licensed nurses on 4/6/2026 regarding: F756 requirements Physician documentation requirements Timely follow-up expectations EMR documentation standards Quality Assurance The DON/designee will audit 5 residents with pharmacist recommendations for the following areas, Weekly x 12 weeks, Biweekly x 12 weeks and then Monthly x 6 months: The DON/designee will audit Consultant Pharmacist recommendations Timeliness of physician review Documentation of action or rationale Completion of tracking log Results of audits of new admissions will be reported by DON to through QAPI committee monthly for 12 months and QA committee for four quarters. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	04/10/2026

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F0756 SS = D	Continued from page 24 desk nurse and unit managers have access to the CP reports daily. She added that the CP completed a medication regimen review upon admission and monthly. She continued to explain that the nurses were expected to address pharmacist concerns with the provider/physician to assure that corrections or updated were completed. She stated that the unit manager was responsible for ensuring recommendations were addressed, including making necessary updates and maintaining documentation to reflect that concerns were resolved. The unit managers should attach a copy of updated report with corrections which would indicate that the concerns were addressed. A review of the facility's "Addressing Medication Regimen Review Irregularities" policy, updated April 2023, included: "It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event... 4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon... d. The nurses will forward the information to the attending physician, who must document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record." NJAC 8:39-29.3(a)1	F0756		04/10/2026
F0761 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	F0761	Corrective Action The [NJ Ex Order 26] observed at bedside was immediately removed and secured in the medication cart. Both residents were assessed as: Authorization for [NJ Exec Order 26.4b1] of medications [NJ Exec Order 26.4] ability and safety to manage medications Physician orders were reviewed and clarified. Where appropriate: A [NJ Exec Order 26.4b1] assessment was completed A physician order was obtained if [NJ Exec Order 26.4b1]	04/15/2026

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F0761 SS = D	Continued from page 25 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, record review, and review of facility documentation, it was determined that the facility failed to properly store and secure medication left at resident's bedside (Resident #15 and #43). This deficient practice was identified for 2 of 2 residents (Resident #15, and #43). This deficient practice was evidenced by the following: 1. On 3/17/2026 at 12:25 PM, the surveyor observed Resident #15 in their room, sitting on the side of their bed. At that time, the surveyor observed a NJ Ex Order 26, 4B1 on top of their bedside table. The surveyor reviewed the medical record for Resident #15. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to; NJ Ex Order 26, 4B1 A review of Resident #15's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, 4B1, included that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1, which indicated that the resident's NJ Exec Order 26 was NJ Ex Order 26, 4B1.	F0761	Continued from page 25 was deemed appropriate Staff involved were immediately re-educated on: Proper medication storage requirements Bedside medication restrictions Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice they can be identified by their medical record. Systemic Change The facility reinforced policy requiring: No medications are to be left at bedside unless: Physician order is present Interdisciplinary assessment supports self-administration Medication is stored securely (locked container if required) A Self-Administration of Medication Policy was re-educated to staff, including: Assessment requirements Documentation requirements Storage expectations A Bedside Medication Monitoring Process was implemented: Nursing staff will check resident rooms each shift for unauthorized medications An in-service education was conducted by U. S. PO on 4/6/2026 for all licensed nurses and CNAs on: F761 requirements Medication security and storage Risks of unsecured medications	04/15/2026

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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
F0761 SS = D	Continued from page 26 A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [redacted] that the resident had an [redacted] status related to NJ Ex Order 26, 4B1 [redacted] Interventions included: Monitor changes in [redacted] NJ Exec Order 26.4b1, [redacted] and [redacted] Monitor for signs and symptoms of NJ Exec Order 26.4b1 and report to the medical doctor as needed. Monitor and report NJ Exec Order 26.4b1 patterns to medical doctor. Review of the Order Summary report (OSR), dated [redacted] included the following physician order (PO): A PO dated [redacted], for NJ Ex Order 26, 4B1 [redacted] prescription [redacted] used by [redacted] to [redacted] NJ Ex Order 26, 4B1 A review of the Medication Administration Record (MAR) revealed that Resident #15 was administered the [redacted] on NJ Ex Order 26, 4B1 On 3/17/2026 at 1:36 PM, the surveyor interviewed the Registered Nurse (RN) #1, who stated that she administered Resident #15's 9 AM medications. She further stated that all medications should be stored in the medication cart and should never be left at the bedside. She added that it should not be left because the resident can take their own medication and can overdose. She added that if the nurse saw the medication at the bedside, the nurse should remove the medication, then put it in a bag and notify the provider and care manager. She further stated that the family would then be notified to pick up the medication. She further stated that the care manager would be notified if the resident wanted to self-administer any medications. On 3/17/2026 at 1:40 PM, the surveyor, accompanied by the Licensed Practical Nurse / Unit Manager (LPN/UM) #2, went to Resident #15's room, and she confirmed the findings. LPN/UM #2 removed the [redacted] from the bedside table and removed the packaging for the [redacted] that was	F0761	Continued from page 26 Unit Managers will review compliance during daily rounds and morning clinical meetings Quality Assurance The DON/designee will audit 10 resident rooms Weekly x 12 weeks, Biweekly x 12 weeks and then Monthly x 6 months Resident rooms for medication storage compliance Self-administration documentation and physician orders Medication security practices Director of nursing submits her findings of the above audits to the QAPI committee monthly for 12 months and Quarterly to the QA committee for 4 quarters or until substantial compliance is achieved. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

