STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315500	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	**1086 DUMONT CIRCLE , 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 Complaint #: 2613158 Survey Dates: 9/23/25 Census: 118 Sample Size: 3 A complaint survey was conducted on 09/18/2025 to 09/23/2025, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.12(a)(1) F 600, as the facility failed to ensure a NJ Ex Order 26, 4B1 resident was protected from NJ Exec Orde after Resident #1 NJ Exec Order the Certified Nursing Aide (CNA #1) NJ Exec Order 26.4b1 them by NJ Exec Orde their NJ Exec and NJ Exec Order 2 them NJ Exe CNA #1 was taken off the resident's assignment but remained on that nursing unit assisting other residents as well as having access to Resident #1. An interview with LPN #1 on 09/18/2025, revealed that Resident #1 was observed after the incident following CNA #1 around the unit in their wheelchair saying, 'NJ Ex Order 26, 4B1 Interviews with the U. S. FOIA (b) (2) and the U. S. FOIA (b) (2) on 09/18/2025, revealed that they were informed of the incident on NJ Exec Order 26.4b1 at approximately 5:00 AM or 6:00 AM, and that the U. S. FOIA told the U. S. FOIA (b) (2) to send CNA #1 home. The U. S. FOIA stated that during the investigation, it was determined that the incident occurred on NJ Exec Order 26.4b1 at 11:30 PM, and that staff should have reported it at that time and sent CNA #1 home. A review of CNA #1's timecard from NJ Exec Order 26.4b1, revealed that she clocked out on NJ Exec Order 26.4b1 at 6:03 AM. The U. S. FOIA (b) (2) was informed of the F 600 IJ and was provided the IJ template on 09/18/2025 at 4:50 PM. An acceptable Removal Plan (RP) was submitted on 09/22/2025 at 1:47 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient	F0000		10/18/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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: 315500	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE , VOORHEES, New Jersey, 08043

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F0000	Continued from page 1 practice to include CNA #1 was [redacted] on [redacted], pending an investigation, and received in-servicing on [redacted] upon her return to the facility on [redacted]. On 09/08/2025, the [redacted] physician, and family were notified. Resident #1 received a [redacted] and [redacted]), a [redacted] and their care plan was updated. On 09/08/2025, LPN #1 and the NS were [redacted] procedures, and on 09/18/2025, the [redacted] provided LPN #1 and the [redacted] with [redacted] training including: different forms, prohibiting, identifying, recognizing, compliance with reporting, prevention, and immediate response. On 09/18/2025, the [redacted] in-serviced the [redacted] on [redacted] and the [redacted] began educating all staff on [redacted]. All supervisors and managers were educated to send employees home immediately upon [redacted] of [redacted] or [redacted] The surveyor verified the implementation of the RP on-site during the continuation of the survey on 09/23/2025, and determined that the immediacy for F 600 was removed on 09/18/2025.	F0000		10/18/2025
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Complaint #: 2613158 Based on interviews, medical record review, and review of pertinent facility documents on	F0600	Facility Response Corrective Action Resident #1 experienced [redacted] by CNA #1 on [redacted]. The [redacted] ensured the safety and well-being of resident #1 who [redacted] by removing CNA #1 from the facility. CNA # 1 was [redacted] pending investigation [redacted] The [redacted] immediately initiated an [redacted] investigation into Resident # 1 [redacted]. Voorhees [redacted] were notified [redacted] number [redacted] Doctor and family made aware on 9/8/25. Resident #1 [redacted] checks were completed with no new findings assessed. [redacted] consultation obtained and completed.	09/24/2025

