STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315500	A. BUILDING _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 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
F 000	INITIAL COMMENTS Complaint #: NJ 155511, NJ 156885, NJ 158428, NJ 159346, NJ 160533, NJ 163074, NJ 163435, NJ 167846 Survey Date: 1/26/24 Census: 100 Sample: 26+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Complaint #NJ00158428 Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to honor the recreational needs and preferences of a resident who was NJ Ex Order 26.4b1 [redacted] for their NJ Ex Order 26.4b1 [redacted] upon admission to the facility and was not assisted to NJ Ex Order 26.4b1 [redacted]. This deficient practice was identified for 1 of 1 residents (Resident #155) reviewed for accommodation of	F 558	F-558 COMPLETION DATE: 3/4/24 CORRECTIVE ACTION: ON 1/22/24, residents #155 was immediately provided with a NJ Ex Order 26.4b1 [redacted]. On 1/22/24, to ensure that all other residents are not affected by the deficient practice, a 100% audit was completed by the admissions director. No other issues found from the audit.	3/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/15/2024

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

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F 558	Continued From page 1 needs. This deficient practice was evidenced by the following: On 01/22/24 at 10:21 AM, the surveyors, who were accompanied by Certified Nursing Assistant (CNA) #1 during an NJ Ex Order 26.4b1 tour of dependent residents, observed Resident #155 lying in bed NJ Ex Order 26. Resident #155 immediately stated that he/she had not had a NJ Ex Order 26.4b1 for two to three days. The resident stated that they asked a couple of people, whose names were unknown by the resident, for a NJ Ex Order 26.4b1 and still had not NJ Ex Order 26.4b1. The resident stated that he/she had to NJ Ex Order 26.4b1 but NJ Ex Order 2 during that time. The surveyors observed the NJ Ex Order 26.4b1 and was set to NJ Ex Order 26.4b1. Review of the Admission Record (an admission summary) revealed that the Resident #155 was admitted to the facility with diagnosis which included but were not limited to: NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), and NJ Ex Order 26.4b1 . The Minimum Data Set (MDS), an assessment tool, was not yet completed and was not available for review. Review of a General Nurse's Note dated NJ Ex Order 26.4b1 at 6:41 AM, indicated that Resident #155 NJ Exec O Review of Resident #155's Care Plan revealed an entry dated NJ Ex Order 26.4b1, with a Focus of NJ Ex Order 26.4	F 558	IDENTIFICATION OF AT RISK RESIDENTS: All residents residing in the facility may be potentially at risk for the deficient practice. SYSTEMIC CHANGE: On 2/6/23, The Administrator and the Admission Director prior to admitting residents to the facility/room an will audit must be conducted through a checklist to ensure that the residents environment is reasonable for accommodation. On 2/4/24, the facility initiated a new system to have extra programed remote controls on each unit to ensue residents needs and preferences are met. Inservice completion 0n 2/12/24 QUALITY ASSURANCE (QA): The admissions director/designee will audit 5 resident rooms weekly x 4 weeks, Bi-weekly x 8 weeks and then monthly X3 months to ensure all residents are provided with a functional television remote control. Any issues from the audit will be addressed immediately and reported to the Administrator and the Director of Nursing as well as the QA committee quarterly for 6 months or until compliance is met.	

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F 558	Continued From page 2	F 558		

NJ Ex Order 26.4b1 The Goal included that resident would have the opportunity to enjoy NJ Ex Order 26.4b1 of choice through the next review date. The sole intervention included: Enjoys the following NJ Ex Order 26. [redacted], NJ Ex Order 26.4b1

During an interview with the surveyor on 01/22/24 at 12:14 PM, CNA #1 stated that when a resident's NJ Ex Order 26.4b1 was missing she ensured that they received a new one timely. CNA #1 stated that she had not worked over the past weekend.

During an interview with the surveyor on 01/22/24 at 2:19 PM, LPN/UM #1 stated that when a NJ Ex Order 26.4b1 was needed over the weekend all that staff had to do was inform the supervisor and a replacement NJ Ex Order 26.4b1 was then provided. LPN/UM #1 stated that it was "not fun" to be unable to NJ Ex Order 26.4b1 [redacted] when desired.

During an interview with the surveyor on 01/22/24 at 3:12 PM, the US FOIA (b)(6) [redacted]) stated that she would have expected that if a resident requested a NJ Ex Order 26.4b1, they would have received a NJ Ex Order 26.4b1. The US FOIA (b) [redacted] stated that staff could have reached out to Maintenance or herself if needed. The US FOIA (b) [redacted] stated that it was a resident right issue if a NJ Ex Order 26.4b1 was not provided when requested. The US FOIA (b) [redacted] stated that she did not have a policy that was directly related to resident NJ Ex Order 26.4b1 when requested.

During an interview with the US FOIA (b)(6) [redacted] he stated that if a resident needed a NJ Ex Order 26.4b1 over the weekend, all the staff needed to do was to call him to get

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F 558	Continued From page 3 another. Review of the policy, "Resident Rights" (Reviewed and Updated October 2023) revealed the following: Federal and state laws guarantee certain basic rights to all residents of this facility. These right include the resident rights to: A dignified existence, to be treated with respect, kindness and dignity,...Self-determination...	F 558		
F 641 SS=D	NJAC 8:39-27.1(a) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined that the facility faciled to accurately code the Minimum Data Set (MDS) for 3 of 29 residents reviewed, Residents # 94, #93, and #50. This deficient practice was evidenced by the following: 1. a. According to the Admission Record, Resident #94 was admitted to the facility with diagnosis which included but were not limited to NJ Ex Order 26.4b1 A review of the resident's progress notes dated, NJ Ex Order 26.4b1 at 11:30 AM, revealed that the resident's family member was present for NJ Ex Order 26.4b1	F 641	F-641 COMPLERTION DATE: 3/4/24 CORRECTIVE ACTION: Resident # 50 is a NJ Ex Order 26.4b1, MDSs (minimum Data set) were reviewed and modified on NJ Exec Order 26 to accurately code section NJ E to reflect the NJ Ex Order 26.4b1. Residents 93 and # 94 closed records reviewed and are no longer in the facility. To ensure other residents were not affected by the deficient practice, on 2/26/24, A 100 % audit was completed by the MDS coordinator/designee of all MDS assessment per the current ARD dates to ensure section O of the MDS is coded accurately IDENTIFICATION OF RESIDENT AT	3/4/24

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F 641	Continued From page 4 teaching and supplies were provided for NJ Ex Order care. Further review of the resident's progress notes dated, NJ Ex Order 26.4b1 at 12:02 PM revealed a discharge note that indicated that the resident was scheduled for discharge, and that prescriptions, paperwork, belongings and discharge instructions were given to the resident's family member. A review of the resident's discharge MDS dated NJ Exec Order 26.4b revealed that the MDS section NJ Exec Order Discharge Status was coded "NJ E", NJ Ex Order 26.4b1 instead of NJ Ex O" NJ Ex Order 26.4b1 . b. According to the Admission Record, Resident # 93 was admitted to the facility with diagnosis which included but were not limited to NJ Ex Order 26.4b1 A review of the progress notes dated NJ Ex Order 26.4b1 at 2:18 PM revealed that Resident # 93 went to the hospital from NJ Ex Order 26.4. Further review of the progress notes dated NJ Ex Order 26.4b1 at 7:11 PM revealed that the resident was admitted to the hospital for NJ Exec Order 26.4b1 A review of the resident's discharge MDS dated NJ Ex Order 26.4b1, indicated on section NJ Ex Order 26 Discharge Status that the resident was coded "NJ Ex" which was discharge to the NJ Ex Order 26.4b1 instead of NJ Ex O" NJ Ex Order 26.4b1 On 01/22/24 at 10:22 AM, the surveyor reviewed Resident #94's and Resident #93's medical record and MDS with the US FOIA (b)(6). The US FOIA (b)(6) stated she would have to	F 641	RISK. All residents may potentially be at risk for the deficient practice. This can be identified by reviewing the medical records. SYSTEMIC CHANGE: The US FOIA (b) was in- serviced on 2/4/24 by the Regional MDS coordinator on the facility policy and procedure on the proper assessment and accurately coding all sections of the MDS. QUALITY ASSURANCE: the Regional MDS coordinator will review Comprehensive and quarterly MDS assessments of 5 residents weekly X 4 weeks and then monthly x 5 months according to the MDS schedule calendar to ensure regulatory compliance. All findings will be addressed immediately and reported to the administrator, as well as the quality assurance committee for six months or until compliance is met.	

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F 641	Continued From page 5 complete a modification to correct the MDS's. c. According to the admission record, Resident # 50 was admitted with diagnoses which included but were not limited to [redacted] (NJ Ex Order 26.4b1 [redacted]), a [redacted] affecting the [redacted] and NJ Ex Order 26.4b1 with [redacted], a [redacted] affecting the [redacted]. A review of the physician order summary revealed an order for NJ Ex Order 26.4b1 [redacted] every shift for NJ Ex Order 26.4b1 dated [redacted]. A review of the medication administration records for NJ Ex Order 26.4b1 indicated that the [redacted] order was signed for on all three shifts from NJ Ex Order 26.4b1, through NJ Ex Order 26.4b1. A review of the MDS dated NJ Ex Order 26.4b1, section [redacted], NJ Ex Order 26.4b1 while a resident was not checked off as having been administered for the fourteen days prior to NJ Ex Order 26.4b1. On 1/24/223 at 12:42 PM the surveyor reviewed Resident #50's medical record and MDS with the US FOIA (b)(6). The US FOIA (b)(6) stated that Resident #50 was on [redacted] during that time, and she would modify the MDS to reflect same. A review of a facility policy titled; "Resident Assessments", reviewed and updated October 2023, included that all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. N.J.A.C. 8:39-11.1	F 641		

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F 658 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 observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to follow professional standards of nursing practice by incorrectly transcribing a physician's order for NJ Ex Order 26.4b1. This deficient practice was identified for 1 of 2 residents (Resident #90) reviewed for NJ Ex Order 26.4b1 This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimen 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 state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	F-658 Completion date: 3/4/24 CORRECTIVE ACTION- Resident # 90 medical record was reviewed for deficient practice. On NJ Exec O an order was obtained by staff nurse from the physician for NJ Ex Orde and NJ Ex Order 26.4b1 levels, results were reported to MD. On NJ Exec Order 26.4b level was done and levels purported to the physician. The affected resident did not have NJ Ex Order 26.4b1 from the deficient practice. IDENTIFICATION OF AT RISK RESIDENTS; All residents are potentially at risk for the deficient practice. This can be identified by reviewing the physician orders. SYSTEMIC CHANGE: On 2/5/24, the Director of Nursing (DON)/ designee started an in-service education program for all licensed staff regarding the standards of clinical practice for obtaining and carrying out the physician order in a timely frame for laboratory orders per the facility policy and to ensure regulatory compliance. Completion of Inservice 2/21/24 The copy of the order receipt will be	3/4/24

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F 658	Continued From page 7 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 1/17/24 at 11:21 AM, the surveyor observed Resident #90 lying NJ Ex Order 2 in bed. The resident stated to the surveyor NJ Ex Order 26.4b1 A review of the Admission Record reflected that Resident #90 was admitted to the facility in with diagnoses which included, but not limited to: NJ Ex Order 26.4b1 (NJ Ex Order 26.4 NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b). A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ Ex Order 2, identified that Resident #90 had a Brief Interview for Mental Status (BIMS) score of NJ out of 15 indicating NJ Ex Order 26.4b1 , and dependent on staff for NJ E . A review of the resident's individualized resident-centered care plan initiated on NJ Ex Order 26.4b1, included a focused care area of NJ Ex Order 26.4b1, with interventions including NJ Ex Order 26.4 work as ordered and report results and follow up as needed. A review of Resident #90's progress notes (PN) revealed a NJ Ex Order 26.4b1 change noted by the	F 658	placed in the Unit Manger (UM) /supervisor mailbox for review and to ensure the order is carried out. QUALITY ASSURANCE: The Director of Nursing Services/designee will audit 10 records per week for 1 month then 5 records every 2 weeks for 2 months, 5 randomly monthly for 3 months to ensure services Provided to Meet Professional Standards for Laboratory orders are carried out and the results are reported to the physician in a timely frame. Discrepancies from the audit will be address immediately and reported to the Administrator as well as the Quality Assurance /QAPI Committee quarterly for 2 quarters or until such a time consistent substantial compliance has been met.	

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US FOIA (b)(6) dated NJ Ex Order 26.4b1 at 2:44 PM indicating Resident #90 had a NJ Ex Order 26.4b1 of NJ Ex Order 26.4b1 of NJ Ex Order 26.4b1 in one month and was put on a regular NJ Ex Order 26.4b1. The US FOIA (b)(6) recommended a new order for NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) by mouth twice a day to provide NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

A review of the physician's "order summary report" (POS) indicated an order with an order date of NJ Ex Order 26.4b1 for NJ Exec O, NJ Exec O, and NJ Ex Order 26.4b1 n labs to be drawn NJ Ex Order 26.4b1 and NJ Ex Order 2.

A review of a PN dated NJ Exec Orde at 2:07 PM, indicated the US FOIA (b)(6) assessed Resident #90, and a NJ Ex Order 26.4 note was initiated stating Resident #90 continued to show an NJ Ex Order 26.4b1, and the US FOIA (b)(6) again recommended labs for NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

Further review of physician's orders indicated an order dated NJ Ex Order 2 at 2:05 PM for a physician's verbal order for NJ Ex Orde and NJ Ex Order 26.4b1.

Review of Resident #90's laboratory medical records revealed new lab results for NJ Ex Orde and NJ Ex Order 26.4b1 collected on NJ Ex Order 26.4b1 and NJ Exec O with collection date of NJ Ex Order 26.4b

On 1/23/24 10:50 AM, the surveyor interviewed Licensed Practical Nurse/Unit

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Manager #1 (LPN/UM1) on who confirmed Resident #90 was on her unit when the labs were ordered and stated that "it was not carried out."

On 1/23/24 at 10:44 AM, the surveyor interviewed Resident #90's attending physician ([US FOIA (b)(6)] who reviewed his notes and was unable to find the lab results.

On 1/23/24 at 12:57 PM, the surveyor interviewed the [US FOIA (b)(6)]) who confirmed that the labs were not collected as recommended and ordered because they were not transcribed correctly.

On 1/24/24 at 10:50 AM, the surveyor conducted a phone interview with the [US FOIA (b)(6)]. The [US FOIA (b)(6)] stated that on [NJ Ex Order 26.4b1] she recommended labs "then nurses took it from there." The [US FOIA (b)(6)] further stated she followed up to review the lab results on [NJ Exec Order 2] and "saw it was not there."

On 1/26/24 at 9:51 AM, in the presence of the survey team and the facility's administration, the [US FOIA (b)(6)] stated that she "cannot deny that the labs were missed."

Review of the facility policy titled, "Laboratory Service and Reporting" with a revised date October 2023, included but was not limited to: "the facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The facility must provide or obtain services to meet the needs of the residents. The facility is responsible for the appropriateness of the laboratory services."