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THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 ROUTE 73 , VOORHEES, New Jersey, 08043

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F0761 SS = D	Continued from page 27 next to the sink. LPN/UM #2 exited Resident #15's room and stated that medication should not have been at the bedside unless the resident had an order to [NJ Exec Order 26.4b1] medication. She further explained that if the resident wanted to [NJ Exec Order 26.4b1] their own medication, they would have to be assessed by the nurse, then the physician must be notified, and an order for [NJ Exec Order 26.4b1] was obtained. On 3/18/2026 at 10:01 AM, the surveyor conducted a follow-up visit with Resident #15, when asked about the [NJ Ex Order 26, 4B1] that was left on top of their bedside table the day before, Resident #15 stated that the nurse gave them the [NJ Ex Order 26] 2. On 3/17/2026 at 12:43 PM, the surveyor observed Resident #43 lying awake in their bed. At that time, the surveyor observed multiple medications on top of bedside table as follows: [NJ Ex Order 26, 4B1] [redacted] On 3/17/2026 at 1:41 PM, the surveyor, accompanied by LPN/UM #2, and another surveyor, went to Resident #43's room. LPN/UM #2 confirmed the findings. LPN/UM # 2 removed the following medications: [NJ Ex Order 26, 4B1] [redacted] LPN/UM#2 asked the resident where they got the medications from, and the resident stated that they brought the medications in from home. LPN/UM #2 explained to Resident #43 that they cannot have medication at their bedside unless they have an order to [NJ Exec Order 26.4b1] the medication. The resident allowed the nurse to remove the medications from their bedside. LPN/UM #2 verified that Resident #43 did not have an order to [NJ Exec Order 26.4b1] their medication. LPN/UM #2 stated that Resident #43 should not have had the medications at their bedside because they did not have an order to [NJ Exec Order 26.4b1] medications. On 3/17/2026 at 2:30 PM, the surveyor reviewed the medical record for Resident #43. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [NJ Ex Order 26, 4B1] [redacted]	F0761		04/15/2026

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F0761 SS = D	Continued from page 28 NJ Ex Order 26, 4B1 A review of resident #43's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, 4B1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 which indicated the resident's NJ Ex Order 26, 4B1. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Ex Order 26, 4B that Resident #43 had an NJ Exec Order NJ Ex Order 26, 4B1 related to NJ Ex Order 26, 4B1 Interventions included: administer medication/ NJ Ex Order 26, 4B1 as ordered. Monitor for effectiveness and side effects. NJ Exec Order 2 the NJ Exec O of the NJ Exec to help facilitate NJ Exec Order 26.4b NJ Exec Order 26.4b Maintain a NJ Exec Order 26.4b1 by encouraging the resident to NJ Ex Order 26, 4B1 . If NJ Exec Order 26.4b cannot be cleared, NJ Exec Order as ordered/required to NJ Exec O NJ Exec Order 26.4b1 Monitor /document changes in NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, NJ Exec Order 2 and NJ Ex Provide as ordered. A review of the Order Summary Report (OSR), dated as of NJ Ex Order 26, 4B1 included a PO dated NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 , and the resident should NJ Exec Order 26.4b1 without NJ Ex Order 26, 4B1 after each use to NJ Exec Order 26.4 the risk of an NJ Ex Order 26, 4B1. On 3/19/2026 at 10:33 AM, the surveyor interviewed the U. S. FOIA (b) (2)), who stated medications should be stored on the medication cart, unless they have an order to NJ Exec Order 26.4b1 medication, then the medication would be stored in a lock cabinet in the resident's room. She further stated that if medication was left at the bedside, it could result in adverse effects. The U. S. FOIA added that she would have to look up the policy for NJ Exec Order 26.4b1 medications because she did not know it off top of her head. On 3/19/2026 at 10:42 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that medications should be stored in the medication cart unless the resident had an order for	F0761		04/15/2026