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F0600 SS = SQC-J	Continued from page 2 09/18/2025, it was determined that the facility failed to implement their NJ Exec Orde policy and procedure to ensure all residents were protected from NJ Exec Orde when a NJ Ex Order 26, 4B1 resident (Resident #1) NJ Exec Order the Certified Nursing Aide (CNA #1) NJ Ex Order 26, 4B1, and CNA #1 was taken off the resident's assignment, but remained on that nursing unit assisting other residents as well as having access to Resident #1. This deficient practice was identified for 1 of 3 residents reviewed (Resident #1). On 09/07/2025 at 11:30 PM, Resident #1 put on their call light, and CNA #1 responded to the resident's room. The Licensed Practical Nurse (LPN #1) heard Resident #1 NJ Ex Order 26, 4B1 and entered the resident's room. LPN #1 observed NJ Exec Ord on the resident's NJ Exec O and Resident #1 stated that CNA #1 NJ Ex Order . LPN #1 immediately reported it to the U. S. FOIA (b) (2), who removed CNA #1 from Resident #1's assignment, but kept them on the same nursing floor, which gave them access to Resident #1 as well as other residents. An interview with LPN #1 on 09/18/2025, revealed that Resident #1 was observed after the incident following CNA #1 around on the unit in their wheelchair saying, NJ Ex Order 26, 4B1." During an interview with the U. S. FOIA (b) (2) on 09/18/2025, the U. S. FOIA (b) stated that they were informed of the incident on NJ Exec Order 26.4b1, at approximately 5:00 AM or 6:00 AM, by the , and the U. S. FOIA (b) stated he told the U. S. FO to send CNA #1 home. The U. S. FOIA stated that during their investigation, it was determined that the incident occurred on 09/07/2025 at 11:30 PM, and staff should have reported it at that time and CNA #1 should have been sent home then. A review of CNA #1's timecard for 09/07/2025, revealed that they clocked out for their shift on NJ Exec Order 26.4b1 at 6:03 AM. The facility's failure to implement their NJ Exec Orde policy including protecting Resident #1 from NJ Exec Orde by not immediately removing CNA #1, who continued to work having access to Resident #1 and other residents until an investigation was completed, placed Resident #1 and all residents at risk for NJ Exec Orde This posed the likelihood of serious physical and psychosocial harm, or impairment which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 09/07/2025 at approximately 11:30 PM, after LPN #1 heard Resident #1 NJ Exec Orde that CNA #1 NJ Exec Orde their NJ Exec and NJ Exec O them NJ Exec and CNA #1 continued to work with other residents as well as	F0600	Continued from page 2 NJ Exec Order 26.4b1 consultation obtained and completed. Care plan updated to reflect incident. Incident reported to Department of Health and Ombudsman on 9/8/2025. CNA #1 received in-servicing on NJ Exec Orde upon return to facility NJ Exec Order 26 LPN #1 and U.S. FOIA (b)(6) received verbal education on procedure 9/8/25. Identification of At-Risk Residents: All residents residing in the facility have the potential to be affected by the deficient practice and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Systemic change: On 9-18-25, NJ Ex Orde provided re-education for the nursing supervisor and nurse #1 on the following: 1) Definition of Abuse 2) The different forms of abuse 3) Prohibit and prevent abuse, neglect and exploitation 4) Identifying what constitutes abuse, neglect, exploitation, and misappropriation of residents properly 5) Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators. 6) Compliance with Reporting process for abuse, neglect, exploitation and misappropriation of resident property, including injuries of unknown sources to their immediate supervisor and facility management. Documenting residents' medical record and obtaining statements from all individuals involved. Immediately reporting to immediate supervisor and discussing in morning meeting	09/24/2025

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F0600 SS = SQC-J	Continued from page 3 have access to Resident #1. The facility was notified of the IJ on 09/18/2025 at 4:50 PM. The facility submitted an acceptable Removal Plan (RP) on 09/22/2025 at 1:47 PM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 09/23/2025 at 12:15 PM. The evidence was as follows: A review of the facility's policy titled "Abuse, Neglect, and Exploitation" updated January 2025, included Policy: It is the policy of this facility to provide protections […] that prohibit and prevent abuse, neglect […] VI. Protection of resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation […] VII. Reporting/Response… 1. Reporting of all alleged violations that the to the Administrator, state agency… within specified timeframes… A review of the Facility Reported Event (FRE) dated [redacted] revealed the following: On the morning o[redacted], the [redacted] was informed that Resident #1 [redacted] that CNA #1 [redacted] the resident while care was being provided. It further indicated that LPN #1 witnessed the incident and stated that CNA #1 was the one that was [redacted] and [redacted] her by Resident #1. The FRE also revealed that CNA #1, "…was sent home and removed from the schedule while the investigation is ongoing." The FRE included a summary of the investigation created by the [redacted], which indicated that LPN #1 was in the room at the time of the incident and that CNA #1, "…acted accordingly, and within the norms of the facility's policies and standards of practice." A further review of the FRE included a written statement from CNA #1, which indicated that upon responding to a call bell for Resident #1, the resident became [redacted] after not hearing CNA #1 enter the room. CNA #1 then saw Resident #1 [redacted] and while attempting to get the resident to [redacted] Resident #1, [redacted] CNA #1 then indicated, "I left the room to go	F0600	Continued from page 3 and/or afternoon meeting. 7) Unusual occurrence types of and reporting 8) Recognition, prevention, and immediate response to allegations of abuse situations regardless of resident cognitive status or witnessed events impaired and appropriate interventions (such as sending accused staff members home to protect all the facility residents) etc... 9) All supervisors and managers were educated in sending employees home immediately upon allegations of abuse or neglect. [redacted] and LPN #1 received the education verbalize understanding by signing the Inservice as an acknowledgement of the education provided. On 9-18-25 and 9-19-25, [redacted] designee began facility wide re-education for all working staff on the following: 1) Definition of Abuse 2) The different forms of abuse 3) Prohibit and prevent abuse, neglect and exploitation 4) Identifying what constitutes abuse, neglect, exploitation, and misappropriation of residents properly 5) Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators. 6) Compliance with Reporting process for abuse, neglect, exploitation and misappropriation of resident property, including injuries of unknown sources to their immediate supervisor and facility management. Documenting residents' medical record and obtaining statements from all individuals involved. Immediately reporting to immediate supervisor and discussing in morning meeting and/or afternoon meeting. 7) Unusual occurrence types of and reporting 8) Recognition, prevention, and immediate response to allegations of abuse situations regardless of resident cognitive status or witnessed events impaired and appropriate interventions (such as	09/24/2025