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F 658	Continued From page 10 NJAC 8:39 27.1(a)	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint #NJ00158428 Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure that NJ Ex Order 26.4b1 care was provided to dependent residents in a timely manner for 2 of 4 residents (Residents #54 and #156) observed for NJ Ex Order 26.4b1 care on 1 of 2 nursing units (NJ Exec Order 26.4b1 and for 1 of 3 residents (Resident #20) reviewed for NJ Exec Order and NJ Exec Order 26 NJ Exec Order 26.4b1 on 1 of 2 nursing units (NJ Exec Order 26 Floor). This deficient practice was evidenced by the following: 1. During an interview with the surveyor on 01/22/24 at 9:40 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 stated that the census on the unit was 42 and there were four Certified Nursing Assistants (CNAs) and three nurses present on the unit to provide resident care. On 01/22/24 at 9:44 AM, the surveyors completed an NJ Ex Order 26.4b1 tour on the NJ Exec Order 26.4b1 Unit and observed the following:	F 677	F-677 C0MPLETION DATE: 3/4/24 CORRECTIVE ACTION: on 1/22/24, NJ Ex Order 26.4b1 care was immediately provided for Resident # 154 and #156. Bothe residents did not have NJ Ex Order 26.4b1 from the deficient practice. Resident # 20 medical record reviewed by the Director of Nursing for the deficient practice. On 1/25/24, a facility wide service was completed by the Assistant Director of nursing on call bell response time. IDENTIFICATION OF AT RISK RESIDENTS: All residents residing in the facility may be potentially at risk for the deficient practice. . SYSTEMIC CHANGE: On 2/6/24, The Assistant Director of Nursing (ADON) started in- servicing education program for all certified nursing assistants to include C.N.A #2 on the facilitys Care policy for Activity of Daily Living (ADL) for dependent residents to include, grooming,	3/4/24

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AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 08043

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F 677	Continued From page 11 During an interview with the surveyor on 01/22/24 at 9:44 AM, Certified Nursing Assistant (CNA) #1 stated that she worked at the facility for NJ Ex Orde years and was assigned to 10 residents. CNA #1 stated that she had not yet completed her AM care. During an interview with the surveyor on 01/22/24 at 10:58 AM, CNA #2 stated that she worked at the facility for NJ Ex Order 2 months and was assigned to 12 residents. CNA #2 stated that she had not yet completed her AM care and agreed to allow the surveyors to observe care rendered to residents who were dependent for NJ Ex Order 26.4b1 care. On 01/22/23 at 11:00 AM, the surveyors accompanied CNA #2 into Resident #154's room. The US FOIA (b)(6)) was in the room and was observed attempting to adjust the bed controls for the resident. The surveyor observed a NJ Ex Order 26.4b1 within the resident's room. The resident NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . CNA #2 left the room and returned with a cup of ice water. The US FOIA (b) also left the room and returned with a beverage for the resident and then proceeded to leave the room. The resident granted permission for the surveyors to observe NJ Ex Order 26.4b1 care. At 11:04 AM, when CNA #2 informed the resident that she intended to NJ Ex Orde the resident. Resident #154 stated, "Getting NJ Ex Order 26.4 was a first." At 11:15 AM, CNA #2 NJ Ex Order 26.4b1 Resident #154's NJ Ex Orc and proceeded to NJ Ex Order 26.4b1 . CNA #2 stated that the resident was new to her and she had not cared for the resident prior to this observation.	F 677	personal and oral hygiene. On 2/6/24, Unit managers/ supervisors were educated to do frequent rounding regularly to validate cares being completed as required in a timely manner to meet the needs and preferences of the residents. On 2/6/24, Facility wide staff in-service started again on call bell response time per the facility policy to include: All department must respond to residents call bell in a timely manner. The call bell should not be turned off until the need of the resident is met. If in the event the staff who responded to the residents call bell cannot provide particular care, the staff must report immediately to the unit supervisor for prompt intervention. Completion of all Inservice is 2/21/24. QUALITY ASSURANCE (QA): The Unit Managers on each unit will or designee will conduct 5 random audits per week for 4 weeks, bi weekly X4 weeks and then monthly 4 months to ensure showers and personal cares provided in a timely manner The Director of Nursing Services, or designee, will conduct a random incontinence audit of residents on at least 2 residents per week for 2 months and then bi weekly 1 month and then monthly X3 months. The Administrator /designee will do a random audit of call bells audits on 5 rooms weekly X 8 weeks, biweekly X 4 Weeks, and then monthly X 3 months. Any issues from the audits will be addressed immediately and reported to	

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F 677	Continued From page 12 At 11:17 AM, CNA #2 NJ Ex Order 2 Resident #154 NJ Ex Order 26.4b1 and the surveyor observed that the NJ Ex Order 26.4b1 . CNA #2 stated that the resident's NJ Ex Order 26.4b1 NJ Ex Order 26.4b1) was NJ Ex Order 26.4b1. When CNA #2 moved the NJ Ex Order 26.4b1 and the surveyor noted that the NJ Ex Order 26.4b1 that covered the mattress was NJ Ex Order 26.4b1 . When the surveyor asked CNA #2 what the NJ Ex Order 26.4b1 represented she stated that it meant that the resident had NJ Ex Order 26.4b1 . The resident stated that he/she was not always NJNJ Ex Order when he/she was NJ Ex Order 26.4b1 CNA #2 stated that there was NJ Ex Order 26.4b1 in the resident's room to NJ Ex Order 26.4b1 . Review of Resident #154's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included: NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1). The surveyor attempted to review Resident #154's Admission Minimum Data Set (MDS), an assessment tool, which was not yet completed or available for review. Review of Resident #154's Progress Notes (PN) revealed an entry dated NJ Ex Order 26.4b1 at 01:43 AM, which revealed that the resident required extensive assistance with NJ Ex Order 26.4b1 . Further review of the PN revealed that there was no documented evidence to indicate that the resident had refused care on NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 .	F 677	the Administrator and DON as well as the Quality assurance Committee quarterly for 6 months or until compliance is met.	

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F 677	Continued From page 13	F 677		

Review of Resident #154's Care Plan revealed an entry dated [redacted], NJ Ex Order 26.4b1, Goal included: Will be NJ Ex Order 26.4b1 related to [redacted] through the next review date. Interventions included: NJ Ex Order 26.4b1 [redacted] thoroughly before NJ Ex Order 26.4b1 ([redacted]) after each episode of [redacted].Provide [redacted] care upon arising, before and after meals, at bedtime and as needed to help promote NJ Ex Order 26.4b1.

Review of Resident #154's CNA Task Report revealed that the resident's assigned CNA documented that [redacted], NJ Ex Order 26.4b1, and [redacted] care was signed as completed on [redacted] at 2:06 AM. There was no documented evidence that [redacted], [redacted], and [redacted] was documented as completed after 18:23 (6:23 PM) on [redacted].

During an interview with CNA #2 on 01/22/23 at 11:37 AM, CNA #2 stated that while she had not observed any other residents NJ Ex Order 26.4b1 today, it was typical to find residents who were [redacted] when she reported to duty in the morning.

On 01/22/24 at 11:39 AM, the surveyors accompanied CNA #2 into Resident #156's room. CNA #2 stated that someone must have started the resident's care because there was a [redacted] and the NJ Ex Order 26.4b1. When interviewed at that time, Resident #156 stated that he/she reported that he/she needed to be [redacted] an [redacted] prior. CNA #2 stated that no one had told her that the resident awaited care. The resident agreed to permit the surveyors to

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F 677	Continued From page 14 observe NJ Ex Order 26.4b1 care. At 11:46 AM, CNA #2 NJ Exec Order 26.4 Resident #156's NJ Ex Ord which was NJ Ex Order 26.4b1. When the surveyor asked the resident when he/she was last NJ Ex Order 26.4b1 the resident stated that it had NJ Ex Orde . CNA #2 stated that the resident's NJ Ex Ord was NJ Ex Order 26.4b1 The NJ Ex Order 26 beneath the resident the resident were noted to be NJ Ex Order 26.4b1 . At that time, the resident requested to use a NJ Ex Order 26.4b1 . At 11:51 AM, the surveyor asked CNA #2 to call LPN/UM #1 into Resident #156's room. LPN/UM #1 presented and observed the resident's NJ Ex Ord and NJ Ex Order 26 with the surveyors and she stated that they were NJ Ex Order 26.4b1 LPN/UM #1 stated that they were NJ Ex Order 26.4b1, and the NJ Ex Order 26.4b1. When the surveyor asked what the NJ Ex Order 26.4b1 meant LPN/UM #1 stated that it meant that the resident was NJ Ex Order 26.4b1 and needed to be NJ Ex Order 26.4b1 The surveyor asked LPN/UM #1 if she noted any NJ Ex Ord ? LPN/UM #1 stated that she was NJ Ex Order 26.4b1 anything as she wore a surgical mask. The surveyor noted a NJ Ex Order 26.4b1 with mask usage. CNA #2 who was present and also wore a mask stated, "the NJ Ex Orde was NJ Ex Order 26.4 LPN/UM #1 stated that it was unusual to find residents NJ Ex Order 26.4b1. When interviewed at that time, LPN/UM #1 was unsure of the state mandated CNA staffing rations and deferred any further questions regarding staffing to the staffing coordinator. Review of Resident #156's Admission Record revealed that the resident was admitted with diagnosis which included but were not limited to: NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1	F 677		

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F 677	Continued From page 15 NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1). Review of Resident #156's Admission MDS revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which meant that the resident was [redacted]. Further review of the assessment revealed that the resident was occasionally NJ Ex Order 26.4b1 and frequently NJ Ex Order 26.4b1. Review of Resident #156's Care Plan revealed an entry dated [redacted], with a Focus of [redacted] which detailed that interventions included: ...Offer NJ Ex Order 26.4b1 care upon arising, before and after meals, at bedtime and as needed to help promote NJ Ex Order 26.4b1 ... Review of Resident #156's CNA Task Report revealed that there was no documented evidence that [redacted] NJ Ex Order 26.4b1 or [redacted] care was rendered on [redacted] as the entries were left blank and were not signed out as completed to indicate that care was rendered. During a later interview with the surveyor on 01/22/24 at 2:19 PM, LPN/UM #1 stated that NJ Ex Order 26.4b1 rounds should be done every two hours unless needed sooner. LPN/UM #1 stated that if CNA #2 did not [redacted] the residents prior to the NJ Ex Order 26.4b1 tour, then the 11-7 shift did resident [redacted] before they left at 6:30 AM.	F 677		

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LPN/UM #1 stated that she arrived at the facilty today at 5:45 AM and there were three CNAs and two nurses assigned to work overnight. LPN/UM #1 stated that the nursing staff who worked on the unit today were from the [redacted] floor nursing unit and were not usual staff.

During an interview with the surveyor on 01/22/24 at 3:12 PM, the [redacted] stated that if a resident were a "typical [redacted]" then they should be checked for NJ Ex Order 26.4b1 every two hours. If the resident were a "heavy [redacted]" than the resident should be checked more frequently. [redacted] stated that the CNA should round every two hours if they were not familiar with the residents. The [redacted] stated that if the [redacted] were NJ Ex Order 26.4b1, then it must have exceeded a period of two hours since the resident NJ Ex Order 26.4b1. The [redacted] stated that she would have expected for there to have been NJ Ex Order 26.4b1 in use for [redacted] residents as it was a standard of practice and did not require a doctor's order.

2. During the initial tour of the facility on 01/17/24 at 11:29 AM, the surveyors observed Resident #20 lying in bed [redacted]. The resident stated that approximately one week ago, he/she [redacted] after the call bell was not answered for one half hour. The resident stated that the incident was reported to the "executor", who the resident could not identify by name. The resident stated that he/she went to the Resident Council Meeting but was NJ Ex Order 26.4b1 to mention the incident.

Review of Resident #20's Admission Record revealed that the resident was admitted with diagnosis which included but were not limited to: NJ Ex Order 26.4b1 ([redacted]) [redacted]

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F 677	Continued From page 17 (NJ Ex Order 26.4b1) and NJ Ex Order 26.4 Review of Resident #20's most recent Minimum Data Set (MDS) revealed that the resident's Brief Interview for Mental Status (BIMS) score was NJ Ex out of 15 which indicated that the resident was NJ Ex Order 26.4b1. Further review of the MDS revealed that the resident was frequently NJ Ex Order 26.4b1 . Review of Resident#20's Care Plan revealed an entry dated NJ Ex Order 26.4b1, with a Focus of NJ Ex Order 26.4b. The Goal included: NJ Ex Order 26.4b needs will be met through the next review date. Interventions included: Needs NJ Ex Order 26.4b1 with NJ Ex Order 26.4, Assist NJ Ex Order 26.4b1 upon arising, before and after each meal, before bedtime and as needed, Remind me to use the call bell when assistance is needed to get up to NJ Ex Order 26.4 ... On 01/22/24 at 9:27 AM, the surveyor requested all incident/accident reports that pertained to Resident #20 and there were none. During an interview with the surveyors on 01/23/24 at 9:43 AM, Certified Nursing Assistant (CNA) #3 stated that a NJ Exec Order 26.4b1 ago Resident #20 rang the call bell and was NJ Ex Order 26.4b1. CNA #3 stated that the resident was NJ Ex Order because he/she had to NJ Ex Order t. When the surveyor asked CNA #3 if she reported the incident she stated, "Everybody knew" as the resident was NJ Ex Order 26.4b1. CNA #3 stated that she did not report the event herself. CNA #3 further stated that the resident was NJ Ex Order 26.4b1 at times.	F 677		

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F 677	Continued From page 18 During an interview with the surveyors on 01/23/24 at 10:08 AM, Licensed Practical Nurse/Unit Manager (LPN/UM) #2 stated that she was not aware of an incident that involved Resident #20 being NJ Ex Order 26.4b1 due to NJ Ex Order 26.4b1 [redacted]. LPN/UM #2 stated that call bells should be answered within the first five seconds with no time delay because anyone could answer the call bell to see what the resident needed. On 01/23/24 at 10:23 AM, LPN/UM #2 questioned CNA #3 regarding the incident in the presence of the surveyors. CNA #3 stated that a couple of weeks ago the call bell went off and the resident was NJ Ex Order [redacted] because he/she had an NJ Ex Order 26.4b1 [redacted]. CNA #3 stated that the resident informed her that someone came into the room and told the resident that someone would be in to assist the resident. CNA #3 stated that she knew that she was supposed to let the nurse know, but she was unsure who she may have reported the incident to. During an interview with the surveyor on 01/23/24 at 1:40 PM, the US FOIA (b)(6) [redacted]) stated that the call bell response time should be within ten to fifteen minutes and staff should not shut off the call bell. US FOIA (b) [redacted] explained that staff should try and find the nurse, the US FOIA (b)(6) or herself so that we could address the issue. Review of the facility policy, "Incontinence" (Implemented 12/13/22) revealed the following: ...Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.	F 677		