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F0761 SS = D	Continued from page 29 NJ Exec Order 26.4b1 A review of the facility's policy undated, titled, "Storage of Medications," revealed Policy Statement: the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage. A review of the facility's policy titled, "Self-Administration of medication," revealed residents in our facility who wish to self-administer medications may do so, if it is determined that they can do so. Self-administration medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for bedside storage, for return to the family or responsible party. NJAC 8:39-29.4(h)	F0761		04/15/2026
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and review of pertinent facility documents, it was determined that the facility failed to honor the food preference for one (1) of two (2) residents (Resident #141) reviewed for nutrition. This deficient practice was evidenced by the following: On 3/19/26 at 12:59 PM, the surveyor reviewed the medical record for Resident #141 which revealed the following:	F0806	Corrective Action Resident #141 is no longer residing in the facility (discharged) and therefore no further corrective action can be implemented for this resident. Prior to discharge, available records were reviewed to identify and address any gaps related to dietary preferences and meal substitutions. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. They can be identified by their medical records. Systemic Change The facility reinforced policy requiring that: All resident food preferences, allergies, and substitutions are honored and documented	04/10/2026

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F0806 SS = D	Continued from page 30 A review of the Admission Record, an admission summary, revealed that Resident #141 had diagnoses which included but were not limited to [redacted] A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident's [redacted] A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [redacted], which indicated that the resident had [redacted]. Interventions included a [redacted] for [redacted] regimen and ongoing monitoring. A subsequent focus area that was on Resident #141's ICCP indicated that the resident had an [redacted] need for [redacted] and that the resident followed a [redacted]). The interventions included: "Honor [redacted] preferences [redacted]) preference, [redacted] allowed. [redacted]. A review of the physician Order Summary Report (OSR) included a physician's orders (PO) dated [redacted] for [redacted]. A review of the [redacted] Evaluation Note dated [redacted] indicated that Resident #141 ate [redacted] at home. The [redacted] intervention included "honor [redacted] as able [redacted]." A review of the [redacted] Evaluation Note dated [redacted] included "continue current [redacted] preference on [redacted] will honor as able." A review of Resident #141's [redacted] slip, dated [redacted], included [redacted] A review of the progress notes included a nurse's note (NN), dated [redacted], which included that the resident rec'd (received) the wrong dinner meal from the kitchen, not respecting [redacted]. The resident care nurse went	F0806	Continued from page 30 A Dietary Preference Verification Process was implemented: Preferences obtained on admission and reviewed quarterly and with any change in condition A Meal Substitution Process was implemented: Residents are offered alternative meals of similar nutritive value when declining the primary meal A Tray Accuracy Verification Process was implemented: Nursing and dietary staff will verify tray accuracy prior to meal service An in-service education was conducted by staff development coordinator for dietary and nursing staff on 4/6/2026 regarding: Honoring preferences and substitutions Documentation standards Interdisciplinary communication between dietary, nursing, and speech therapy was reinforced Quality Assurance The Dietary Manager and DON/designee will audit 10 residents daily and then Weekly x 12 weeks, Biweekly x 12 weeks and then Monthly x 6 months regarding: Tray accuracy Preference compliance Substitute meal offerings	04/10/2026

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F0806 SS = D	Continued from page 31 to the kitchen three different times to accommodate residents' food wishes and the resident was given a NJ Exec Order 26.4b1 . Resident [relation redacted] NJ Exec Order 26 with NJ Exec Order 26.4b1 . The 3-11 supervisor made aware that a kitchen error was corrected and made family aware that he would escalate issues with his superiors." On 3/19/26 at 11:28 AM, the surveyor interviewed the U. S. FOIA (b) (2)), who stated that the meal trays should be accurate for the most part. She added that she would check the meal ticket to ensure that the tray was correct. On 3/23/26 at 12:08 PM, the surveyor interviewed the U. S. FOIA (b) (2)) who stated that the U. S. FOIA (b) (2) would check to verify the NJ Exec was correct before placing the tray on the cart for transport to the unit. She further stated that the U. S. FOIA (b) (2)) would then distribute the meal tray to each resident when it arrived on the unit. On 3/19/26 at 1:39 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that she would meet with every resident upon admission to the facility to get their NJ Exec Order 26.4b1 . She stated she would educate them if they were on an NJ Exec Order 26.4b1 , and she would offer the resident written education about their NJ Exec O if they wanted it. The U. S. FO stated that she would then go into the food service portal and update the preference or send it to the U. S. FOIA so she could update it. She added that each resident was provided with a food preference questionnaire to complete. She further stated that if the resident did not complete the food preference form, the U. S. FOIA would go to the resident and obtain the resident's food preference, so their likes and dislikes, and food preference would be documented on the NJ Exec Order 26.4b1 The RD further stated that Resident #141 required a NJ Ex Order 26, 4B1). Upon admission to the facility the resident and the family were notified that this was not a NJ Ex Order 2 facility, and they did not have NJ Ex Order 26, 4B1 . She further stated that Resident #141 did not want to be served any NJ Exec O from the facility. She noted that when Resident #141 first arrived at the facility, the resident's NJ Exec was modified to a NJ Ex Order 2 . She stated that considering the facility would not have been able to give them a NJ Ex Order 26, 4B1 meal o NJ Ex Order 26, 4B , they accommodated the resident with a . The U. S. F explained that she had received complaints regarding meal accuracy, and	F0806	Continued from page 31 Documentation accuracy *The findings of the above audits will be reported by the Director of Nursing to the QAPI committee monthly and the QAA committee quarterly for 12 months * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	04/10/2026