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F0600 SS = SQC-J	Continued from page 4 get the nurse to assist me with the resident and make her aware of what happened." CNA #1's statement did not corroborate the FRE that indicated LPN #1 witnessed the incident since CNA #1 documented that she left the room to get [LPN #1] to assist her and make her aware of what just happened. According to the Admission Record face sheet (an admission summary), Resident #1 was admitted to the facility with diagnoses which included but were not limited NJ Ex Order 26, 4B1 [redacted] According to the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, 4B1 Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1, indicating the resident was NJ Ex Order 26, 4B1 . A review of Resident #1's Progress Notes (PN) revealed a Nursing Note dated NJ Ex Order 26, 4B1 [redacted] created by LPN #1, that described the incident that occurred. LPN #1's note included, [the] resident put on [their] call light, and [CNA #1] entered the room after knocking on the door. [The] resident [was] observed NJ Ex Order 26, 4B1 [redacted] r. [CNA #1] asked the [resident] NJ Ex Order [redacted]. [The] resident declined. The [CNA #1] left the room and called out to [LPN #1] for assistance with redirection to NJ Ex Order 26, 4B1 [The resident] NJ Ex Order 26, 4B1 at [CNA #1] to get out of their room, you cannot just enter my room pushing the NJ Exec Order 26 nto [CNA #1] NJ Ex Order 26, 4B1 NJ Ex O [redacted]. [LPN #1] directed [CNA #1] to remove self from room. A review of the Police Department's Incident Report, dated NJ Ex Order 26, 4B1, indicated that they responded to a report that a resident stated being NJ Ex Order 26, 4B1 [redacted] a staff member that morning. During an interview on 09/18/2025 at 10:07 AM, Resident #1 was observed lying in bed awake. The resident stated that staff had been treating them well and said no when asked if anyone had not been nice to them. Resident #1 then began talking about family visiting and the surveyor was unable to redirect to the details of the incident. On 09/18/2025 at 11:39 AM, the surveyor attempted to conduct a telephone interview with CNA #1, who	F0600	Continued from page 4 sending accused staff members home to protect all the facility residents) etc... 9) All supervisors and managers were educated in sending employees home immediately upon allegations of abuse or neglect. The staff who received the education verbalize understanding by signing the Inservice as an acknowledgement of the education provided. All newly hired staff will be educated during orientation by the U. S. FOIA (b) (2) . On 9-18-25 The U. S. FOIA (b) (2) educated the U. S. FOIA (b) (2) [redacted] on 1) Definition of Abuse 2) The different forms of abuse 3) Prohibit and prevent abuse, neglect and exploitation 4) Identifying what constitutes abuse, neglect, exploitation, and misappropriation of residents properly 5) Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators. 6) Reporting process for abuse, neglect, exploitation and misappropriation of resident property, including injuries of unknown sources to their immediate supervisor. Documenting in resident's medical record and obtaining statements from all individuals involved. Immediately reporting to immediate supervisor and discussing in morning meeting and/or afternoon meeting. 7) Unusual occurrence types of and reporting 8) Recognition, prevention, and immediate response to allegations of abuse situations regardless of resident cognitive status or witnessed impaired events and appropriate interventions (such as sending accused staff members home to protect all the facility residents) etc... The U. S. FOIA (b) (2) [redacted] received the education verbalizes understanding by signing the Inservice as an acknowledgement of the education provided.	09/24/2025