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F 677	Continued From page 19 NJAC 8:39-27.1(a), 27.2 (h)	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint NJ 00163435 Based on interviews, record review, and review of facility documentation, it was determined that the facility failed to follow their policies and procedures for documenting and investigating accidents and incidents for 1 of 2 residents reviewed for accidents (Resident #148). This deficient practice was evidenced by the following: According to the Admission Record, Resident # 148 was admitted to facility with diagnoses that included but not limited to NJ Ex Order 26.4b1 ([redacted] NJ Ex Order 26.4b1 [redacted]). Review of Resident #148's Discharge minimum data set (MDS), an assessment tool dated NJ Ex Order 26.4 indicated a brief interview of mental status (BIMS) of [redacted], indicating NJ Ex Order 26.4b1. The MDS also revealed that Resident #148	F 689	F-689 Completion date: 3/4/24 CORRECTIVE ACTION: Resident # 148 closed records reviewed; no corrective action for this resident as they no longer reside in the facility. To ensure that there were no other residents affected by the deficient practice, on 1/28/24, 100% audit for all documented incident and accident reports for January 2024 was completed by the US FOIA (b)(6) [redacted] services. No issues were found from the audit. IDENTIFICATION OF AT RISK RESIDENTS: All resident residing in the facility are potentially at Risk for the deficient practice. SYSTEMIC CHANGE: On 2/4/24, the Director of Nursing (DON) initiated an in service for all the nursing staff on the facility policy on the importance of completing an accident incident report	3/4/24

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F 689	Continued From page 20 received NJ Ex Order 26.4b1 for activities of daily living (ADLs) except NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1; always NJ Ex Order 26.4b1, and NJ Ex Order 26. with NJ Ex . On 01/23/24 at 12:04 PM, the surveyor interviewed the US FOIA (b)(6)) who stated there were no reportable events and no incidents while Resident #148 was in facility. Further record review revealed a physician note dated NJ Ex Order 26.4 at 1:10 PM, documented as a late note, which included that the resident was NJ Ex Order 26.4b1 by a US FOIA (b)(6) on NJ Ex Order 26.4. Resident #148 stated the resident NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . Review of progress note dated NJ Ex Order 26.4 at 9:32 PM revealed: "post NJ Ex Order 26. NJ Ex Order 26.4b1 during the shift. NJ Ex Order 26.4b1. will continue to monitor. call bell within reach." Review of progress note dated NJ Ex Order 26.4 at 5:13 AM revealed: "post NJ Ex Order 26.4b1 . NJ Ex Order 26.4b1 during the shift. NJ Ex Order 26.4b1 ordered.no NJ Ex Ord noted during the shift. will continue to monitor." There was no further documentation of the description of the resident's NJ Ex O or NJ Ex Order 26.4 assessment in the electronic medical record, nor in the paper closed record. On 01/25/24 at11:00 AM, the surveyor interviewed the US FOIA (b) who stated that NJ Ex Order 26.4 assessment was to be completed on the resident's incident report. She further stated that	F 689	immediately upon occurrence to ensure regulatory compliance. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit to the Director of Nursing Services. Incident/Accident reports will be reviewed daily at clinical meetings for trends related to accidents and implement appropriate interventions. In-service completion 2/21/24. Quality Assurance (QA): DON/designee will audit all documented incidents and accidents daily for completion of incident reports per the facility. Any issues found from the audit will be addressed immediately and reported to the administrator as well as the QA Committee quarterly for six months.	

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AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 08043

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the nurses usually write a note and the [NJ Ex] and [NJ Ex Order 26.4] assessment should have been documented in the electronic medical record.

During a follow up interview on 01/26/24 at 09:54 AM, the [US FOIA (b)] stated that on [NJ Ex Order 26.4] the facility switched facility names and the Electronic Medical Record system. She stated there was a twelve-hour period where neither system was available for documentation at the time of the [NJ Ex C] Staff was informed to use paper for any needed documentation during the EMR downtime. She also stated that she spoke with the nurse, the aide, and the supervisor that were on at that time and none remember incident and/or whether a paper incident report was completed. The [US FOIA (b)] confirmed that an incident report for Residen'ts #148's [NJ Ex] was not completed, and that there shoud have been documentation in the medical record regarding the resident's [NJ Ex C]

Review of policy "Incidents and Accidents" implemented on 01/27/23, included:
"It is the policy of this facility for staff to utilize Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident...The following incidents/accidents require an incident/accident report but are not limited to: fall...Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so ...The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital...The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and

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will document all pertinent information...Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions."

Review of policy "Accidents and Incidents - Investigating and Reporting", reviewed and updated October 2023, provided by the DON on 1/25/24 included:
"The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident."
"The following data, as applicable, shall be included on the Report of Incident/Accident form: The date and time the accident or incident took place; The nature of the injury/illness; The circumstances surrounding the accident or incident; Where the accident or incident took place; The name(s) of witnesses and their accounts of the accident or incident; The injured person's account of the accident or incident; The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions; The date and time the injured person's family was notified and by whom; The condition of the injured person, including his/her vital signs; The disposition of the injured ...."
"The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services."
The Director of Nursing shall ensure that the Administrator receives a copy of the Report of Incident/Accident form for each occurrence."
"Incident/Accident reports will be reviewed by the Safety committee for trends related to accident or

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F 689	Continued From page 23 safety hazard in the facility and to analyze any individual resident vulnerabilities." Review of policy "Documentation in Medical Record, updated October 2023, provided by the DON on 1/25/24 included: "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. NJAC 8:39-27.1(a)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		3/4/24

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F 690	Continued From page 24 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Complaint #NJ00156885 Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure NJ Ex Order 26.4b1 care was provided to prevent NJ Ex Order 26.4b1. This deficient practice was identified for 1 of 5 residents (Resident #155) reviewed for NJ Ex Order 26.4b1 care. This deficient practice was evidenced by the following: On 01/22/24 at 10:21 AM, the surveyors observed Certified Nursing Assistant (CNA) #1 as she provided NJ Ex Order 26.4b1 care to Resident #155 with resident permission. The surveyors observed that the resident had an NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . On 01/22/24 at 10:48 AM, CNA #1 used	F 690	F-690 COMPLETION DATE: 3/4/24 CORRECTIVE ACTION: Resident #155 medical record was reviewed by the US FOIA (b)(6)) for deficient practice. The resident did not have NJ Ex O from the deficient practice. On 1/22/24 C.N.A #1 (Certified Nursing Assistant) was immediately in-serviced by the Infection Control Preventionist (IP) on the facility□s Practice Guideline for perineal care through competency and return demonstration. IDENTIFICATION OF AT RISK RESIDENTS: All residents that have been identified as incontinent according to section H of the MDS (Minimum Data Set) may be potentially be affected by the deficient practice SYSTEMIC CHANGE: On 2/4/24, The	

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F 690	Continued From page 25 [redacted] as she proceeded to [redacted] and [redacted]. CNA #1 then used a [redacted] to [redacted] and [redacted]. CNA #1 then proceeded to [redacted] the resident [redacted]. CNA #1 then [redacted] and [redacted] and proceeded to [redacted] Review of Resident #155's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: [redacted] . Resident #155's Minimum Data Set (MDS), an assessment tool, was not completed or available for review. Review of Resident #155's Care Plan revealed an entry dated [redacted], with a Focus that included: [redacted]. The Goal was for no complications related to [redacted] through the next review date. The Interventions included: Current [redacted], and observed for any of the following: increased [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] or [redacted], change in [redacted] or [redacted] etc...Administer [redacted] as ordered by the physician. Assess effectiveness and notify the physician if symptoms are not resolving. During an interview with the surveyor on 01/22/24	F 690	Assistant Director of Nursing (ADON) started in servicing all certified nursing assistants to include C.N.A #1 on the facilitys Perineal Care policy. In-service training included observation of each nursing assistant performing the procedure. A Competency Checklist was completed for each individual observed to determine if the individual was performing the procedure correctly. Findings were reviewed with each nursing assistant. Corrective action was provided as needed. Quality Assurance (QA): The Director of Nursing (DON), or designee, will complete random weekly competency checklists of 3 nursing assistants performing perineal care for 8 weeks to ensure nursing assistants are performing perineal care in accordance with our facilitys Practice Guideline. competency checklists will be reported to the Administrator and DON for review as well as the Quality Assurance/QAPI Committee for 2 quarters or until such time consistent substantial compliance has been achieved as determined by the committee.	

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at 12:14 PM, the surveyor interviewed CNA #1 who stated that she provided [redacted] with [redacted]. CNA #1 stated that she was required to [redacted] because if you [redacted] you could cause the resident to [redacted]. CNA #1 stated that she had not recalled that she used improper technique of [redacted] during the observation.

During an interview with the surveyor on 01/22/24 at 2:19 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) #1 stated that when care was provided staff were required to [redacted] or it would be possible for the resident to [redacted].

During an interview with the surveyor on 01/22/24 at 3:12 PM, the [redacted]) stated that when care was provided the aide was required to [redacted].

During an interview with the surveyor on 01/24/24 at 10:59 AM, the [redacted] stated that the correct way to perform care was to [redacted] to prevent [redacted] infection that could be introduced if the resident were [redacted].

Review of the facility policy, "Perineal Care" (Implemented 12/14/2022) revealed the following: It is the practice of this facility to provide perineal care to all incontinent residents during routine

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F 690	Continued From page 27 bath and as needed to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Perineal care refers to the care of the external genitalia and anal area. ...Wet washcloth and apply perineal cleanser. If using prepackaged product, open package and...cleanse the perineum...wiping in direction from front to back (from pubic area toward anus)... NJAC 8:39-27.1(a)	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined that the facility failed to a.) ensure appropriate storage for NJ Ex Order 26.4b1 equipment and b.) obtain a physician's order for a NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1). This deficient practice was identified for 1 of 3 residents reviewed for NJ Ex Order 26.4b1 equipment (Resident #31) and was evidenced by the following: On 1/18/24 at 9:53 AM, the surveyor toured the NJ Exec Order 26.4b unit and entered Resident #31's room.	F 695	F 695 COMPLETION DATE: 3/4/24 CORRECTIVE ACTION- Resident # 31 medical record was reviewed for deficient practice. On NJ Exec Order 26, an order was obtained from the resident□s physician for the NJ Ex Order 26 administration. NJ Ex Order 26.4b1 was noted from the deficient practice. On NJ Exec Order 26, the NJ Ex Order 26.4b1 for the NJ Ex Order 26.4b1 was replaced with a new	3/4/24

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F 695	Continued From page 28 Resident #31 was NJ Ex Order 2[redacted] and in bed. The surveyor observed the resident's NJ Ex Order 26.4b1 face down on top of the NJ Ex Order 26.4b1. There was a NJ Ex Order 26.4b1 that was hung from the side of NJ Ex Order 26.4b1. The surveyor observed a NJ Ex Order 26.4b1 placed on the resident's side table with a NJ Ex Order 26.4b1 [redacted]. At that time, the surveyor interviewed Resident #31 who stated she/he received his/her NJ Ex Order 2[redacted] every night since readmission to the facility on NJ Ex Order 26.4b1 and the NJ Ex Order 26.4b1 was removed daily by the 05:00 AM nurse. The surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN1) regarding usage of NJ Ex Order 2[redacted] who stated nursing staff have been applying NJ Ex Order 2[redacted] since the resident's readmission on NJ Ex Order 26.4b1[redacted]. A review of the Admission Record (an admission summary) reflected that Resident #31 was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26[redacted] NJ Ex Order 26.4b1 [redacted]) and NJ Ex Order 26.4b1 [redacted] NJ Ex Order 26.4b1 [redacted]). A review of the resident's Quarterly Minimum Data Set, included that the resident had a Brief Interview for Mental Status (BIMS) of NJ Ex[redacted] which indicated that the resident's congition was NJ Ex Order[redacted]. A review of the resident's care plan initiated on NJ Ex Order 26.4b1[redacted], revealed the resident had a focus for NJ Ex Order 26[redacted]. The goal was that the resident would have NJ Ex Order 26.4b1 related to NJ Ex Order 26.4b1 [redacted] through the next review. Interventions included assist as needed to NJ Ex Order 26.4[redacted] to NJ Ex Order 26.4b[redacted], NJ Ex Order 26.4b1 [redacted],	F 695	NJ Ex O[redacted]. On 1/18/24, Unit manager LPN #1 was educated by the infection control preventionist not to touch the inside of the respiratory bag without gloves. IDENTIFICATION OF AT RISK RESIDENTS; All residents receiving respiratory treatment are potentially at risk for the deficient practice. This can be identified by reviewing the residents medical records. SYSTEMIC CHANGES On 2/5/24, the ADON (Assistant Director of Nursing/designee started an In-service for the staff nurses again on proper storage of respiratory equipment per the facility policy to ensure regulatory compliance. On 2/5/24, Nurses, UM/Supervisors all in serviced by the ADON/designee on medication/ discharge order reconciliation policy and procedures. Nurses will check the hospital discharge orders against the previous physician orders, consults, and home medication orders to ensure orders are correctly transcribed and documented. The Unit manager/ designee will review the physician orders with the resident/resident representative upon admission and discharge. In-Service completion is 2/21/24. QUALITY ASSURANCE (QA): All new/readmission charts will be audited by the Director of Nursing (DON)/ designee daily to ensure Hospital discharge order, Home orders and previous physician orders are reconciled and correctly transcribed.	

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F 695	Continued From page 29 and NJ Ex Order 26.4b1 daily in the morning when removing it. A review of the active physician orders did not include an order for the resident's NJ Ex Order 2 . A review of the NJ Ex Order 26.4b1 Medication Administration Record (MAR) did not include the NJ Ex Order 26.4b1. A review of the NJ Ex Order 26.4b1 progress note dated NJ Ex Order 26.4b1 revealed the resident's NJ Ex Order 2 setting were NJ Ex Ord and the NJ Ex Order 26.4b1, NJ Ex Order 2, and NJ Ex Order were in NJ Ex Order 26.4b1. On 01/22/24 at 9:39AM, the surveyor entered Resident #31's room and observed the NJ Ex Order 26.4b1 , face down on top of the NJ Ex Order 26.4b1. At that time, the surveyor interviewed the resident who stated the US FOIA (b)(6) removed NJ Ex Order 26.4b1 when the treatment was finished. On 01/22/24 at 10:00 AM, surveyor #1 and surveyor #2 interviewed UM/LPN#1 regarding policy and procedures on NJ Ex Order 26.4b1 treatment and storage. UM/LPN #1 acknowledged that the NJ Ex Order should have been NJ Ex Order 26.4 and NJ Ex Order 26.4b1 . At that time, surveyor #1 accompanied by surveyor #2 asked UM/LPN #1 to go to Resident #31's room. UMLPN #1 observed the resident's NJ Ex Order 26.4b1 out of the NJ Ex O , placed her hands inside the NJ Ex Order 26.4b1, removed her hands, grabbed the NJ Ex Order 26.4b1, enter the resident's bathroom, and closed the door. The surveyors heard water running. UM/LPN #1 opened the bathroom door, holding the NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1	F 695	The Infection Control Preventionist (IP) will do random checks on residents with respiratory treatment weekly x 4 weeks, bi-weekly x 8weeks and then monthly x3 to ensure proper handling and storage of respiratory items. Any issues found during the audit will be addressed immediately and reported to the administrator as well as to the QA committee quarterly for 2 quarters.	

