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 03/17/2026

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 #: 2716078, 2721239 Survey Date: 3/17/26 Census: 104 Sample Size: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		04/02/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F0842	Corrective Action Resident #1 [NJ Exec Order 26.4] resides in the facility. A closed record review was conducted. Identification of At-Risk Residents The facility determined that all residents have the potential to be affected by this deficient practice This can be identified by reviewing the medical records. Systemic Changes All nursing staff were re-educated on the facility policy for ADL documentation. Education was initiated by Staff Development on 3/18/2026 and will continue until completion. Certified Nursing Assistants (CNAs) were re-educated on the importance of completing ADL documentation prior to the end of each shift. Education was initiated on 3/18/2026 and will continue until completion. Education was initiated by Staff Development on 3/18/2026 and will continue until completion. Unit Managers and Nursing Supervisors will monitor	05/02/2026

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: 315500	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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F0842 SS = D	Continued from page 1 (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations	F0842	Continued from page 1 ADL documentation daily per shift to ensure completion prior to the end of each shift. The Director of Nursing (DON) or designee will monitor the clinical dashboard during the daily clinical morning meeting to ensure completion of ADL documentation. Quality Assurance / Monitoring 1. Director of Nursing or designee will monitor the clinical dashboard daily for ADL documentation completion for six months. A weekly audit will be completed for ADL documentation completion for six months. Any trends of non-compliance identified will receive corrective counseling and re-education immediately. 2. The audit findings will be reported to the QAPI meeting monthly and to the QA committee quarterly by the director of nursing. 3. The Director of Nursing or designee 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.	05/02/2026

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F0842 SS = D	Continued from page 2 conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT #2716078 Based on interviews, review of medical records and other pertinent facility documentation on 3/16/26 and 3/17/26, it was determined that the facility failed to maintain an accurate and complete medical record in accordance with acceptable professional standards of practice. This deficient practice was identified for 1 of 4 residents reviewed (Resident #1) and was evidenced by the following: Resident #1 was NJ Exec at the facility at the time of the survey. A closed record review was conducted. A review of the Admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. The comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 2, revealed a Brief Interview of Mental Status (BIMS) of NJ Ex out of 15, which indicated that the resident was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Further review of the MDS indicated that Resident #1 NJ Exec Order 26 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of Resident #1's care plan (CP), revealed NJ Exec related to the resident NJ Exec Or at NJ Exec for NJ Exec NJ Exec Order 26.4b1. Interventions for this focus included: checking for NJ Exec Order 26.4b1 routinely, offering NJ Exec Order 2 every 2-3 hours, and keeping the NJ Exec as NJ Exec Or and NJ Ex as possible. Further review revealed an additional focus related to the resident having NJ Exec Order 26.4b1. The resident also had a focus related to having a NJ Exec Order 26 NJ Exec Order 26.4b1 Interventions for this focus included the resident requiring NJ Exec Order 26.4b1 for NJ Exec Order 26 and all NJ Exec Order 26.4	F0842		05/02/2026

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F0842 SS = D	Continued from page 3 A review of Resident #1's "Documentation Survey Report v2" (DSR) for [NJ Exec Order 26.4b1] included that the following should be documented during each shift. There was no evidence of documentation on the following dates and shifts: [NJ Exec Order 26.4b1]: [NJ Exec] Night [NJ Exec] Day [NJ Exec] Day [NJ Exec] Evening & Night [NJ Exec] Evening [NJ Exec Order 26.4b1]: [NJ Exec] Night [NJ Exec] Day [NJ Exec] Day [NJ Exec] Night [NJ Exec] Evening [NJ Exec Order 26.4b1] [NJ Exec] Night [NJ Exec] Day [NJ Exec] Day [NJ Exec] Night [NJ Exec Order 26.4b] [NJ Exec] Night [NJ Exec] Day [NJ Exec] Day [NJ Exec] Evening & Night [NJ Exec] Evening	F0842		05/02/2026

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F0842 SS = D	Continued from page 4 A review of Resident #1's Progress Notes (PN) for the corresponding dates did not reveal any documentation related to the above tasks on the corresponding dates. During an interview on 3/17/26 at 6:14 PM with U.S. FOIA (b)(6) stated that certified nursing assistants were primarily responsible for assisting residents with toileting and incontinent care. further stated that they were to document all care provided in each resident's electronic medical record (EMR). further stated that documentation was important because it confirmed that care was completed. She stated that there should be no blanks and that it was the responsibility of each to verify that CNAs were documenting. During an interview on 3/17/26 at 6:33 PM with CNA #1, she stated that CNAs were primarily responsible for assisting residents with and care. CNA #1 stated that they were to document all care provided in each resident's electronic medical record (EMR). She stated that documentation was important because it communicated to everyone the type of care that the resident required and was provided. CNA #1 recalled to Resident #1 and stated that sometime they are so busy providing the care that she forgets to document what was actually done. During a joint interview with the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) on 3/17/26 at 7:25 PM, they both stated that CNAs were responsible for providing care and that they were expected to enter all care provided into each EMR. They further stated that documentation was important because it could signify that care was not provided. They further stated that nursing supervisors should be verifying that all care was documented. A review of the facility's undated "Charting and Documentation" policy revealed that all services provided to residents should be documented and that documentation should be complete and accurate. The policy listed what information was to be documented and included, "…Treatment or services performed…"	F0842		05/02/2026

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F0842 SS = D	Continued from page 5 N.J.A.C. 8:39-27.1(a)	F0842		05/02/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 5/5/26 in relation to the 3/17/26 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		05/05/2026

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