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F0600 SS = SQC-J	Continued from page 5 did not answer. On 09/18/2025 at 12:23 PM, the surveyor attempted to conduct a telephone interview with [redacted] who did not answer. During an interview on 09/18/2025 at 12:28 PM, with the [redacted], she stated that she was the facility's designated [redacted], and that once an [redacted] was reported, the staff involved were to be removed from work and that the [redacted] were to be called to ensure resident safety. The [redacted] stated that she was informed the next morning via a telephone call from the [redacted] and she could not recall the time. The [redacted] stated that LPN #1 was in the "hallway and witnessed it." The [redacted] continued that CNA #1 entered Resident #1's room and saw Resident #1 [redacted]. When CNA #1 questioned the resident why they were [redacted] The [redacted] stated LPN #1 was in the hallway, heard [redacted], and told CNA #1 to get out, and that was what was reported to her. The [redacted] further stated that the NS removed CNA #1 from Resident #1's assignment for the remainder of the shift. The [redacted] stated that while on the telephone, she asked the [redacted] to collect CNA #1's statement prior to her leaving. A review of CNA #1's timecard indicated that she clocked in on 09/07/2025 at 11:02 PM, and she clocked out at 09/08/2025 at 6:03 AM. During a joint interview with the [redacted] on 09/18/2025 at 2:09 PM, the [redacted] stated that any staff that witnessed or were informed of an [redacted] should immediately separate those involved to ensure the resident's safety. The [redacted] further stated that if a staff member was involved in the incident, that the staff member should be immediately sent home pending the outcome of the investigation. The [redacted] stated that the [redacted] and himself were notified of Resident #1's [redacted] against CNA #1 on [redacted] around 5:00 AM or 6:00 AM, via a group message. The [redacted] stated, "I immediately said get a statement and send her home." The [redacted] stated that it was phrased to her that the [redacted] was aware that the resident had a [redacted] and that since the incident was witnessed by LPN #1, she felt that the reassigning of CNA #1 would [redacted] the situation, but that CNA #1 should have been sent home at the time of the incident. When asked if the [redacted] had interviewed LPN #1 regarding the incident, she stated that no statement was collected because LPN #1 had written a Progress Note.	F0600	Continued from page 5 The Regional Director of Nursing or designee will conduct monitoring and tracking of all allegations of staff to resident abuse utilizing a form to ensure that appropriate interventions are in place per requirements of F600. Quality Assurance: The Regional Director of Nursing or designee will report all findings from the tracking form to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for the next 6 months, and initiate corrective actions based on identified trends. This will completed monthly for the next 6 months. The QA committee will review the effectiveness of the implemented corrective action quarterly over the next four quarters and determine if further action is needed or until such a time consistent substantial compliance has been met. This will be completed monthly for the next 6 months.	09/24/2025

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F0600 SS = SQC-J	Continued from page 6 During a telephone interview on 09/18/2025 at 2:28 PM, LPN #1 stated that she recalled the incident that occurred on [redacted], LPN #1 stated that at approximately [redacted], CNA #1 and herself were gathering supplies to [redacted] a resident, when Resident #1's call bell went off, and CNA #1 answered it. LPN #1 stated that when CNA #1 entered Resident #1's room, CNA #1 was no longer in her line of sight. LPN #1 further stated that she then heard [redacted] but could not recall the time span from when CNA #1 entered the room, to when she heard it. LPN #1 stated that when she looked into the room, she saw the resident standing with a walker, [redacted] that CNA #1 [redacted] [the resident's] [redacted] [the resident] up. LPN #1 stated that CNA #1 said that she was trying to [redacted] the resident get into [redacted] so that she could [redacted] the [redacted] LPN #1 then stated that based on the [redacted] made by the resident, she immediately notified the [redacted], who changed the assignments on the unit. LPN #1 further stated that after the reassignment, CNA #1 was no longer providing care to Resident #1 but remained on the unit, and she observed Resident #1 following CNA #1 around the unit while seated in a wheelchair, saying, [redacted] During a follow-up interview with the [redacted] and the [redacted] on 09/18/2025 at 4:00 PM, both stated that the reason a staff member should immediately be sent home after an [redacted] was to protect all residents, pending the outcome of the investigation. An acceptable Removal Plan (RP) was submitted on 09/22/2025 at 1:47 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate [redacted] deficient practice to include CNA #1 was suspended on [redacted] pending an investigation, and received in-servicing on [redacted] upon her return to the facility on [redacted]. On [redacted], the [redacted], physician, and family were notified. Resident #1 received a [redacted] and [redacted] ([redacted]), a [redacted], and their care plan was updated. On 09/08/2025, LPN #1 and the [redacted] were verbally educated on [redacted] procedures, and on 09/18/2025, the [redacted] provided LPN #1 and the [redacted] with [redacted] training including: different forms, prohibiting, identifying, recognizing, compliance with reporting, prevention, and immediate response. On 09/18/2025, the [redacted]	F0600		09/24/2025

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F0600 SS = SQC-J	Continued from page 7 U. S. FOIA in-serviced the U. S. FOIA (b) (2) on NJ Exec Orde and the U. S. FOIA began educating all staff on NJ Exec Orde. All U. S. FOIA (b) (2) were educated to send employees home immediately upon NJ Exec Order 26.4b1 of NJ Exec Orde or NJ Exec Order 26 The surveyor verified the implementation of the RP on-site during the continuation of the survey on 09/23/2025 at 12:15 PM. NJAC 8:39-4.1(a)(5)	F0600		09/24/2025

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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
F0000	INITIAL COMMENTS A revisit was conducted on 11/17/2025 in relation to the 09/23/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		11/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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