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F 695	Continued From page 30 while drying it with a paper towel. UM/LPN #1 then placed it back into the resident's [NJ Ex Order 26.4 redacted]. During an interview with the surveyor on 1/22/24 at 11:51AM, the [US FOIA (b)(6) redacted] stated the [NJ Ex Order 26.4b1 redacted] treatments were administered by the nurses. After the treatments were completed, the [NJ Ex Order redacted] should be washed, dried, and placed into a [NJ Ex Order 26.4b1 redacted]. The [US FOIA (b redacted] stated that a physician's order was required for a resident who was using a NJ Ex Order 26.4b1. The surveyor reviewed Resident #31's medical record with the [US FOIA (b redacted] who confirmed there was no order. A review of a facility policy titled, "Oxygen tubing and Respiratory Products" policy with a revision date of October 2023. The policy included that all nebulizer tubing and equipment should be cleaned after each use and kept in a bag and dated. A review of a facility policy titled, "Noninvasive Ventilation" (CPAP, BIPAP,) with a revision date of August 2023 included that all CPAP/BIPAP vary by manufacturer, common equipment including machine, tubing, mask, headgear/straps, disposable/non-disposable filter and humidifier and the facility will obtain an order for the use of the device and settings from the practitioner. NJAC 8:39-25.2 (b), c (4)	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		3/4/24

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F 697	Continued From page 31 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, and record review it was determined that the facility failed to ensure a NJ Ex Order 26.4b1 regime was followed in accordance with physician orders. This deficient practice was identified in 1 of 1 resident reviewed for [redacted] (Resident #5) and was evidenced by the following: On 01/17/24 at 10:52 AM, during the initial tour of the facility the surveyor observed Resident #5 in bed and [redacted]. The surveyor asked the resident if he/she were NJ Ex Order 26.4b1. Resident #5 told the surveyor that he/she had [redacted] and that [redacted] were completed at the facility. The resident told the surveyor he/she was currently receiving NJ Ex Order 26.4b1 as ordered by the physician. The surveyor asked if the medication was effective and the resident responded, "[redacted]." The surveyor reviewed Resident #5 Admission Record which indicated the resident had medical diagnoses which included but were not limited to NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 ([redacted]), NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. The surveyor then reviewed the [redacted]-day Medicare Minimum Data Set (MDS), an assessment tool dated [redacted]. Section [redacted] titled NJ Exec Order 26.4b1 indicated that the resident was on a scheduled [redacted]. Section [redacted] also revealed that the resident's [redacted] was "[redacted]."	F 697	F-697 COMPLETION DATE: 3/4/24 CORRECTIVE ACTION: On 1/25/24, resident # 5 medical record was reviewed for the deficient practice, the order for [redacted] for [redacted] management was updated to reflect [redacted] to [redacted] to ensure clear indication of administration. On 1/25/24, All staff nurses were in-service by the Director of Nursing (DON) on the facility policy and procedure of accurately evaluating pain using the numeric pain scale to administer pain medication per the physician orders. IDENTIFICATION OF AT RISK RESIDENTS: All residents on pain management are potentially at risk for the deficient practice. This can be identified by reviewing the physician orders and medication administration record. SYSTEMIC CHANGE: On 2/8/24, the Pharmacy Consultant /designee started re- education for all staff nurses on the importance of ensuring pain medications are administered per the physician orders, evaluate the indication/pain scale and the effectiveness of the pain management per the facility policy and regulatory standards. Completion of education is 2/21/24.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 32 Further review of the MDS revealed the resident had a Brief Interview of Mental Status (BIMS) of [redacted], meaning the resident was [redacted]. On 01/23/24 at 09:36 AM, the surveyor reviewed the physician orders which revealed the resident was prescribed the following orders: [redacted] two tabs every six hours for [redacted] tabs every 6 hours for [redacted] and [redacted] every 12 hours around the clock. All the medications were ordered on [redacted]. Review of the graphic sheet with [redacted] assessments indicated that the resident was being assessed for [redacted] four times daily and [redacted] levels on the [redacted] for [redacted] to [redacted] for [redacted]) went from a [redacted] to a [redacted]. On 01/23/24 at 09:41 AM, the surveyor reviewed the Medication Administration Record (MAR) which showed that the resident received the [redacted] one time on [redacted], for a [redacted] level of a [redacted]). Further review of the MAR showed that in the month of [redacted] the resident received [redacted] on [redacted] when the residents' [redacted] was [redacted] on [redacted] when [redacted] was a [redacted], on [redacted] when [redacted] was a [redacted] and [redacted] times when the residents' [redacted] level was a [redacted]). The [redacted] was ordered for [redacted] On 01/23/24 at 09:50 AM, the surveyor reviewed	F 697	Quality Assurance (QA): The DON/designee will complete a weekly audit of 5 residents for 4 weeks biweekly X 8 weeks and monthly X 3 months. The pharmacy consultant will do a monthly audit on all residents receiving pain medication for accurate documentation of pain scale, indication and effectiveness of pain medication per the physician orders. Any issues found will be addressed immediately and reported to the Administrator as well as the QA Committee quarterly for 6 months or until compliance is met.	

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Resident #5 care plan which showed a focus of [redacted] (NJ Ex Order 26.4b1). The care plan was initiated on [redacted] with the goal of the resident having no reaction or side effects to the [redacted] The interventions were to administer [redacted] medication(s) as ordered by the physician and to monitor the effectiveness of the medications and notify the physician if ineffective.

On 01/23/24 at 11:49 AM, the surveyor interviewed the unit Licensed Practical Nurse (LPN #5) regarding [redacted] scales and assessments. LPN #5 told the surveyor, "We use verbal [redacted] I will ask [redacted] levels from [redacted] to [redacted] I will then ask [redacted]." The surveyor asked LPN #5 to define the [redacted] and she responded, "[redacted] is [redacted] could be [redacted], and [redacted] is [redacted] The surveyor asked LPN5 what she would do if someone came to her with [redacted] of [redacted] and only had [redacted] medication ordered for [redacted]. The nurse responded, "I would offer the [redacted] for [redacted], but I will definitely call the doctor for something else." The surveyor then asked what if a resident's [redacted] was a [redacted] but only had medication ordered for [redacted]. LPN5 responded, "I would call doctor and see what else we can get them. I would also do [redacted] for [redacted]."

During interview with the surveyor on 01/26/24 at 09:31 AM, the [redacted] stated that the nursing staff ask the resident's their [redacted] scale prior to [redacted] the residents.

On 01/29/24 at 01:15 PM, the surveyor reviewed the policy titled, "Pain Management" dated October 2023. Under the section titled, "Pain Management and Treatment", number seven

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F 697	Continued From page 34 indicated that pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain. Under number eight, it revealed that if reassessment findings indicate pain is not adequately controlled, the pain management regimen and plan of care will be revised as indicated. NJAC 8:39-27.1 (a)	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		3/4/24

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F 725	Continued From page 35 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint # NJ 156885, NJ 158428, NJ 159346, NJ 160533, NJ 163074, NJ 163435 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to: a. maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey and b.) provide adequate staff to ensure all residents were provided with timely NJ Ex Order 26.4b1 care for 2 of 4 residents reviewed for NJ Ex Order 26.4b1 care (Resident #154 and Resident #156) on 1 of 2 units (NJ Exec Order 26.4b1 and for 1 of 3 residents (Resident #20) reviewed for NJ Ex Order and NJ Ex Order 26.4b1 on 1 of 2 units (NJ Exec Order 26 Floor). This deficient practice was evidenced by the following: Refer to F677E 1. 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 (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift.	F 725	F-725 COMPLETION DATE: 3/4/24 CORRECTIVE ACTION: Resident #154 and #156, and # 20 medical records were reviewed by the Director of Nursing (DON) for deficient practice. The residents did not have NJ Ex Order 26.4b1 from the deficient practice. Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will offer shift differentials and referral bonuses to fill in any open spots in the schedule. In addition, on 1/25/24, all residents were evaluated by the Unit Mangers/supervisors for the deficient practice, no issues found for the evaluation. Certified Nursing Assistants (CNA's) have been asking cognitive residents if they need to go to the rest room. Cognitive impaired as well as cognitive intact residents will be toiled prior to breakfast, during morning ADL care, before or after lunch, before or after dinner and as needed. IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by the deficient practice. In order to identify any residents that may have been affected by the deficient practice, the Administrator conducted an interview with 5 residents on 1/25/24 concerning their care and	

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F 725	Continued From page 36 One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports" requested revealed the following: For the week of Complaint staffing from 07/31/2022 to 08/06/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/31/22 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/01/22 had 7 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/02/22 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/03/22 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/04/22 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/05/22 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/06/22 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. For the week of Complaint staffing from 08/14/2022 to 08/20/2022, the facility was	F 725	staffing no complaints were made. SYSTEMIC CHANGE: On 1/26/24, the facility Administrator has put in place a bonus structure to help increase the levels of staffing according to the census. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. In addition, the director of nursing or designee will meet daily with the staffing coordinator to ensure appropriate staffing: Additionally, on 2/6/24, Education was provided by the Assistant Director of Nursing (ADON) to the staff regarding call outs and how it affects the facility, the residents', and their peers. The facility staffing policies and procedures reviewed with the staff. The facility has initiated a new system, the Administrator, and the DON, will hold a staff meeting quarterly to provide updates to staff, as well as to receive staff feedback and input. On 2/6/24, Facility wide staff in-service started again on call bell response time per the facility policy to include: All department must respond to the residents call bell in a timely manner. The call bell should not be turned off until the need of the resident is met. In-services will be completed on 2/21/24. QUALITY ASSURANCE (QA): To ensure corrective actions are sustained, Social worker/s and or designee will interview 5 random competent residents from	

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F 725	Continued From page 37 deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -08/14/22 had 7 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/15/22 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/16/22 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/17/22 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/18/22 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/19/22 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/20/22 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. For the week of Complaint staffing from 10/23/2022 to 10/29/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/23/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/24/22 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -10/25/22 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -10/26/22 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -10/27/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -10/28/22 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -10/29/22 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. For the week of Complaint staffing from	F 725	different shifts weekly for 4 weeks, biweekly for 8 weeks then monthly for 3 months to determine staffing satisfaction and residents' needs are meet through staffing. The Director of Nursing Services, or designee, will conduct a random incontinence audit of residents on at least 2 residents per week for 2 months and then biweekly 1 month and then monthly X3 months. The Administrator /designee will do a random audit of call bells audits on 5 rooms weekly X 8 weeks, biweekly X 4 Weeks, and then monthly X 3 months. Any issues from the audits will be addressed immediately and reported to the Administrator and DON as well as the QA Committee quarterly for 6 months or until compliance is met. Shift Bonus Weekend Bonus: Pick up Friday, Saturday and Sunday and get an extra $5 per hour if you work the full shift and all three days! Pick up Shift: Pick up an extra shift in addition to your regular schedule and earn extra! $3 per hour for CNA $4 per hour for LPN $5 per hour for RN	

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12/25/2022 to 12/31/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-12/25/22 had 7 CNAs for 91 residents on the day shift, required at least 11 CNAs.
-12/26/22 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.
-12/27/22 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.
-12/28/22 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs.
-12/29/22 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-12/30/22 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-12/31/22 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs.

For the week of Complaint staffing from 03/26/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:

-03/26/23 had 7 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-03/28/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-03/29/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-03/31/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-04/01/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs.

For the week of Complaint staffing from 04/16/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts and deficient in CNAs to total staff on 1

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of 7 evening shifts as follows:

-04/16/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.
-04/17/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.
-04/17/23 had 6.25 CNAs to 14.25 total staff on the evening shift, required at least 7 CNAs.
-04/18/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.
-04/20/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-04/21/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-04/22/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs.

For the week of Complaint staffing from 09/24/2023 to 09/30/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows:

-09/24/23 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs.
-09/30/23 had 11.5 CNAs for 102 residents on the day shift, required at least 13 CNAs.

For the 2 weeks of staffing prior to survey from 12/31/2023 to 01/13/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:

-12/31/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-01/01/24 had 9.25 CNAs for 95 residents on the day shift, required at least 12 CNAs.
-01/13/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.

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2. On 01/22/24 at 9:44 AM, the surveyors completed an NJ Ex Order 26.4b1 tour on the NJ Exec Order 26.4b1 Unit. The surveyors were accompanied by two CNAs and an US FOIA (b)(6) during the care of four residents for NJ Ex Order 26.4b1 care. Of the four residents observed, two residents (Resident #154 and Resident #156) were found with NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

On 01/17/24 at 11:29 AM, Resident #20 reported that he/she had an episode of NJ Ex Order 26.4b1 after a delayed call bell response that was later confirmed by the resident's assigned US FOIA (b)

During an interview with the surveyor on 01/22/24 at 9:40 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 stated that the census on the unit was 42 and there were four Certified Nursing Assistants (CNAs) and three nurses present on the unit to provide resident care. LPN/UM #1 was unable to state the mandated CNA staff ratios and deferred further questioning to the US FOIA (b)(6).

During an interview with the surveyor on 01/24/24 at 09:45 AM , the US FOIA (b)(6) stated she was aware of the staffing ratios, and staffing has always been a struggle.