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F0806 SS = D	Continued from page 32 based upon an internal investigation, the person who made the meal trays did not look at the ticket. She added that they had new team members and there has been a 100% turnover. On 3/23/26 at 11:22 AM, the surveyor interviewed the[U. S. FOIA (b) (2) redacted] who stated that resident meals should be accurate and added that the [NJ Ex Order 26, 4B redacted] would obtain the resident's food preference upon admission to the facility. The [U. S. FOIA redacted] further stated that the facility could not accommodate a resident with a [NJ Ex Order 26, 4B redacted] and different [NJ Exec Order 26.4b1 redacted] so they would offer a [NJ Ex Order 26, 4B1 redacted]. He added that the meals trays should be accurate. On 3/24/2026 at 11:22 AM, the surveyor conducted a follow-up interview with the [U. S. FO redacted] who stated that upon admission to the facility Resident #141 had a preference for a [NJ Ex Order 26, 4B redacted] and always maintained a [NJ Ex Order 26, 4B redacted] throughout their admission to the facility. She added that a [NJ Ex Order 26, 4B redacted] did not require a physician's order since it was a preference and the resident's preferences would be printed on the meal ticket. She further stated that the kitchen must verify the [NJ Exec redacted] that was on the meal ticket. The [U. S. F redacted] added that once the meal was delivered to the unit, the [U. S. FOIA (b redacted] would again verify the meal ticket when distributing the trays. The [U. S. FOIA redacted] stated that "half the staff probably doesn't know what a [NJ Ex Order 26, 4B redacted] is." She further stated that she was aware of the incident when the grievance was filed. She noted that Resident #141 received [NJ Exec O redacted] that was not [NJ Ex Orde redacted] and the family informed the facility, and it was taken care of. The [NJ Exec Order 26.4b1 redacted] evaluation that was completed by the [redacted] should have reflected that the resident preferred a [NJ Ex Order 26, 4B redacted]. She then stated, "That is why she doesn't work here anymore." A review of the facility's Resident Food Preferences," policy, updated January 2026, included "Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications for diet will only be ordered with the resident's or representative's consent." A review of the facility's "Resident Rights" updated January 2026, included "Residents are entitled to exercise their rights and privileges to the fullest extent possible." NJAC 8:39-17.4(a)1, e	F0806		04/10/2026

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F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) prepare food in a manner to prevent food-borne illness, b.) maintain the kitchen equipment in a sanitary manner, and c.)maintain food-contact equipment in a sanitary condition for 2 of 2 bistros (second and third floor bistros). This deficient practice was evidenced by the following: On 3/17/26 at 10:17 AM, the surveyor began the initial tour of the kitchen and observed the following: Immediately at the start of the tour, the surveyor observed the U. S. FOIA (b) (2)) with hair extending near her shoulder blades, uncovered and not within the hairnet that she was wearing. At that time, the surveyor interviewed the U. S. FOIA, who stated that hairnets must be worn while in the kitchen. She added that if the hair cannot be tucked under the hairnet, the hair would be tucked behind them, in their shirts. She further stated that for food safety, hair should never be exposed. At 10:41 AM, the U. S. FOIA (b) (2)	F0812	Corrective Action: All identified concerns were immediately corrected: Staff with improper hair restraint were corrected in real time and re-educated by the dietary director beginning on 3-23-26 All ice machines (main kitchen and both bistros) were taken out of service, emptied, cleaned, and disinfected in accordance with manufacturer guidelines and infection control standards. Ice machine components (including spouts and affected areas) were cleaned and/or replaced as needed. Ice scoops were removed, cleaned, and placed in appropriate containers that allow for drainage. Improper storage items (e.g., paper towels, pans) were discarded and replaced with approved storage methods. Dishwasher temperature and chemical levels were immediately verified and logs completed. Identification of Residents at Risk: All residents who eat food from the kitchen have the potential to be affected. These residents can be identified by facility census. Systemic Change: The facility reinforced and re-educated all dietary staff by the dietary director beginning on 3-23-26 regarding; Hair restraint policy (100% coverage required for all staff entering food prep areas) Ice machine cleaning and maintenance policy Food-contact surface sanitation standards Dishwasher monitoring requirements (temperature + chemical logs) A cleaning schedule was revised and clarified: Ice machines: weekly cleaning + as needed Bistro ice machines added to routine schedule A Dishwasher Monitoring Process was implemented:	04/15/2026