A review of the facility staffing policy updated 2/2023, titled, "Staffing" included that the facility provided sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with

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F 725	Continued From page 41 resident care plans and the facility assessment. 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. NJAC 8:39-5.1(a)	F 725		
F 755 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(g). 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, 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	F 755		3/4/24

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F 755	Continued From page 42 §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: Based on observation, interview, and pertinent record review, it was determined that the facility failed to ensure the accountability of the narcotic shift count logs were completed in accordance with facility policy and accurately account for and document the administration of controlled medications. This deficient practice was identified on 3 of 3 medication carts and was evidenced by the following: On 1/17/24 at 9:58 AM, the surveyor, interviewed Licensed Practical Nurse #4 (LPN #4) who stated all nurses assigned to carts were responsible for the organization, and maintenance of the medication cart. She further stated that narcotic shift to shift count logs were to be completed by two nurses (the incoming and outgoing nurses) at the same time once they confirmed an accurate count of the narcotics in the cart. She also confirmed that logs should not be missing any documentation, signatures, or have a pre-signed field for future count times. The surveyor, in the presence of LPN #4, then reviewed the "[redacted] nursing unit's medication cart 1 narcotic log binder. The log binder contained a "Narcotic and Controlled Substance Shift-to-Shift Count Sheet" which revealed the following: The second shift - afternoon count column for 1/14/24 was missing a count number. The second shift - afternoon count off-going nurse column for 1/17/24 was pre-signed.	F 755	F-755 COMPLETION DATE: 3/4/24 CORRECTIVE ACTION: Resident # 71 and # 95 medical records were reviewed by the Director of Nursing for deficient practice. On 1/18/24 LPN #3 and # 4 (License Practical Nurse) was immediately educated by the Director of Nursing (DON)on the facility policy and procedure on Controlled medications are counted at the end of each shift by the nurse coming on duty and the nurse going off duty determine the count together. On 1/18/24, The shift □ shift narcotic count books for both units were audited by the DON for missing signatures. All nurses that were identified to have missed signing the shift count log were immediately in service on the facility policy and standard of practice on signing at the beginning of the shift and at the end of the shift by two nurses to determine the count together, On 1/18/24 LPN#1 and # 2 were educated by the DON on the facility policy on dispensing narcotic, to immediately sign out the medication from the declining inventory sheet open dispensing form the packaging. IDENTIFICATION OF AT RISK	

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F 755	Continued From page 43 On 1/17/24 at 10:54 AM, the surveyor, interviewed LPN #3 who stated all nurses assigned to carts were responsible for the organization, and maintenance of the medication cart. She further stated that narcotic shift to shift count logs were to be completed by two nurses (the incoming and outgoing nurses) at the same time once they confirmed an accurate count of the narcotics in the cart. She also confirmed that logs should not be missing any documentation, signatures, or have a pre-signed field for future count times. The surveyor, in the presence of LPN #3, then reviewed the "[NJ Exec Order 26.4] nursing unit's medication cart 2 narcotic log binder. The log binder contained a "Narcotic and Controlled Substance Shift-to-Shift Count Sheet" which revealed the following: 1/4/24 third shift - night count off-going nurse signature was not completed. The second shift - afternoon count off-going nurse column for 1/17/24 was pre-signed. On 1/17/24 at 11:33 AM, the surveyor, interviewed LPN #2 who stated all nurses assigned to carts were responsible for the organization, and maintenance of the medication cart. She further stated that she did not complete the "individual patient's controlled drug record" (declining inventory) log at the time of dispensing the controlled substance, but rather after she administered the controlled medication. She confirmed that logs should not be missing any documentation, signatures, and the count on the log should match the number of medications on hand for that controlled substance. The surveyor, in the presence of LPN #2, then reviewed the "[NJ Exec Order 26.4] nursing unit's medication cart 3 narcotic log binder. The log binder contained a	F 755	RESIDENTS: All residents are potentially at risk for the deficient practice. SYSTEMIC CHANGE: ON 1/8/24 The pharmacy consultant/designee started servicing all staff nurses on the importance of providing pharmacy services to meet the needs of each resident to include, shift to shift narcotic count and signing on the log sheet. Dispensing and administration of narcotics per the facility policy and regulatory standards. In-service completion 2/21/24. Quality Assurance (QA): The DON/designee will do a daily audit of all shifts to shift count narcotic sheets for completion of signatures X 4 weeks, weekly x 4 weeks, biweekly x4 weeks and then monthly X 3. The pharmacy consultant will do a monthly Unit inspection to include checking shift to shift narcotic count sheets as well as observing medication administration pass. Any issues found from the audit will be addressed immediately and reported to the Administrator and DON as well as the QA/QAPI Committee quarterly for 6 months or until compliance is met.	

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declining inventory log for NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 for Resident #71, which was reflected a missing nurse administering signature for the dose administered NJ Ex Order 26.4 at 9 AM.

Review of Resident #71's Admission Record reflected that Resident #71 was admitted to the facility with diagnosis which included but was not limited to NJ Ex Order 26.4 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1.

Review of Resident #71's Physician Order Summary (POS) included an order with a start date of NJ Ex Order 26.4b1 for NJ Ex Order 26. Oral Tablet NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) Give 1 tablet by mouth two times a day for NJ Ex Order 26.4b1 .

Review of Resident #71's NJ Ex Order 26.4b1 Medication Administration Record (MAR) indicated this medication was signed off by the nurse as being administered on NJ Ex Order 26.4 at 9:00 AM.

On 1/18/24 at 8:37 AM, the surveyor observed LPN #1 during medication administration on the first floor nursing unit. The US FOIA dispensed and administered medications to Resident #95, which included a NJ Ex Order 26.4b1 medication NJ Ex Order 26.4b1 , which she dispensed at 8:51 AM. The US FOIA confirmed the medication in the MAR as well as in the NJ Ex Order 26.4b1 log binder and the declining inventory log for that medication. At 9:26 AM, the US FOIA completed the medication administration for Resident #95, and had not yet signed the dispensed NJ Ex Order 26.4b1 dose out in the declining inventory log. The US FOIA informed the

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surveyor she was complete with this resident's administration and would be moving on to the next resident.

At that time, the surveyor interviewed LPN #1, who stated that she does not sign the declining inventory log until she goes back to assess the efficacy of the medication, in "about 20-25 minutes." The surveyor inquired of the purpose of the declining inventory log, at which point the [US FOIA] acknowledged that it was intended to be completed to indicate the medication was dispensed and should be completed once dispensed from the packaging.

Review of Resident #95's Admission Record indicated the resident was admitted to the facility with diagnosis which included but was not limited to NJ Ex Order 26.4b1 [NJ Ex Order 26.4b1] .

Review of the POS indicated a physician's order with a start date of [NJ Ex Order 26.4] for NJ Ex Order 26.4b1 give one tablet by mouth every four hours as needed for [NJ Ex Order 26.4b1].

On 1/18/24 at 12:48 PM, the surveyor interviewed the US FOIA (b)(6)) who stated controlled substance shift to shift logs were to be completed with two nurses (incoming and outgoing nurse) at the change of shift together after they both complete a count of the controlled substances in the medication cart and were accounted for. She stated the purpose was for accountability of the controlled medications. The [US FOIA (b)] further stated that declining inventory logs were expected to be signed out when a narcotic was removed from its packaging and not when waited until administered with the purpose to

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F 755	Continued From page 46 indicate the narcotic was removed from the packaging. Review of the facility's "Controlled Substances" policy with a reviewed and updated date of October 2023 included but was not limited to: "controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift ...the nurse administering the medication is responsible for recording: name of the resident receiving the medication; name, strength, and dose of the medication; time of administration; method of administration; quantity of the medication remaining and signature of nurse administering medication ... controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together." NJAC 8:39-29.7(c)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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.) ensure all medications were administered without error of 5% or more, and b.) ensure medications were properly stored, dispensed, prepared for administration and administered. This deficient practice was observed during the medication administration	F 759	F- 759 COMPLETION DATE: 3/4/24 CORRECTIVE ACTION: Resident 96 and # 36 and # 32 medical records were reviewed and assessed by the [redacted] for deficient practice. Resident # 96 did not have [redacted]	3/4/24

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F 759	Continued From page 47 observation on 1/18/24, and during medication storage observations on 1/17/24. The surveyor observed three (3) nurses administer medications to four (4) residents with a total of 34 opportunities, and two (2) errors were observed which calculated a medication administration error rate of 5.88% during medication administration observation. This deficient practice was identified for 2 of 4 residents (Resident #96 and Resident #36) that were administered medications by 2 of 3 nurses on the second-floor nursing unit, and 1 of 3 medication carts observed during medication storage observation. The deficient practice was evidenced by the following: a.) On 1/18/24 at 9:43 AM, during medication administration observations, the surveyor observed Licensed Practical Nurse #2 (LPN #2) dispensing and preparing to administer medication to Resident #96. During the process of medication administration, after showing the surveyor the medication cards ("Bingo card" containing individually packaged pills), one at a time, for observation, the [US FOIA] dispensed the first two medications into a small plastic medication cup. After the [US FOIA] showed the surveyor the third and fourth bingo cards, she placed the cards back down on top of the medication cart without dispensing those two medications. After the fifth medication was shown to the surveyor, the [US FOIA] then stated to the surveyor, "I forgot to pop these last two." She then dispensed the two previous medications which were forgotten and continued the process. The [US FOIA] then asked Resident #96 if they had any [NJ Ex Orde] to which Resident #96 confirmed they had [NJ Ex Orde] At 9:55 AM, LPN #2 identified the resident was ordered	F 759	[NJ Ex Order 2] from not receiving the medication. Resident # 36 did not have [NJ Ex Order 26.4b1] from the medication without meals or immediately following a meal. Resident # 32 did not have [NJ Ex Order 26.4b1] from receiving medications that were pre-dispensed. resident physicians were notified of the deficient practice. On 1/8/24, A one to one education on medication administration was provided per the facility policy and regulatory rules for LPN # 2 and LPN # 3 by the Director of Nursing IDENTIFIED RESIDENTS AT RISK: All residents residing in the facility are potentially at risk for the deficient practice. This can be identified by reviewing physician orders, medication administration and Treatment administration records. SYSTEMIC CHANGE: On 2/6/24, the pharmacy consultant/designee started Inservice training for all staff nurses to include LPN#2 and LPN #3 on proper medication administration per the facility policy and procedure and the manufacturer specifications; that is to read the cautionary for medications if to give with meal/food. To triple check medications orders prior to administration to ensure all medication orders have been dispensed. Ensure the resident is physically present and ready prior to dispensing and administration of medication. QUALITY ASSURANCE (QA): to prevent future medication errors Random medication administration audits will be	

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F 759	Continued From page 48 NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) as needed for NJ Ex Order 26.4b1, she obtained the stock supply bottle of NJ Ex Order 26.4b1 from the top drawer of the medication cart, gave it to the surveyor for confirmation, and when given back to the US FOIA (b) she did not dispense the ordered dose into the medication cup with the other medications, and placed the bottle back into the medication cart. The US FOIA signed the computerized medication administration record (MAR) as having administered the NJ Ex Order 26.4b1 she then administered the other medications not including NJ Ex Order 26.4b1 to Resident #96 (error 1). At that time, the surveyor inquired with LPN #2 about not having dispensed the NJ Ex Order 26.4b1 to which LPN #2 stated she was "sure" she administered it and questioned the surveyor stating, "NJ Exec Order 26.4b1." On 1/18/24 at 9:58 AM, the surveyor observed LPN #3 during medication administration. LPN #3 prepared and administered the ordered medications for Resident #36, which included NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1. That medication had a pharmacy sticker on the bingo card which instructed to "give with or IMMEDIATELY after meal." The surveyor observed Resident #36 in their room as LPN #3 administered the medication, the surveyor did not observe any meal trays, snacks, or other food in the vicinity of the resident to indicate any meal was recently eaten. LPN #3 did not offer the resident any food with the medication. Once completed and back at the medication cart with the US FOIA (b) the surveyor inquired about when meals were delivered to the resident. The US FOIA	F 759	conducted by the DON/designee for one nurse on each shift for 4 weeks, then two nurses monthly for 3 months, then one nurse monthly on-going to ensure compliance with facility. The pharmacy consultant will do a random medication administration pass for one nurse monthly. The nurses involved in the medication errors pass will be subjected to increase random med pass audit by the pharmacy consultant. Any findings from the audit will be addressed immediately and reported to the DON and Administrator as well as the QA/QAPI Committee quarterly.	

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stated breakfast was delivered at 8:00 AM. The [US FOIA] then confirmed the pharmacy instructions for this medication to be taken with meal and acknowledged that 9:58 (1 hour and 58 minutes) from the last meal would not be considered with or immediately after meal (error 2). The [US FOIA] then asked another staff member to have the kitchen send the resident crackers.

Review of Resident #96's Admission Record reflected the resident was admitted to the facility with diagnosis which included but was not limited to NJ Ex Order 26.4b1 ([NJ Ex Order 2]).

Review of Resident #96's Physician Order Summary (POS) included an order for [NJ Ex Order 26.] (NJ Ex Order 26.4b1) oral capsule [NJ Ex Order 26.4] give two tablets by mouth every six hours as needed for [NJ Ex Or] with start date [NJ Ex Order 2].

Review of Resident #36's Admission Record reflected the resident was admitted to the facility with diagnosis which included but was not limited to NJ Ex Order 26.4b1 ([NJ Ex Ord]) ([NJ Ex Order 26.4b1]).

Review of Resident #36's POS included an order for NJ Ex Order 26.4b1 oral tablet NJ Ex Order 26.4b1 tablet by mouth two times a day for [NJ Ex Orde] with start date [NJ Ex Order 26.4].

b.) On 1/17/24 at 10:54 AM, the surveyor, in the presence of LPN #3, observed the "[NJ Exec Order 26.4]" nursing unit's medication cart 2. In the top drawer of the cart, the surveyor observed two unlabeled medication plastic cups, one containing six pre-dispensed unidentifiable medication pills of various colors and shapes, the other containing four pre-dispensed unidentifiable medication pills

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of various colors and shapes. LPN #3 quickly removed the cups and stated, "you didn't see this." The surveyor asked the [US FOIA] to place these cups on top of the medication cart for observation. The [US FOIA] complied and upon surveyor inquiry, the [US FOIA] informed that these were medications she pre-dispensed from the bingo cards for two different residents (Resident #32 and Resident #61), whom she was waiting to be ready to receive their medications.

At 11:25 AM, the surveyor inquired if this was appropriate procedure for administration, to which the [US FOIA] stated "no" and would not administer. At that time, the surveyor stepped back from the medication cart, and observed LPN #3 place the medication cup with four pills back in the drawer of the cart, secured the drawer, and took the second cup with six pills to Resident #32 to administer.

On 1/18/24 at 12:48 PM, the surveyor interviewed the US FOIA (b)(6) The [US FOIA (b)] acknowledged that medications should be administered to residents as ordered, she also stated that medications required to be given with meals should not be given any later than 30 minutes after a meal to be considered immediately after meal, and two hours after a meal was not considered to be given with meal. Regarding pre-dispensing of medications from bingo cards for later administration, the [US FOIA (b)] stated this should "absolutely not" happen stating this could cause risk of medications being administered to the wrong resident, and that doing this is "all around not a good practice."

Review of the facility's "Administering Medications" policy with a review and updated

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F 759	Continued From page 51 date of October 2023 included but was not limited to, "medications are administered in a safe and timely manner, and as prescribed... medications are administered in accordance with prescriber orders, including any required time frame ...medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)." Review of the facility's "Storage of Medications" policy with a review and updated date of October 2023 included but was not limited to, "drugs and biologicals are stored in the packaging containers or other dispensing systems in which they are received ... the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner." NJAC 8:39- 29.2(d)	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		3/4/24

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F 761	Continued From page 52 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined that the facility failed to properly store medications, maintain clean and sanitary medication storage areas, and properly label opened multidose medications. This deficient practice was observed in 3 of 3 observed medication carts on 2 of 2 nursing units and 1 of 1 medication storage rooms and was evidenced by the following: On 1/17/24 at 9:58 AM, the surveyor interviewed Licensed Practical Nurse #4 (LPN #4) who was assigned to the [redacted] nursing unit medication cart 1. LPN #4 stated that all nurses assigned to the medication carts were responsible for maintaining the cart and keeping it organized and clean. She further stated that all opened multi-dose medication containers should be labeled with date opened as well as with the resident's name on the actual medication containing device or container and there should be no loose pills in the cart. At that time, the surveyor reviewed [redacted] medication cart 1 in the presence of LPN #4 and observed the following: One (1) Incruse Ellipta inhalation powder 62.5 micrograms (mcg) (medication used to treat lung	F 761	F-761 Completion date: 3/4/23 CORRECTIVE ACTION: On 1/17/24, the Med-bridge Unit and Ashland medication carts were checked by the Pharmacy consultant for deficient practice. All undated drugs and biologicals items were removed, replace with open /discard dates and residents names. All loose unidentified medications removed from the medication card and properly disposed of in the drug buster. Drug busters for wasted medications were placed on each medication cart by the Unit managers. Both Units med room refrigerator temperatures were checked by the Unit managers and were within the normal range per the facility policy and regulatory compliance. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents may be potentially at risk for the deficient practice. This can be identified by reviewing the resident physician orders and the medication administration record.	

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F 761	Continued From page 53 disease) inhaler which was opened and dated 1/17 but was not labeled with resident's name on the inhaler device. One box of albuterol sulfate inhalation solution 0.083% 2.5 milligrams (mg) per 3 milliliters (ml) (medication used to treat lung disease) undated with an opened date, containing seven single use vials not in the manufacturer's foil pouch. LPN #4 stated "this is no good, have to discard that." Two boxes of albuterol ipratropium bromide and albuterol sulfate inhalation solution (medication used to treat lung disease) 0.5 mg/3 mg per 3 ml containing opened foil pouches one pouch contained 24 single dose vials, the other 21 single dose vials. Both were not dated with an opened date and had manufacturer's instructions to use within two weeks of opening. Five (5) unidentifiable loose pills of various colors, shapes, and sizes. At that time, LPN #4 disposed of the three undated albuterol medication boxes containing the medication vials in the trash bin attached to the side of the medication cart. On 1/17/24 at 10:54 AM, the surveyor interviewed LPN #3 who was assigned to the "[redacted] nursing unit medication cart 2. LPN #3 stated that multi-dose, single resident medications should be labeled with the resident's name and the date it was opened once it is opened for use by the nurse. The surveyor at this time reviewed the [redacted] medication cart 2 with LPN #3 and observed the following: One box lebalbuterol inhalation solution	F 761	SYSTEMIC CHANGF: On 2/8/24, All nursing staff started a re-in serviced by the Pharmacy Consultant/designee on the following 1) on dating drugs and labeling biologicals with the open and discard date per the manufacturer specification. 2) Proper disposal of wasted medications into the drug buster. 3) Drug buster was placed in every medication cart, 4) education provided to maintain the cleanliness of medication carts by disposing of loose unidentified medications from the medication carts 4) medication rooms refrigerator/ nourishment refrigerator temperatures are to be checked daily by the 11-7 shift supervisor and log on the sheet provided. Inservice completion date is 2/21/24. QUALITY ASSURANCE: The Unit Managers /designee will do a weekly audit of all medication carts for dating and labelling drugs and biologicals with the residents name, open and discard dates, medication rooms and nourishment refrigerator temperatures accurately documented on the temperatures log sheets daily, and cleanliness of the medication carts for 3 months, then bi-weekly for 3 months. The pharmacy consultant will do a monthly Unit inspection to include: checking med rooms/nourishment refrigerator temperature logs, cleanliness of all medication carts, labelling and dating drugs and biologicals. Any issues found from the audit will be addressed immediately and reported to the Director of nursing and the	

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F 761	Continued From page 54 (medication used to treat lung disease) 1.25 mg/ 3ml containing an opened foil pouch containing seven single dose vials labeled by the manufacturer to use within two weeks of opening and labeled with an opened date of 12/16/23. One box budesonide inhalation suspension (medication used to treat lung disease) 0.5mg/2ml containing an opened foil pouch with six single dose vials with no opened date and labeled by manufacturer to use within two weeks of opening. On 1/17/24 at 11:33 AM, the surveyor interviewed LPN #2 who was assigned to the [redacted] nursing unit's medication cart 3. LPN #2 stated single resident multi-dose medications and containers should be labeled with the resident's name and date opened once opened for use. She also stated that there should not be any loose medications in the cart and all nurses assigned to the cart are responsible for maintaining the organization and cleanliness of the medication cart. She stated that medications should be disposed of in the drug buster bottle. At that time, the surveyor reviewed the [redacted] medication cart 3 in the presence of LPN #2, and observed the following: One opened foil pouch of ipratropium bromide and albuterol sulfate inhalation solution (medication used to treat lung disease) 0.5mg/3mg per 3ml labeled by the manufacturer to use within two weeks of opening and dated with a "11/28" opened date containing six single dose vials. Two opened foil pouch of ipratropium bromide and albuterol sulfate inhalation solution	F 761	Administrator, as well as the Quality Assurance Committee/QAPI quarterly for 6 months or until compliance is met.	

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F 761	Continued From page 55	F 761		

(medication used to treat lung disease) 0.5mg/3mg per 3ml containing 13 vials in one pouch and 29 vials in the other neither of which were dated with an opened date.

15 unidentifiable loose pills of various colors, shapes, and sizes.

On 1/17/24 at 12:17 PM, the surveyor, in the presence of LPN/Unit Manager #1 (LPN/UM #1), reviewed the first-floor nursing unit's medication storage room. The following was observed:

The medication refrigerator temperature monitoring log was not completed for 1/7/24 and 1/16/24.

The medication freezer temperature monitoring log was not completed for 1/16/24.

At this time, LPN/UM #1 stated that the 11 PM - 7AM nursing shift were responsible for checking and documenting the temperature of the medication refrigerator and freezer, and she double checked with them once she arrived in the morning.

On 1/18/24 at 12:48 PM, the surveyor interviewed the US FOIA (b)(6) She stated that the expectation was that medications were labeled with resident name and dated once opened. She confirmed that the 11-7 nursing shift was responsible for checking the medication refrigerators for temperature monitoring daily to ensure the temperature stayed in the appropriate range for storing medications, otherwise it could affect the medication's efficacy. She acknowledged that if it's not documented, it's not done. The US FOIA (b) stated that all medications should

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F 761	Continued From page 56	F 761		

be discarded in the drug buster bottles that were kept on each medication cart. She stated if the one on the cart runs out, there are drug buster bottles on the nursing floor, and it was never appropriate to throw medications of any kind in the trash.

Review of the facility's "Storage of Medications" policy with a reviewed and updated October 2023 included but was not limited to "drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls ... the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed."

Review of the facility's "Storage of Medication Requiring Refrigeration" policy with a reviewed and updated date of March 2023 included but was not limited to, "temperature should be maintained between 36-46 degrees F ... temperature to be monitored daily to ensure proper temperature control and documented on the temperature log."

Review of the facility's "Administering Medications" policy with a reviewed and updated date of October 2023 included but was not limited to "the expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container."

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F 761	Continued From page 57 N.J.A.C. 8:39-29.4	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. 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 ensure appetizing and palatable temperature of food for 1 of 1 lunch meals observed on 1 of 2 nursing units ([redacted]). This deficient practice was evidenced by the following: On 01/18/24 at 11:00 AM, the surveyor conducted a Resident Council meeting which included five residents (Residents #14, #37, #53, #71, and #74). All five residents informed the surveyor that the food was served cold on all shifts. On 01/23/24 at 11:15 AM, the surveyors informed the [redacted]) that they wanted to observed the lunch meal service for that day including food temperatures. The [redacted] acknowledged the request and stated that the lunch service began at 11:20 AM.	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp Corrective Action: On 1/23/24 the cook changed out the roasted potatoes for an alternate pan from the oven. The roasted potatoes at the temperature of 139 F were reheated to 165 F. Medical records reviewed for residents #14, #37, #53, #71 and #74 reveling [redacted] from food served below 135* or above 41*. On 1/25/24, the nursing staff were in serviced by the Assistant Director of Nursing (ADON) on the new meal trays delivery system, the kitchen will announce that the meal cart is leaving the kitchen. Identification of Residents at Risk: All residents who eat food from the kitchen have the potential to be affected.	3/4/24

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F 804	Continued From page 58 On 01/23/24 at 11:20 AM, the US FOIA (b) informed the surveyor that he had already calibrated (procedure used to confirm accuracy) his thermometer prior to the surveyors arrival. The US FOIA (b) then proceeded to obtain food temperatures from the food that was on the steam table. The temperature were recorded as follows: chopped spinach 178 degrees Fahrenheit (F), mashed potatoes 177 F, breaded veal 165 F, creamed spinach 171 F, pureed bread 80 F, chopped veal 175, pureed veal 184 F, roasted potatoes 139 F were replaced with an alternate pan from the oven and were 177 F. The US FOIA (b) utilized plastic insulated domes and bases and heated plates to maintain temperature and an induction heating device was used to heat the plastic base prior to assembly. On 01/23/24 at 11:43 AM, the surveyor requested to have a regular tray placed on the first food truck for NJ Exec Order 26.4b1 Unit as a test tray. The surveyor also requested that the US FOIA record temperatures of the food in the presence of the surveyors on the nursing unit using a calibrated thermometer. The US FOIA calibrated a digital, thin probe thermometer in an ice bath to 32 F. The US FOIA and the surveyors immediately proceeded to leave the kitchen at that time and followed the food cart to the NJ Exec Order 26.4b1 nursing unit. On 01/23/24 at 11:45 AM, the US FOIA and US FOIA (b)(6)) arrived on the NJ Exec Order 26.4b1 nursing unit with the food truck. The nursing staff began to deliver meal trays to the residents at 11:54 AM. On 01/23/24 at 12:05 PM, the US FOIA confirmed that the last resident's meal tray had been served. The surveyor asked the US FOIA (b) what the	F 804	These residents can be identified by facility census. Systemic Change: Beginning on 1/23/24 Dietary Staff were all in service on the new policy that effective 1/23/24 all food trucks will be announced on the overhead pager. Beginning on 1/23.24 all staff was in-service on the “Danger Zone” and how to properly hold and serve food. Beginning on 1/23/24 Nursing staff was in-serviced on the new procedure for announcing the carts and passing the trays in a timely manner. Quality Assurance: The Food Service Director/Designee will document a daily audit to ensure all staff are announcing food trucks before they leave the kitchen. The findings will be addressed and reviewed with administrator weekly and presented to QAA committee quarterly over the next year. A test tray will be done by the food DD/Designee 3x’s weekly at different meals to ensure all potentially hazardous foods (PHF) foods are maintained at or below 41 F and at or above 135 F at the time of service. The findings will be addressed timely, reviewed with the administrator weekly and presented to the QAA committee quarterly over the next year. Starting in February 2024 and every month for 3 months the Dietary Director will request an invitation to the resident	

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F 804	Continued From page 59 temperature should hot foods and cold foods be served at, and the US FOIA responded that hot food should be served above 135 F and cold food should be served below 40 F. At this time, the surveyor observed the US FOI obtain the following temperatures using the calibrated thermometer for the regular lunch meal tray: Breaded Veal 136 F Potato Wedge 129 F Spinach 138 F Milk 48 F Fruit Cocktail 49 F At that time, the US FOI stated that the tray pass should have occurred immediately when the food truck arrived to the nursing unit. The US FOI further stated that it took about fifteen minutes for the staff to begin to pass the trays. The US FOI acknowledged that the potato wedge was below the acceptable temperature of 135 F or above and both the milk and the fruit cocktail were both above 40 F and should have been below 40 F. The US FOIA stated that he had received some complaints of cold food recently and noted that there have been some issues related to maintaining food temperature. On 01/25/24 at 2:45 PM, the surveyors met with the US FOIA (b)(6) and the US FOIA (b)(6)) in the presence of the survey team, and shared their concerns regarding food temperatures. Review of an undated policy, "Food Preparation Guidelines" revealed the following: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's	F 804	council meeting to discuss food temperatures, nutritive value, and palatability with the council. The findings of the meeting and the resolutions will be reviewed with administrator and presented to the QAA committee Quarterly over the next year. Starting on 1/23/24 the Dietary Director/designee with complete a meal satisfaction survey with 8 residents per week at different meals. The findings will be reported to the Administrator for review and presented to the QAA committee Quarterly over the next year. once a week the dietary director will meet with residents #14, #37, #53, #71 and #74 to discuss meal satisfaction. The meeting will be documented and reviewed with Administrator weekly and presented to the QAA committee quarterly over the next year.	

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F 804	Continued From page 60	F 804		

nutrition and hydration status.
...Proper (safe and appetizing) temperature means both appetizing to the resident and minimizing the risk for scalding or burns.
...Foods shall be prepared by methods that conserve nutritive value flavor and appearance. This includes, but is not limited to: ...Minimizing holding time prior to meal service....Foods and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: ...Serving hot foods/drinks hot and cold foods/drinks cold, Addressing resident complaints about food/drinks...

Review of the facility policy, "Food Preparation and Service" (Reviewed and updated January 2024) revealed the following:
Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices.
...Appropriate measures are used to prevent cross contamination. These include:
Storing raw meat separately and in drip-proof containers, and in a manner that prevents cross-contamination from other foods in the refrigerator...Cleaning and sanitizing work surfaces (including cutting boards) and food-contact equipment between uses, following food code guidelines. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Handwashing sinks are located near food preparation and clean dish areas and are separate from ware washing sinks...
Food Preparation, Cooking and Holding Time/Temperatures: The "danger zone" for food temperatures in between 41 F (degrees Fahrenheit) and 135 F. This temperature

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F 804	Continued From page 61 promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods (PHF) include meats, poultry, seafood, cut melon, eggs, milk, yogurt, and cottage cheese. The longer foods are in the "danger zone" the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41 F or above 135 F...Fresh, frozen or canned fruits and vegetables are cooked to holding... NJAC 8:39-17.4(a)(2)	F 804		
F 812 SS=F	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 observations, interviews, and other facility documentation, it was determined that the	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary	3/4/24

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F 812	Continued From page 62 facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner. This deficient practice was evidenced by the following: On 01/17/24 from 9:40 AM until 10:31 AM, the surveyor observed the following in the presence of the US FOIA (b)(6) 1. A rolling rack of plastic bowls was stored in front of the handwashing sink. At that time, a US FOIA (b)(6)) retrieved the rack and proceeded to place salad inside of the bowls. When interviewed, the US FOIA stated that since the bowls were stored upside down it did not pose a risk of contamination. 2. In the galley the kitchen: Caribbean Jerk Seasoning, Poultry Seasoning, and NJ Ex Order 26.4b1 Seasoning were not labeled with an opened date and a use-by date. US FOIA stated that when the spices were opened they should have been labeled and dated with a use by date. US FOIA then proceeded to place labels on the spices with an opened date of 12/01/23 and an expired date of 05/01/24. When asked how he knew when the spices were opened, he stated that he labeled them according to the holiday menu change. 3. The main deck oven was in use and the bottom of the oven was noted to be soiled with a black substance and food debris was noted on the bottom of the oven. The US FOIA stated that it was cleaned last week. 4. In the walk-in refrigerator:	F 812	Corrective Action: On 1/17/24 the Dietary Director immediately removed the rolling rack of plastic bowls from in front of the hand sink. The bowls and cart were washed. rinsed, sanitized, and allowed to air dry before being put back into service. The Caribbean Jerk Seasoning, Poultry Seasoning, NJ Ex Order 26.4b1 Seasoning, two-quart container of chocolate pudding, the lettuce stored next to the turkey logs were removed and discarded on 1/17.2024. The main deck of the oven and can opener both were cleaned immediately on 1/17/2024. The NJ Exec Order 26.4b1 put on a hairnet immediately on 1/17/2024. Two plastic spatulas were discarded. 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: Beginning on 1/17/2023 the dietary staff was in-serviced on proper storage of tray service equipment to avoid cross contamination. Audits will be weekly for 4 weeks, and then monthly for 5 months. Dietary Director/Designee will document a weekly audit for one year to ensure that all equipment is properly stored to avoid cross contamination. Beginning on 1/17/2024 Dietary Director started a labeling and dating in-service with all dietary staff. Audits will be weekly for 4 weeks, and then monthly for 5 months. Dietary Director/Designee will	