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F0812 SS = D	Continued from page 34 [redacted] was observed making peanut butter and jelly sandwiches. At that time, he was wearing a [redacted] with hair exposed along both sides and the back of his head. The [redacted] removed his hat. The hairnet was noted to be flat on top of his head and was not expanded to cover the hair on the sides and nape of his neck. At 10:45 AM, the surveyor requested that the [redacted] open the ice machine door. The white hard plastic area inside was noted with black and brown residue, and some buildup in various areas. At that time, the surveyor interviewed the [redacted], who stated that she did not know when the ice machine was last cleaned. She further stated that the ice machine should be deep-cleaned weekly and as needed, and it should be maintained in a clean and sanitary manner. On 3/18/26 at 12:31 PM, the surveyor toured the [redacted] floor bistro, and the following was observed: The ice machine was noted with slime-like residue in the drip tray. The ice machine contained white corrosion on the interior and exterior parts of the spout. The ice scooper was resting in a metal container and was unable to drain freely. On 3/18/26 at 1:25 PM, the surveyor toured the [redacted]-floor bistro, and the following was observed: The ice machine contained a buildup of residue and corrosion around the interior and exterior parts of the spout. An ice scooper and a tong were noted resting on a yellow-tinged paper towel inside a metal pan. At that time, the Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated "that should not be like that," referring to the ice scooper, tong, and the yellow-tinged paper towel. On 3/23/26 at 8:32 AM, the surveyor returned to the kitchen for a follow-up visit. The surveyor requested the dishwasher temperature log. There was no entry on the log for 3/23/26. At that time, the surveyor interviewed the [redacted] who stated that two wash cycles were completed that morning. She stated that the dishwasher temperature	F0812	Continued from page 34 Temperatures and chemical levels must be checked prior to first use each day Documentation required before operation A Food Service Sanitation Checklist was implemented for: Daily kitchen and bistro inspections Quality Assurance: The Dietary Manager and/or designee will audit daily the following: Hair restraint compliance Ice machine cleanliness and maintenance Ice scoop storage practices Dishwashing temperature and chemical logs Overall kitchen and bistro sanitation Reviewed by dietary director during daily stand-up / kitchen rounds Audit Sample: Daily kitchen check Weekly full sanitation audit Audit Frequency: Daily monitoring x 4 weeks , Weekly x 12 weeks, Biweekly x 12 weeks and then Monthly x 6 months Audit findings will be reported to the QAPI committee monthly and QAA committee quarterly by the dietary 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 (LNHA) The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	04/15/2026

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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
F0812 SS = D	Continued from page 35 and chemical levels should have been checked and documented before running a cycle to ensure that the dishes were properly cleaned. On 3/23/26 at 8:36 AM, the surveyor interviewed the dietary aide, who stated that he was responsible for washing the dishes. He stated that he did not check the temperatures and chemical levels because he had to scrape four big racks of plates from last night's dinner. On 3/23/26 at 9:55 AM, the surveyor interviewed the U. S. FOIA (b) (2) , who stated that housekeepers were responsible for cleaning the ice machines. He further stated that the ice machines were deep-cleaned every three months or as needed. He also stated he agreed that the drip trays on the ice machines needed to be cleaned and or replaced. He added that he would attempt to clean them, and if they were uncleanable, he would replace them. The U. S. FO also stated that he would try to clean the ice machine spouts, and if they are uncleanable, he would replace them. On 3/23/26 at 10:16 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that the ice machines should be maintained in a clean and sanitary manner at all times. She added that the ice scoopers should be washed daily and drain freely, and not where water could be collected and lead to bacteria buildup. On 3/23/26 at 10:37 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that the ice machine was cleaned quarterly and as needed. He added that the ice machines should be maintained in a clean and sanitary manner. He also stated that the ice scoopers should drain freely for infection control purposes. The U. S. FOIA P further stated that dishwasher temperatures should be checked every morning and documented. He added that it was important to check the temperature so they knew it was running properly. A review of the facility's "Infection Prevention and Control Program" policy, undated, included, "This facility has established and maintains 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 disease and infections as per accepted national standards and guidelines."	F0812		04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 ROUTE 73 , VOORHEES, New Jersey, 08043

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F0812 SS = D	Continued from page 36 A review of the facility's "Hair Restraint (Net) Policy" updated January 2025, included, "It is the policy of this facility that hair restraints prevent hair from contacting food, food service equipment, and utensils, thus avoiding cross-contamination. This policy applies to all food service staff within the facility, including those preparing, cooking, or serving food and/or any visitor or staff entering the kitchen area…Hair restraints must cover all head hair completely. This includes securing bangs and other loose strands that might escape from primary restraints." A review of the facility's "Ice Machines and Ice Storage Chests" Updated January 2025, included, "Ice Machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. … Our facility has established procedures for cleaning and disinfecting ice machines and storage chests, which adhere to the manufacturer's instructions. The Infection Preventionist maintains a copy of these procedures." A review of the facility's "Ice" policy, revised 10/2022, included "Ice will be prepared and distributed in a safe and sanitary manner. …Ice scoops will be cleaned and stored in a separate container that limits exposure to dust and moisture retention." NJAC 8:39-17.2(g)	F0812		04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	**113 ROUTE 73 , VOORHEES, New Jersey, 08043**

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S0000	Initial Comments 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.	S0000		04/07/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for two weeks of AAS-11 staffing reviewed, the facility was deficient in CNA (Certified Nurse Aide) to total staff for residents on 1 of 14-evening shifts and deficient in CNA staffing for residents on 1 of 14-day shifts as follows: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift.	S0560	1 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. In meantime the facility will utilize agencies to fill open slots in the schedule. 2 All residents have the potential to be affected by the deficient practice of not meeting the NJ staffing requirement ratios. 3 The following measures have been put into place to prevent the deficient practice from recurring: Additional agencies have been contracted to attain the appropriate staff ratios for the facility census. . Advertisements/ job postings for CNAs have been posted on hiring platforms and social media websites Partnerships have been established with local vocational schools and CNA training programs to create an avenue for staffing.	04/10/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

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S0560	Continued from page 1 One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of AAS-11 staffing from 01/19/2025 to 02/01/2025, the facility was deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -01/27/25 had 11 CNAs to 24 total staff on the evening shift, required at least 12 CNAs. For the 2 weeks of AAS-11 staffing from 06/15/2025 to 06/28/2025, the facility was deficient in CNA staffing for residents on1 of 14-day shifts as follows: -06/17/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. On 03/24/2026 at 9:12 AM the surveyor conducted an interview with the facility Staffing Coordinator (SC). The SC told the surveyor that she had been employed at the facility for approximately one (1) year. The surveyor asked the SC if she was familiar with the minimum staffing requirements for nursing homes. The SC stated that she was and told the surveyor that the ratios were 1 (CNA) to 8 residents for the day shift (7AM-3PM), 1 (CNA) to 10 residents on the evening shift (3PM-11PM) and 1 (CNA) to 14 residents on the night shift (11 PM - 7AM). The surveyor then asked the SC if the facility consistently met the minimum staffing requirements and the SC responded, "Yes." The surveyor reviewed the facility provided policy titled, "Staffing" updated and reviewed 6/20/24. The following was revealed under Policy Statement: Our facility will provide sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. In addition, the following was observed under Policy Interpretation and Implementation: Licensed nurses and certified nursing assistants are available 24	S0560	Continued from page 1 Incentives are offered to CNAs to work extra shifts such as gift cards and bonuses. Many 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 bring in good staff and quickly. Tap Check payout system implemented for staff to receive instant pay as incentive to employ more staff. Overtime is made available to all current employees. 4 The DON will do weekly staffing audits for the upcoming 7 days to proactively identify potential gaps. Administrator will meet weekly with staffing coordinator to review a 7 day prospective of staffing and implement measures to fill any identified staffing gaps proactively. Quality Assurance The DON/designee will review staffing levels daily for all three shifts to ensure that we have adequate staffing. Findings will be reported to the administrator daily and reviewed with the QA committee quarterly until substantial compliance is obtained. The administrator/designee will review the staffing schedule weekly to monitor the staffing ratio on all shifts weekly x 90 days. The administrator will report findings to the QA committee on a quarterly basis x 4 quarters and monthly to QAPI committee for 12 months.	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

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S0560	Continued from page 2 hours a day to provide direct resident care services. One CNA to every eight residents for the day shift, one direct care staff member (RN, LPN, or CNA) to every 10 residents for the evening shift; and one direct care staff member (RN, LPN, or CNA) to every 14 residents for the night shift.	S0560		04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 04/16/2026 in relation to the 03/24/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		04/16/2026

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 reverse for further 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.

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 04/16/2026 in relation to the 03/24/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		04/16/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - POWERBACK** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	**113 ROUTE 73 , VOORHEES, New Jersey, 08043**

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/18/26 and 03/19/2026. The Subacute at Autumn Lake was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The nursing home building construction was stated to be in 2012, with no current major renovations or noted additions. It is a three-story building Type II (222) construction and is fully sprinklered. The exterior 600 KW (diesel) generator does 100% of the building. The building has 10 smoking zones. The building has 2 elevators. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator is stated to be tied to the fire alarm control panel, cross corridor- door holds open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 124 certified beds. At the time of the survey the census was 115.	K0000		04/07/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 03/19/26 in the presence of the U. S. FOIA (b) (2)), it was determined that the facility failed to conduct	K0291	Corrective Action The emergency battery back-up lighting is fully functional. A 30 second test was done as well as a 90 minute yearly test. The tests were documented in the test logs with Tels. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change U. S. FOIA (b) (2) was in serviced by the	04/15/2026

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 reverse for further 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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K0291 SS = F Bldg. 01	Continued from page 1 functional testing of emergency lighting system in accordance with NFPA 101: 2012 Edition, Sections 19.2.9.1 and 7.9. This deficient practice had the potential to affect all residents and was evidence by the following: At 1:12 PM, documentation dated 3/18/26 was provided by the [U. S. FO] for review regarding emergency battery back-up lighting functional testing. The documentation contained checked marks indicating "PASS." Further review of the record revealed no documentation to confirm that monthly functional testing of the batter back-up emergency lighting system was conducted for a minimum of 30 seconds. Additionally, there was no documentation to confirm that annual testing was conducted for a duration of 90 minutes. In an interview at 1:02 PM, the [U. S. FO] confirmed that the documentation did not reflect the required testing durations for monthly and annual emergency lighting tests. The facility's [U. S. FOIA (b) (2)] was notified of the deficient practice at the Life Safety Code survey exit conference at 2:41 PM. N.J.A.C 8:39-31.9(e).	K0291	Continued from page 1 [U. S. FOIA (b) (2)] that the emergency battery back-up lighting needs to be tested monthly for 30 seconds and 90 minutes yearly. Quality Assurance The maintenance director will submit findings of the monthly emergency battery back-up lighting testing to the QA committee for 4 quarters and the yearly 90 minute testing yearly at the QA meeting for one year or until substantial compliance has been met. The QA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to ensure continued compliance and improvement	04/15/2026
K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K0321	Corrective Action The wedge that was placed by the kitchen doors that made the doors prop open were removed. The wedge in the central supplies closet that made the door prop open was removed. The housekeeping supply storage room door that had a ½-inch gap at the meeting edge was fixed and there is no gap. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The maintenance director in serviced the kitchen staff as well as the central supplies director on the importance to ensure that fire-rated self-closing doors to hazardous areas are kept in a closing position at all time and are separated by smoke resisting partitions in accordance with NFPA 101:	04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - POWERBACK** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

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K0321 SS = F Bldg. 01	Continued from page 2 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observations and interview on 03/18/26 in the presence of the U. S. FOIA (b) (2)), it was determined that the facility failed to ensure that fire-rated self-closing doors to hazardous areas were kept in a closing position at all time and were separated by smoke resisting partitions in accordance with NFPA 101: 2012 Edition, Sections 19.3.2.1,19.3.2.1.3,19.3.2.1.5,19.3.6.3.5,19.3.6.4, 8.3, 8.3.5.1,8.4,8.5.6.2 and 8.7. This deficient practice had the potential to affect all residents and was evidenced by the following: At approximately 9:40 AM, observations in the kitchen area revealed that two of the three self-closing doors were observed to be propped open. Observation at 1:30PM, revealed that the self-closing door to the central supply storage room was held open with a door wedge. Observation at 1:50PM, revealed that the housekeeping supply storage room set doors had a ½-inch gap at the meeting edge. In an interview at the time, the U. S. FO confirmed the findings. The facility's U. S. FOIA (b) (2) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/19/2026 at 2:41 PM. N.J.A.C 8:39-31.9(e).	K0321	Continued from page 2 2012 Edition, and the director will audit 5 smoke resistant partitions monthly to ensure that they are fully sealed. Quality Assurance The maintenance director will submit finding of the monthly door inspections to the QA committee for 4 quarters or until substantial compliance has been met.	04/15/2026

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K0372 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observations and interview on 03/03/2026 in the presence of the U. S. FOIA (b) (2)), it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6,8.3.5, This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:37 AM, revealed the smoke barrier assembly near the auditorium on the NJ Ex floor had unsealed wire/pipe penetrations through the wall above the smoke barrier doors. An observation at 11:26 AM, revealed the smoke barrier assembly near room NJ Ex On the NJ Ex floor had unsealed wire/pipe penetrations through the wall above the smoke barrier doors. An observation at 11:31 AM, revealed the smoke barrier assembly near room NJ Exec on the NJ Ex floor had unsealed wire/pipe penetrations through the wall above the smoke barrier doors. An observation at 12:34 PM, revealed the smoke barrier assembly near room NJ Ex on the NJ Ex floor had unsealed wire/pipe penetrations through the wall above the smoke barrier doors. An observation at 1:01 PM, revealed the smoke barrier assembly near room NJ Ex on the NJ Ex floor had unsealed wire/pipe penetrations through the wall	K0372	Corrective Action the smoke barrier assembly near the auditorium on the NJ Ex floor wire/pipe penetrations through the wall above the smoke barrier doors were sealed up. the smoke barrier assembly near room NJ Ex on the NJ Ex floor that had unsealed wire/pipe penetrations through the wall above the smoke barrier doors was sealed up. the smoke barrier assembly near room NJ Ex on the NJ Ex floor that had unsealed wire/pipe penetrations through the wall above the smoke barrier doors was sealed up. the smoke barrier assembly near room NJ Ex on the NJ Ex floor that had unsealed wire/pipe penetrations through the wall above the smoke barrier doors was sealed up. the smoke barrier assembly near room NJ Ex On the NJ Ex floor that had unsealed wire/pipe penetrations through the wall above the smoke barrier doors was sealed up. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The U. S. FOIA (b) (2) was in serviced by the U. S. FOIA (b) (2) r that the corridor doors penetrations through smoke/fire barriers are protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, and will audit that all smoke resistant partitions are fully sealed quarterly. Quality Assurance The maintenance director will submit finding of the monthly door inspections and quarterly smoke resistant partitions quarterly to the QA committee for 4 quarters or until substantial compliance has been met.	04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - POWERBACK** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	**113 ROUTE 73 , VOORHEES, New Jersey, 08043**

(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
K0372 SS = F Bldg. 01	Continued from page 4 above the smoke barrier doors. In an interview at the time, the [U.S.FD] confirmed the findings. The facility's [U. S. FOIA (b) (2)] was notified of the deficient practice at the Life Safety Code survey exit conference on 03/19/2026 at 2:41 PM. N.J.A.C 8:39-31.9(e).	K0372		04/15/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 03/18/26 in the presence of the [U. S. FOIA (b) (2)] it was determined that the facility failed to ensure that resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2,9.2.1 and NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations between 9:20 AM and 2:25 PM, revealed that the resident's bathrooms ventilation systems in the A-wing, B -wing and C -wing were not functioning when tested by the [U.S.FC] In an interview at the time, the [U.S.FD] confirmed the findings. The facility's [U. S. FOIA (b) (2)] was notified of the deficient practice at the Life Safety Code survey exit conference on 03/19/2026 at 2:41 PM. N.J.A.C 8:39-31.9(e).	K0521	Corrective Action the resident's bathrooms ventilation systems in the A-wing, B -wing and C -wing have proper ventilation. A company was called down and replaced the bad Fuses. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. The [U. S. FOIA (b) (2)] was in serviced by the [U. S. FOIA (b) (2)] on the importance to ensure that resident bathrooms are provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2,9.2.1 and NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. The Maintenance director will audit 10 rooms monthly to ensure that the ventilation works properly in the residents bathroom. Quality Assurance The maintenance director will submit finding of the monthly audits and to the QA committee for 4 quarters or until substantial compliance has been met and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to ensure continued compliance and improvement will be done.	04/15/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101	K0363	Corrective Action The back hall corridor set doors to the lobby had a	04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - POWERBACK** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	**113 ROUTE 73 , VOORHEES, New Jersey, 08043**

(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
K0363 SS = D Bldg. 01	Continued from page 5 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observations and interview on 03/18/2026 in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with NFPA 101: 2012 LSC Edition, Section 19.3.6,19.3.6.1 and 19.3.3.6.5. This deficient practice had the potential to affect 21 of 115 residents and was evidenced by the following: Observation at approximately 12:26PM, revealed back hall corridor set doors to the lobby had a ½ inch gap at the meeting edge. In an interview at the time, the U.S.FO confirmed the	K0363	Continued from page 5 ½ inch gap at the meeting edge was closed up. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The U. S. FOIA (b) (2) was in serviced by the U. S. FOIA (b) (2) that the corridor doors have to be able to resist the passage of smoke in accordance with NFPA 101: 2012 LSC Edition, and the director will audit 5 smoke resistant partitions monthly to ensure that they are fully sealed. Quality Assurance The maintenance director will submit finding of the monthly door inspections quarterly to the QA committee for 4 quarters or until substantial compliance has been met.	04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - POWERBACK** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	**113 ROUTE 73 , VOORHEES, New Jersey, 08043**

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K0363 SS = D Bldg. 01	Continued from page 6 finding. The facility's U. S. FOIA (b) (2) was notified of the deficient practice at the Life Safety Code survey exit conference on 03/19/2026 at 2:41 PM. N.J.A.C 8:39-31.9(e).	K0363		04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	**113 ROUTE 73 , VOORHEES, New Jersey, 08043**

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/18/26 and 03/19/26. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		04/07/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - POWERBACK** B. WING	(X3) DATE SURVEY COMPLETED **04/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	**113 ROUTE 73 , VOORHEES, New Jersey, 08043**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 4/16/2026 in relation to the 3/24/2026 Life Safety Code survey. The facility 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 Occupancy.	K0000		04/28/2026

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 reverse for further 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.

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