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F 812	Continued From page 63 On the top shelf of a four-tiered rack, a two quart container of chocolate pudding was dated with an opened date of 01/10/24 and a use-by date of 01/14/24. [US FOIA] stated that the item should have been discarded. 5. On the bottom shelf of a four-tiered rack a container that had three, five pound turkey logs was stored in a plastic container next to lettuce. [US FOIA] stated that they should be separated to avoid the chance of cross-contamination. 6. In the food preparation area, a can opener was mounted on the counter. The [US FOIA] pulled the can opener out of the sleeve and revealed that there was a dried, dark red substance on the blade of the can opener. [US FOIA] stated that it should have been washed as it posed a chance of cross-contamination if used. 7. In the galley of the kitchen: The [US FOIA (b)] wore a baseball hat instead of a hair net which left his hair exposed on both sides and in the lower portion of the back of his head during food preparation. [US FOIA] stated that the [US FOIA (b)] should have had a hair net on. 8. Two plastic spatulas hung above the food preparation area and both had pitting and cracks in them. [US FOIA] stated that they should have been discarded to prevent plastic from getting into the food. On 01/23/24 from 11:15 AM until 11:43 AM during a return visit to the kitchen, the surveyor observed the following in the presence of the [US FOIA] 1. The [US FOIA (b)] obtained food temperatures from the	F 812	document a weekly audit for 5 months that all food items are properly labeled and dated according to policy. The cleaning schedule was updated to ensure ovens and can openers are scheduled to be cleaned more frequently. On 1/17/2024 an in-service began with all the dietary staff on how to properly follow cleaning procedures for ovens and can openers and following daily/weekly/monthly cleaning schedules. Audits will be weekly for 4 weeks, and then monthly for 5 months. Dietary Director/Designee will document a weekly audit of the daily/weekly/monthly cleaning log checking all areas of the kitchen for cleanliness. Starting on 1/17/2024 all staff were in-serviced on hair restraints. Audits will be weekly for 4 weeks, and then monthly for 5 months. Dietary Director/Designee will document a weekly audit for 5 months to ensure all staff is correctly restraining hair. Beginning on 1/23/2024 Dietary Director/Designee in-serviced all staff on glove use, hand hygiene and proper storage of utensils during tray line to avoid cross contamination. Audits will be weekly for 4 weeks, and then monthly for 5 months. Dietary Director/Designee will document a weekly audit for 5 months to ensure all staff are following proper glove use and hand hygiene. Quality Assurance: A quarterly review of dietary audits will be conducted and documented by the Food Service Director. Audits will be weekly for	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 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
F 812	Continued From page 64 steam table and did not first perform hand hygiene prior to food handling and did not donn gloves. At 11:25 AM, the [redacted] donned gloves without first performing hand hygiene. 2. There were multiple ice cream scoops and a metal spatula that were placed on the stainless steel food prep area in front of the steam table. The [redacted] picked up the ice cream scoops and spatula and placed them directly into the food to be served on the steam table. 3. The [redacted] scratched his head and removed his glasses and set them down on the counter with his gloved hands before he obtained a plate from the plate warmer and proceeded to plate the lunch meal. When interviewed, the [redacted] stated that he washed his hands after he went to the bathroom before the surveyor arrived in the kitchen. At 11:46 AM, the surveyor interviewed the [redacted] who stated that the [redacted] should have washed his hands before he donned gloves, and after he removed his glasses and scratched his head to avoid contamination. [redacted] further stated that the serving utensils should have been placed directly into the food instead of on the stainless steel food prep area to avoid contamination. The surveyor reviewed the undated policy, "Date Marking for Food Safety" which revealed the following: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for food safety food. Definitions: Time/temperature control for food safety food (formerly "potentially hazardous food) includes	F 812	4 weeks, and then monthly for 5 months. Any concerns/recommendations will be made at that time and addressed as needed. Results of the review will be reported to the Administrator (LNHA) as well as the Quality Assurance committee at their quarterly meeting.	

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F 812	Continued From page 65 animal food that is raw or heart treated... The Head Cook, or designee, shall spot check refrigerators weekly for compliance, and document accordingly... The Dietary Manager, or designee shall spot check refrigerators weekly for compliance, and document accordingly... The surveyor reviewed an undated policy, "Maintaining a Sanitary Tray Line" which revealed the following: Policy: The facility prioritizes tray assembly to ensure foods are handled safely and held at proper temperatures in order to prevent the spread of bacteria that may cause food borne illness. ...During tray assembly, staff shall: ...Wear gloves when handling food items...Wash hands before and after wearing or changing gloves...Change gloves after sneezing, coughing or touching face, hands, or hair with gloved hand. Wear hair restraints (bonnets, caps, nets to cover hair) when preparing or handling food. NJAC 8:39-17.2(g), 19.4 (a)	F 812		
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles	F 836		3/4/24

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F 836	Continued From page 66 that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. 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 notify CMS (Centers for Medicare & Medicaid Services) and receive approval from the New Jersey Department of Health for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the	F 836	F836 Completion Date: 3/4/24 Corrective Action Facility Notified CMS and received approval from the New Jersey Department of Health for a change in the facility's name. Identification of At-Risk Resident The facility has determined that all residents have the potential to be affected by this deficient practice. Systemic Change	

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F 836	Continued From page 67 Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership;	F 836	The Administrator will ensure all appropriate licenses, permits and certifications required for operation under state and federal regulation will be obtained and maintained within the required timeframe and kept available for inspections as indicated. Quality Assurance When a name change is initiated, or licensure issue the administrator will confirm and verify license standing with appropriate authorities immediately. The findings will be reviewed by the QA committee as they arise over the next 4 quarters.	

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F 836	Continued From page 68	F 836		

(ii) Any adverse legal action; or
(iii) A change in practice location.
(2) All other changes in enrollment must be reported within 90 days."

On 01/18/2024 at 09:00 AM during the second day of survey, the surveyors observed a sign outside of the facility with a different facility name then the day prior. The sign read, "Autumn Lake Healthcare at Voorhees." Upon entrance to the facility, the surveyor observed the posted license for the facility that was titled, Promedica Skilled Nursing and Rehab-Voorhees West. A review of the electronic medical records (EMR) were titled with the facility name, Autumn Lake Healthcare at Voorhees.

During an interview with the surveyor on 01/22/24 at 11:14 AM, the US FOIA (b)(6) stated the facility name was changed over the summer to Autumn Lake Healthcare at Voorhees and the new ownership took over as of NJ Ex Order 2.

On 01/22/24 at 11:16 AM, the US FOIA (b)(6) provided an email and paperwork with a change of new ownership, but not the NJ approved license nor approval from CMS.

On 01/23/24 at 08:49 AM, the surveyor requested the NJ approved license and the application for name change (855A) from the US FOIA (b)(6)

During a follow up interview with the surveyor on 01/23/24 at 09:17 AM, the US FOIA (b)(6) stated they only submit the 855A when they recieved a new license, and did not have the license for the new facility name.

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F 836	Continued From page 69 NJAC 8:39-5.1 (a)	F 836		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		3/4/24

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F 880	Continued From page 70 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain proper infection control practices by performing appropriate hand hygiene: a.) during NJ Ex Order 26.4b1 care and b.) during medication administration. This deficient practice was identified for 2 of 2 Certified Nursing Assistants (CNAs) observed on 1 of 2 nursing	F 880	F-880 COMPLETION DATE: 3/4/24 CORRECTIVE ACTION: Resident # 155, # 96 and #154 charts reviewed by the DON for deficient practice on performing Hand hygiene in a manner that would decrease the spread of infection per the	

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F 880	Continued From page 71 units ([redacted] and for 1 of 3 nurses observed during medication administration on 1 of 2 nursing units ([redacted] This deficient practice was evidenced by: 1. On 01/22/24 at 10:03 AM, the surveyors observed CNA #1 as she provided [redacted] care to an unsampled resident with resident permission. When finished, CNA #1 doffed (removed) her gloves and washed her hands for 13 seconds. CNA #1 then donned gloves and assisted the resident to sit on the edge of the bed before she assisted the resident out of bed to the wheelchair. CNA #1 then assisted the resident into the [redacted] and set the resident up with the necessary supplies for the resident to brush his/her teeth. CNA #1 then removed the resident's bed linens from the bed and placed them in a plastic trash bag to be laundered. CNA #1 then proceeded to push the resident in their wheelchair back to the bedside. CNA #1 used her gloved hands to hand the resident the television remote and over bed table. CNA #1 then doffed her gloves and washed her hands for 14 seconds. At 10:17 AM, CNA #1 took the soiled laundry and trash bags from the resident's room and placed them in the soiled utility room. When finished, CNA #1 washed her hands for 10 seconds. On 01/22/24 at 10:21 AM, the surveyors observed CNA #1 as she prepared to perform [redacted] care on Resident #155 with resident permission. CNA #1 washed her hands under the stream of running water for 22 seconds before she donned (put on) gloves. CNA #1 first [redacted] the resident's [redacted]. At 10:40 AM, she doffed her gloves and washed her hands for eight	F 880	facility policy. The residents did not have [redacted] from the deficient practice. On 1/18/24, LPN #2, (License Practical Nurse) was immediately in-serviced through a competency with return demonstration by the Infection Control preventionist (IP) on proper hand hygiene procedures. On 1/25/24 C.N.A # 1 and C.N.A #2 (Certified Nursing Assistant) were immediately in-serviced through a competency with return demonstration by the Infection Control preventionist (IP) on proper hand hygiene procedures. IDENTIFICATION OF AT RISK RESIDENTS: All Residents may be potentially at risk for this deficient practice. These residents can be identified by reviewing the Physician orders, Medication administration Record and the resident□s medical records. SYSTEMIC CHANGES: On 2/4/24, the IP re- in-serviced all personnel on the facility□s policy for hand hygiene. In-service training includes random observation of personnel performing hand hygiene procedures according to facility policy. Findings are reviewed with all personnel. Corrective action is provided as needed. Upon hire at the facility all staff will receive in-services and competencies on handwashing per the facility policy and the CDC guidelines. Inservice completion is 2/21/24. QUALITY ASSURANCE (QA): A random weekly audit of 5 staff members will be	

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F 880	Continued From page 72 seconds under running water. CNA #1 then donned gloves and NJ Ex Order 26.4 the resident's NJ Ex Order 26.4b1. CNA #1 then emptied the basin in the sink and refilled it with water and then proceeded to NJ Ex Order 26.4b1 with clean water. CNA #1 then NJ Ex Orde the resident's NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. CNA #1 then proceeded to perform NJ Ex Order 26.4b care NJ Ex Order 26.4b1) without first doffing her gloves and performing hand hygiene. On 01/22/24 at 10:58 AM, the surveyors observed CNA #2 use alcohol based hand rub (ABHR) prior to being interviewed by the surveyors. CNA #2 stated that she planned to provide NJ Ex Order 26.4b1 care to Resident #154. The surveyors observed the care with resident permission. At 11:06 AM, CNA #2 obtained a basin, filled it with water in the sink and then donned gloves. CNA #2 then proceeded to NJ Ex Orde the resident who was NJ Ex Order 26.4b1. At 11:25 AM, CNA #2 placed the NJ Ex Orde in the bathroom sink and doffed her gloves. She failed to perform hand hygiene after. CNA #2 then returned to the resident and assisted the resident to NJ Ex Order 26.4b1 in bed and handed the resident their bed control. At 11:28 AM, CNA #2 double bagged the resident's linens and garbage. She then proceeded to donn gloves without first performing hand hygiene. At 11:29 AM, CNA #2 emptied the basin in the toilet and flushed the toilet with her gloved hand. CNA #2 then reached into her uniform pocket with her gloved hand and obtained a trash bag. CNA #2 then proceeded to dry the basin with a paper towel and hung it in a trash bag from the towel rack. At 11:32 AM, after the observation CNA #2 washed her hands for 20 seconds.	F 880	done by the Infection Control Preventionist/DON/ designee on Hand washing for 3 months, then biweekly x 3 months, then on-going as needed to ensure compliance with facility guidelines. Any issues identified will be immediately addressed and findings will be reported to the Administrator as well as the Quality Assurance Committee Quarterly for 6 months or until compliance is met.	

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F 880	Continued From page 73	F 880		

During an interview with the surveyor on 01/22/24 at 12:14 PM, CNA #1 stated that she was required to wash her hands for 20 seconds under the running water. CNA #1 stated that she sang the happy birthday song to determine the correct amount of time to wash her hands.

During an interview with the surveyor on 01/22/24 at 12:44 PM, CNA #2 stated that she was required to perform hand hygiene when she doffed her gloves. CNA #2 stated that if she changed her gloves instead of performing hand hygiene after doffing it could lead to contamination.

During an interview with the surveyor on 01/22/24 at 2:19 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 stated that staff were required to wash their hands both before and after resident care. LPN/UM #1 stated that hand washing was required after gloves were doffed for infection control purposes. LPN/UM #1 stated that hands were required to be washed with soap and water out of the stream of running water to kill all germs on the hands.

During an interview with the surveyor on 01/22/24 at 3:12 PM, the US FOIA (b)(6) stated that hands should be washed for 20 to 30 seconds and make sure to get absolutely everything, including the nails out of the stream of running water. US FOIA (b) further stated that when gloves were doffed you were supposed to wash your hands for infection control.

During an interview with the surveyor on 01/24/24 at 10:59 AM, the US FOIA (b)(6) stated that the process to wash hands was to: Turn on warm water, wet hands, get soap and

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wash hands out of the running water, in a downward fashion for twenty seconds, then rinse hands separately. Then dry your hands on a paper towel and discard it after. Then turn off the faucet with a clean paper towel and discard it. [redacted] stated that if hands were washed under running water then you would just transfer the germs back and forth on your hands. [redacted] stated that if hands were not washed for twenty seconds or better then your hands were not clean and you were spreading bacteria that was on your hands. [redacted] further stated that you must wash your hands after you doffed your gloves. [redacted] explained that you had to wash your hands rather than change gloves so that you did not contaminate, because your hands were still dirty and someone could get sick from whatever was on your hands.

The [redacted] provided the surveyor with Hand Washing Competencies that were completed by both CNA #1 and CNA #2 on 10/12/23, 01/18/24, and 01/23/24.

2. On 1/18/24 at 9:40 AM, the surveyor observed Licensed Practical Nurse 2 (LPN #2) while she administered medication to Resident #96. LPN #2 prepared to initiate medication administration to the resident by first obtaining a rolling vitals machine (a machine used to check blood pressure (BP), heart rate, blood-oxygen saturation, and temperature), rolled it to the room where the resident was sitting in a wheelchair by the room entrance. The [redacted] donned (put on) disposable gloves, took out a container of sanitizing wipes from the medication cart, used a single wipe to wipe down the components of the vitals machine, then disposed of the wipe in the trash, doffed (took off) the gloves and disposed of

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them in the trash, then without performing hand hygiene opened the medication cart drawer and began to take out the medication cards for this resident and placed them on the cart surface to begin medication administration. The US FOIA then, without using gloves placed the BP cuff on the resident's arm and began to obtain the resident's vitals. Once completed, the US FOIA removed the equipment off the resident, without performing hand hygiene, then began the process of dispensing and administering the resident's medication.

On 1/18/24 at 12:41 PM, the surveyor interviewed LPN #2. She acknowledged that there should have been hand hygiene performed after sanitizing the equipment, doffing the gloves, and before handling the medications, stating, "I should have."

On 1/18/24 at 12:48 PM, the surveyor interviewed the US FOIA (b)(6)), who confirmed that hand hygiene should be performed between doffing and donning gloves, after sanitizing medical equipment and before handling resident's medications stating the purpose is to ensure no cross contamination and infection control.

Review of the facility's provided "Hand Hygiene" policy with accessed date of April 2023 included but was not limited to: "hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, ...after touching a patient or the patient's immediate environment ... immediately before putting on gloves and after glove removal ... Alcohol-based hand sanitizers effectively reduce the number of germs that may be on the hands of healthcare workers after interacting with patients."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 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
F 880	Continued From page 76 Hand hygiene technique when using soap and water: Wet hands with water. Avoid using hot water to prevent drying of skin. Apply to hands the amount of soap recommended by the manufacturer. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers, Rinse hands with water. Dry thoroughly with a single-use towel. Use clean towel to turn off the faucet. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility's provided "Handwashing/Hand Hygiene" policy (Reviewed and Updated October 2019) revealed the following: This facility considers hand hygiene the primary means to prevent the spread of infections...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors....Use an alcohol-based hand rub containing at least 62% alcohol: or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...before moving from a contaminated body site to a clean body site...After contact with a resident's skin. Hand hygiene is the final step after removing and disposing of personal protective equipment (equipment worn to protect the body from disease or injury). The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315500	A. BUILDING _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	**1086 DUMONT CIRCLE VOORHEES, NJ 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
F 880	Continued From page 77 NJAC 8:39-19.4(a)(n)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	158336	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 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) COMPLETE DATE
S 000	Initial Comments Complaint # NJ 156885, NJ 158428, NJ 159346, NJ 160533, NJ 163074, NJ 163435 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 deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ 156885, NJ 158428, NJ 159346, NJ 160533, NJ 163074, NJ 163435 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S-560 Completion Date 3/4/2024 CORRECTIVE ACTION: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents have the potential to be at risk for deficient practice. SYSTEMIC CHANGE: The facility Administrator has put in place a bonus structure as of 1/26/24 to help increase	3/4/24

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

Electronically Signed | 02/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	158336	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 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) COMPLETE DATE
S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports" requested revealed the following: 1. For the week of Complaint staffing from 07/31/2022 to 08/06/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/31/22 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/01/22 had 7 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/02/22 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs.	S 560	the levels of staffing according to census. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. In addition, the director of nursing or designee will meet daily with the staffing coordinator to ensure appropriate staffing. QUALITY ASSURANCE: The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly until compliance is met. Shift Bonus Weekend Bonus: Pick up Friday, Saturday and Sunday and get an extra $5 per hour if you work the full shift and all three days! Pick up Shift: Pick up an extra shift in addition to your regular schedule and earn extra! $3 per hour for CNA $4 per hour for LPN $5 per hour for RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	158336	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 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) COMPLETE DATE
S 560	Continued From page 2 -08/03/22 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/04/22 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/05/22 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/06/22 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. 2. For the week of Complaint staffing from 08/14/2022 to 08/20/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -08/14/22 had 7 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/15/22 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/16/22 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/17/22 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/18/22 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/19/22 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/20/22 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. 3. For the week of Complaint staffing from 10/23/2022 to 10/29/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/23/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/24/22 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -10/25/22 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	158336	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 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) COMPLETE DATE
S 560	Continued From page 3 -10/26/22 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -10/27/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -10/28/22 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -10/29/22 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. 4. For the week of Complaint staffing from 12/25/2022 to 12/31/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -12/25/22 had 7 CNAs for 91 residents on the day shift, required at least 11 CNAs. -12/26/22 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -12/27/22 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -12/28/22 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -12/29/22 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/30/22 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/31/22 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs. 5. For the week of Complaint staffing from 03/26/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -03/26/23 had 7 CNAs for 99 residents on the day shift, required at least 12 CNAs. -03/28/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -03/29/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 4 -03/31/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -04/01/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. 6. For the week of Complaint staffing from 04/16/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -04/16/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -04/17/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -04/17/23 had 6.25 CNAs to 14.25 total staff on the evening shift, required at least 7 CNAs. -04/18/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -04/20/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -04/21/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -04/22/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. 7. For the week of Complaint staffing from 09/24/2023 to 09/30/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -09/24/23 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -09/30/23 had 11.5 CNAs for 102 residents on the day shift, required at least 13 CNAs. 8. For the 2 weeks of staffing prior to survey from 12/31/2023 to 01/13/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	158336	A. BUILDING: _____ B. WING _____	C 01/26/2024

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S 560	Continued From page 5 -12/31/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -01/01/24 had 9.25 CNAs for 95 residents on the day shift, required at least 12 CNAs. -01/13/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. During an interview with the surveyor on 01/24/24 at 09:45 AM , the staffing coordinator stated she was aware of the staffing ratios, and staffing had always been a struggle. A review of the facility staffing policy updated 2/2023, titled, "Staffing" included that the facility provided 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. 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.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315500 Y1	A. Building B. Wing Y2	3/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 08043

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0558	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	03/04/2024	LSC	03/04/2024	LSC	03/04/2024
ID Prefix F0677	Correction	ID Prefix F0689	Correction	ID Prefix F0690	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	03/04/2024	LSC	03/04/2024	LSC	03/04/2024
ID Prefix F0695	Correction	ID Prefix F0697	Correction	ID Prefix F0725	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	03/04/2024	LSC	03/04/2024	LSC	03/04/2024
ID Prefix F0755	Correction	ID Prefix F0759	Correction	ID Prefix F0761	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	03/04/2024	LSC	03/04/2024	LSC	03/04/2024
ID Prefix F0804	Correction	ID Prefix F0812	Correction	ID Prefix F0836	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(a)-(c)	Completed
LSC	03/04/2024	LSC	03/04/2024	LSC	03/04/2024

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315500 Y1	A. Building B. Wing Y2	3/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 08043

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/04/2024				

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/26/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
158336 Y1	A. Building B. Wing Y2	3/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 08043

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/04/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315500	A. BUILDING **01** B. WING _____	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	**1086 DUMONT CIRCLE** **VOORHEES, NJ 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
E 000	Initial Comments Surveyor: NJ Ex Order 26.4b1 This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting.	E 015		3/4/24

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

Electronically Signed | 02/15/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315500	A. BUILDING **01** B. WING _____	**01/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	**1086 DUMONT CIRCLE** **VOORHEES, NJ 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
E 015	Continued From page 1 (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. 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 develop a three day emergency food supply menu and ensure that all required emergency food items were maintained in stock in accordance with the facility policy. This deficient practice was evidenced by the following: On 01/17/24 at 10:25 AM, during the tour of the kitchen with the[redacted]) when the	E 015	E015 Subsistence Needs for staff and Patients Corrective Action: On 1/18 and 1/19/24 the facilitys three-day emergency food supply was delivered to the facility. A three-day emergency menu was posted in the dietary department. Identification of Residents at Risk: All residents who eat food from the kitchen have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315500	A. BUILDING **01** B. WING _____	**01/26/2024**

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AUTUMN LAKE HEALTHCARE AT VOORHEES	**1086 DUMONT CIRCLE** **VOORHEES, NJ 08043**

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E 015	Continued From page 2 the surveyor asked to see the emergency food supply the US FOI stated, "There was no emergency food supply." US FOIA further stated that the three day emergency food supply was used in the past few months due to COVID-19 outbreaks. US FOI stated that the three day emergency food supply was something that the facility was required to have on hand. On 01/17/24 at 10:32 AM, the US FOIA (b)(6) was notified that there was no three day emergency food supply as required. The US FOIA (b)(6) stated, "A three-day emergency food supply would be here by tomorrow." On 01/18/24 at 1:00 PM, the surveyors returned to the kitchen to view the three day emergency food supply. The US FOIA stated that while he had received boxes of cereal, oatmeal, ravioli, beef stew, chili and three bean salad from another facility the remainder of the inventory would not arrive to the facility until tomorrow. The surveyor requested to see the three day emergency menu. The US FOIA stated that he did not have a menu, but could create one. The US FOIA instead provided the surveyor with a list of food items that included: cereal, oatmeal, ravioli, beef stew, chili, three bean salad, peas, mixed vegetables, mashed potatoes, peanut butter, cheese sauce, vanilla pudding, chocolate pudding, pineapples and jello. The US FOIA confirmed that he did not have powdered milk in stock for dried cereal. On 01/23/24 at 11:15 AM, the surveyors returned to the kitchen and viewed the three day emergency food supply with the US FOIA in the presence of the US FOIA (b)(6)). When interviewed, the US FOI stated, "There should have	E 015	These residents can be identified by facility census. Systemic Change: Emergency food supply is stored separately in a designated secure area, and all items are labeled and dated with expiration dates. Starting on 1/19/2024 all staff including US FOIA (b)(6) were in-serviced on where the emergency supplies are stored, avoid using the emergency supply unless it is an emergency and to report to Dietary Director if you cannot avoid using any emergency supplies. The Emergency food will be cycled every 6 months to maintain safe dating and storage and to adhere to facility policy. Dietary Director/Designee will document an audit weekly for 4 weeks, and then monthly for 5 months. Also will ensure emergency food and menu are available. Quality Assurance: A quarterly review of dietary audits will be conducted and documented by the Food Service Director for 5 months. Any concerns/recommendations will be made at that time and addressed as needed. Results of the review will be reported to the Administrator (LNHA) as well as the Quality Assurance committee at their quarterly meeting for 5 months.	

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	315500	A. BUILDING **01** B. WING _____	**01/26/2024**

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

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E 015	Continued From page 3 been a three day emergency food supply in stock." The US FOIA confirmed that the three day food supply inventory was now complete. On 01/25/24 at 2:45 PM, the surveyor informed the US FOIA (b)(6) and the US FOIA (b)(6) of the surveyors findings related to the absence of an emergency three day food supply and corresponding menu plan. Review of the facility policy, "Emergency Food Supply" (Updated January 2024) revealed the following: It is the policy of this facility to establish procedures to ensure that food is available for residents, staff, and volunteers in case of emergency. The Dietary Manager shall maintain a 3 [sic.] supply of nonperishable foods and supplies of disposable dishes/utensils. The food and supplies are stored in the storage room. The emergency food is rotated/replenished every six months. The facility shall maintain emergency enteral supplies for residents on tube feedings for at least 3 days. The amount of food needed is estimated based on the facility assessment, and considers census, total staff, and average number of volunteers/visitors. The type of food will consider resident population and dietary needs, as reflected in the emergency menu... Review of the undated facility policy, "Customer Emergency/Disaster Plan" revealed the following: Supplement: Summary of Food Service Disaster Requirements Keep the following on hand: Convenience items (canned chili, soups, fruits, vegetables, meats and bread, etc.), Ready to use items (juice, pudding, gravy, etc.), Ready to use items (juice, pudding, gravy, etc.), Individually wrapped items	E 015		

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	315500	A. BUILDING **01** B. WING _____	**01/26/2024**

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E 015	Continued From page 4 (portion pack condiments, granola bars, cookies, etc.), Nutritional products (high calorie, high protein, snacks and shakes), Food items for pureed diets (canned puree meats, fruits, and vegetables, shelf-stable thickened liquids, food thickener, nutritional supplements)... NJAC 8:39-31.6(n)	E 015		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by CertiSurv, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/24/2024 and Promedica Skilled Nursing & Rehab Voorhees West 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. Promedica Skilled Nursing & Rehab Voorhees West was built in 2006 and is a 2-story building with no basement. The building is of Type II (111) construction and is fully sprinklered with hard-wire smoke detection in resident rooms and in corridors and spaces open to the corridor. The facility has 5 smoke barriers.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		3/4/24

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K 345	Continued From page 5 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire alarm system in accordance with an approved program complying with the requirements of NFPA 70, National Electrical Code, and NFPA 72, National fire Alarm and Signaling Code. LSC (12) section 9.6.1.3, 9.6.1.5. This deficient practice had the potential to affect all 110 residents who reside in the facility. Findings included: During an observation on 01/24/2024 at 8:45 AM, the surveyor noted the main entrance fire alarm annunciator panel was in trouble alarm. This issue was brought to the attention of the NJ Exec Order 26.4b1. The US FOIA (b)(6) stated the facility was having issues with the fire panel and had a technician from the fire alarm company onsite on 01/23/2024 to resolve the issue but he was not aware that the issue was not resolved. The US FOIA (b)(6) then called the fire alarm company to see why the issue was not resolved. The US FOIA (b)(6) was informed by the company that the technician who had worked on the fire alarm panel had not put in the work order ticket, so they were unaware of why the issue was not resolved. On 01/24/2024 at 11:15 AM, the surveyor noted the main fire alarm annunciator panel was in trouble alarm. During an interview on 01/24/2024 at 1:45 PM,	K 345	K-345 1. The trouble and repair for the non-functioning SLC wire was completed on 1/31/24. It was at this time the trouble code was cleared and the fire panel was showing normal operation. The fire safety vendor was made aware for the semi annual requirement and will complete and meet that requirement moving forward. It is due to be inspected on the upcoming inspection from the fire safety vendor. 2. Many residents and staff have the potential to be affected by this. 3. The US FOIA (b)(6) was educated on the importance of ensuring the alarm is not kept in trouble. the maintenance director was educated on the requirements for the alarm testing and keeping the system of the trouble. 4. the Maintenance director and department will be responsible for conducting monthly audits x3 in all areas that have the potential to have this deficient practice. results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate. The QA committee meets quarterly, the committee will determine if further action	

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K 345	Continued From page 6 the US FOIA (b)(6) stated the facility had a work order in the fire alarm system. According to the US FOIA (b)(6) the technician had assured him the repair would be minor and would be taken care of soon. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	is needed. Work order that cleared the fire panel trouble code on 1/31/24 has been attached.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315500 Y1	A. Building B. Wing Y2	3/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 08043

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0015	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(b)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/04/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315500 Y1	A. Building 01 - MANOR CARE AT VOORHEES B. Wing Y2	3/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE VOORHEES, NJ 08043

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0345	03/04/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO