STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Complaint #: 364581, 364578, 364575, 364569, 364580, and 2562911 Survey Dates: 08/04/25 – 08/07/25 Survey Census: 105 Sample Size: 33 Supplemental Sample: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F0000		09/05/2025
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the facility failed to assess one resident (Resident (R) 7) of 33 sampled residents to [redacted] medications prior to leaving medications at the bedside. This had the potential for the resident not to receive their ordered medications. Findings include:	F0554	1.Resident #7's [redacted] and [redacted] were immediately removed from the bedside on [redacted] Resident #7 was re-educated on [redacted] regarding the facility policy and process for requesting [redacted] of medications. Resident #7 was assessed by the interdisciplinary team on [redacted] for ability to [redacted] medications. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. 3. All licensed nursing staff were re-educated on 8-28-25 by staff development regarding the policy and procedure for resident self-administration of medications. The identified nurse received one o one counseling and re-education by staff development on	09/08/2025

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F0554 SS = D	Continued from page 1 During an observation on 08/04/25 at 11:26 AM, an [NJ Exec Orde] and a bottle of [NJ Exec Order 26.4b] were sitting on the bedside table. The resident was asked why they were there. R7 stated, “I need to use them.” Review of R7’s undated “Admission Record” found in the electronic medical record (EMR) under the “Profile” tab, indicated the resident was admitted to the facility on [NJ Exec Order 26] with diagnoses of [NJ Exec Order] and [NJ Exec Order 26.4b1] Review of R7’s quarterly “Minimum Data Set (MDS)” with an Assessment Reference Date (ARD) of [NJ Exec Order 26] and found in the EMR under the “MDS” tab, indicated a “Brief Interview for Mental Status (BIMS)” score of [NJ E] out of 15 which indicated the resident was [NJ Exec Order 26.4b] Review of the R7’s EMR under the “Orders” tab revealed physician orders on [NJ Exec Order 26] for [NJ Exec Order 26.4b1], [NJ Exec Ord] one time a day for [NJ Exec Orde] And on [NJ Exec Order 26] [NJ Exec Order 26.4b1], two [NJ Exec Ord] in both [NJ Exec Orde] one time a day for [NJ Exec Ord] and [NJ Exec Order 26.4b1] Review of R7’s comprehensive “Care Plan” located in the EMR under the “Care Plan” tab was reviewed and indicated no “Care Plan” related to the resident administering [NJ Exec Order 26.4b1]. During an interview on 08/07/25 at 1:24 PM, Licensed Practical Nurse (LPN)7 was shown the medication at the bedside. LPN7 stated, “These medications should not be there.” During an interview on 08/07/24 at 2:34 PM, the Unit Manager (UM)2 was asked if the resident should have medications at the bedside. The UM2 stated residents should be assessed and verified that R7 had not been assessed. During an interview on 08/07/25 2:56 PM, the [US FOIA (b)(6)] was asked about residents having	F0554	Continued from page 1 8-18-25. Unit managers during routine nursing rounds daily will verify that no medications are left at the bedside unless explicitly approved. The rounds will be turned in daily to the director of nursing for review. Any non-compliance will be immediately corrected, and staff involved will receive re-education and/or counseling. 4. The director of nursing/designee will conduct weekly audits of selected self-administering residents to verify compliance with self-administration assessments and care plan documentation for 3 months, then biweekly for 3 months then monthly for 6 months. Any non-compliance will be immediately corrected and staff involved will receive re-education and/or counseling. The Director of Nursing will review the unit manager unit round audits daily for compliance for 12 months. The audit findings from the director of nursing self-administering resident and the unit manager round audits will be reported to the QAPI meeting monthly and the QAA committee quarterly for 12 months. The administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. if necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0554 SS = D	Continued from page 2 medication at the bedside. The [US FOIA] stated, “Not without an assessment.” Review of the undated facility policy titled, “Self-Administration of Medications” revealed, “Policy Statement: Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. Policy Interpretation and Implementation: As part of their overall evaluation, the staff and practitioner (Interdisciplinary team) will assess resident’s mental and physical abilities, to determine whether a resident is capable of self-administering medication. . .” NJAC 8:39-29.2(c)6	F0554		
F0557 SS = D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of policy, the facility failed to ensure a resident's [NJ Exec Ord] was maintained when [NJ E] laid in bed with [NJ Ex] [NJ Exec Order 26] walking in the hallway outside of [NJ Ex] room for one resident (Resident (R) 102) out of a total sample of 33 residents. This failure had the potential to cause [NJ Exec Order] to the resident and other residents and visitors who might witness the [NJ Exec Order 26.4] Findings include: Review of R102's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed [NJ E] was admitted to the facility on [NJ Exec Order 26] with diagnoses including NJ Exec Order 26.4b1 . Review of "Evaluations" tab of the EMR revealed R102 scored [NJ E] out of 15 on the "Brief Interview for Mental Status (BIMS)" dated [NJ Exec Order 26] which indicated [NJ Exec Order 26.4]	F0557	Corrective Action Resident #102 on 8-5-25, staff immediately covered [NJ Exe] with a blanket and ensured [NJ E] [NJ Exec O] were properly NJ Exec Order 26.4b1 Resident #102 was assessed for any NJ Exec Order 26.4b1, and [NJ Exec Order 26.4b1] was provided. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change All licensed nursing staff were-re-educated initiated on 8-8-25 and continue until completion date by staff development regarding the policy and procedure for resident dignity, privacy practices, and maintaining appropriate coverage. Education emphasized the expectation to immediately correct any instances of potential exposure. During daily rounds unit managers will monitor any identified dignity issues and provide corrective action immediately. Any non-compliance will be immediately corrected, and staff involved will receive re-education and/or counseling. Quality Assurance 1. Director of nursing or designee will audit random	09/08/2025

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F0557 SS = D	Continued from page 3 NJ Exec Order 26.4b1. During an observation on 08/05/25 at 8:30 AM, R102's room door was fully open with R102 lying in the far bed on NJ Exec Order 26.4b1 from the door. R102 wore a gown, tied at the neck and open in the back with NJ Ex [redacted]. NJ Ex wore ar NJ Exec Order 26.4b1 which was also observed and covered the NJ Exec O [redacted] but not the NJ Exec Order 26.4b1. The top of NJ Exec Order 26.4b1 covered a strip of NJ Exec Order 26.4b1 and the NJ Exec Order 26.4 of the blanket covered NJ Exec Order. No privacy curtain was pulled around the bed. During constant observation of R102's hallway on 08/05/25 from 8:30 AM to 9:30 AM, four staff were observed walking past the door and three residents passed the doorway. None appeared to look into the room. During an interview and observation on 08/05/25 at 9:30 AM, Licensed Practical Nurse (LPN) 2 was asked by this surveyor to look at R102. LPN2 stated NJ Ex privacy curtain needed to be pulled to provide dignity, as R102 was currently NJ Exec Order 2 to anyone who might look into NJ Ex room. LPN2 pulled the privacy curtain around the bed, stated she would get a certified nursing assistant (CNA), and asked the resident if NJ E wanted to get up. R102 responded with a NJ Exec Order 26.4b1 but did not NJ Exec Order 26.4b1. During an interview and observation on 08/07/25 at 3:10 PM, R102 laid in bed facing away from the door. The door was partially closed, which made it difficult to see R102 from the hallway. The resident was observed from the doorway; the privacy curtain was not pulled around NJ Ex bed. R102 was NJ Exec Order 26.4b1 [redacted] from the doorway. When asked if NJ Ex wanted others to see NJ Exec Order 26.4b, R102 NJ Exec Order 26.4b1 but did NJ Exec Order 26.4b1. During an interview on 08/06/25 at 4:11 PM, the U.S. FOIA (b) (6) stated she expected staff to maintain residents' dignity and to close doors or pull privacy curtains as needed. Review of the facility's "Dignity and Respect" policy, updated January 2025, revealed that, "Residents shall be treated with dignity and respect at all times. … Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. …"	F0557	Continued from page 3 halls for any identified dignity issues weekly for 3 months, then biweekly for 3 months then monthly for 6 months. Any non-compliance will be immediately corrected, and staff involved will receive re-education and/or counseling. 2. The audit findings for dignity issues will be reported to the QAPI meeting monthly and the QA committee quarterly by the director of nursing. 3. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0557 SS = D	Continued from page 4 NJAC 8:39-4.1(a)	F0557		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure residents were free from NJ Exec Order 26.4b1 for two residents of three residents (Resident (R8 and R55) reviewed for NJ Exec Ord out of a sample of 33 residents. Findings include: 1. Review of R8's "Admission Record," located in the "Profile" tab of the EMR, revealed R8 admitted to the facility on NJ Exec Order 26 with diagnoses including NJ Exec Order [redacted]. Review of R8's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26 revealed he scored NJ E out of 15 on the "Brief Interview for Mental Status (BIMS),' NJ Exec Order 26.4b1 [redacted] 2. Review of R55's "Admission Record," located in the "Profile" tab of the EMR, revealed R55 admitted to the facility on NJ Exec Order 26 with diagnoses including NJ Exec Or [redacted]	F0600	Corrective Action On 5-31-25, immediately following the incident, staff NJ Exec Order 26.4 residents #8 and #55 to ensure safety. Resident #55 was assessed for NJ Exec Order and appropriate treatment was provided. Resident #55's responsible party and physician were notified promptly. Resident # 8 was removed from the area, assessed by nursing and social services, and monitored closely for further NJ Ex Order 26.4(b) concerns. Incident was reported per the facility policy to the Administrator, Director of nursing, state department of health, police and office of ombudsman. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change All licensed nursing staff were-re-educated on 6-3-25--6-5-25 by staff development regarding the policy and procedure for abuse. All staff were re-educated on 6-3-25---6-5-25 by staff development regarding Zero tolerance for abuse Proper supervision during group activities and meals Immediate interventions when resident-to-resident altercations occur. Documentation and reporting requirements. Activity staff were educated on 6-3-25--6-5-25by staff development to NJ Exec Resident #8 NJ Exec O from residents with NJ Exec Order 26.4b1 like resident #55. Resident #8's care plan was updated on 6-1-25 to include additional interventions such as increased NJ Exec Order 26.4b during activities and NJ Exec Order 26.4b techniques. Quality Assurance	09/08/2025

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F0600 SS = D	Continued from page 5 Review of R55's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] revealed he scored [redacted] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating [redacted]. Review of a "Nurse's Notes" located in the EMR under the "Notes" tab written by Licensed Practical Nurse (LPN) 4, dated [redacted], revealed “nurse reported R8 [redacted] R55 in [redacted] and an incident report was needed. Upon investigation, residents were in dining room in activities and when R8 got in reach of R55, R8 [redacted] R55’s [redacted] When asked why R8 stated "I don't know." Residents [redacted] immediately.” Review of the “Self-Report Form” provided by the facility, dated [redacted] at 8:04 AM revealed the incident occurred on [redacted] at 11:40 AM. Further review revealed the incident did occur and R8 did NJ Exec Order 26.4b1 R55 in the [redacted] During an interview on 08/06/2025 at 11:29 AM with Unit Manager (UM)1 revealed she spoke with R8 after the incident occurred and [redacted] stated that [redacted] R55 in the [redacted] because [redacted] did not like the way [redacted] (R55) [redacted] to a [redacted] and [redacted] thought R55 was being NJ Exec Order 26.4b1 During an interview on 08/06/25 at 12:07 PM, LPN4 said on [redacted] staff came and told her there was an issue. She saw R55’s [redacted] and it was [redacted] She said she got statements from the staff and spoke with R8 who stated NJ Exec Order 26.4b1 . During an interview on 08/07/25 at 12:43 PM, the Activities Aide (AA)1 said on [redacted] R8 and R55 were sitting together in the dining room, while she was reading the daily chronicle to the residents. R8 went to [redacted] and on [redacted] way back [redacted] reached across and [redacted] R55 in the [redacted] AA1 stated she immediately took R55 to the US FOIA (b)(6) and then went back and took R8 to [redacted] During an interview on 08/07/25 at 5:09 PM, the US FOIA (b)(6) stated the investigation concluded that the incident did occur. He said they were able to see the incident occur on the security cameras. He said R8 [redacted] R55 because [redacted] R55 said something	F0600	Continued from page 5 1. Director of nursing or designee will review all incident/accident reports daily in the clinical morning meeting for 12 months to ensure appropriate follow-up, documentation, and care plan updates are completed. Nursing supervisors will conduct random dining/activity room observations 3 times per week for 4 weeks then weekly for 11 months, to ensure adequate supervision and immediate intervention when needed. The dining/activity room audits will be submitted weekly to director of nursing for review. Any non-compliance will be immediately corrected, and staff involved will receive re-education and/or counseling. 2. The audit findings from the daily clinical incident review by the director of nursing and the weekly audits submitted by nursing supervisor will be reported to the QAPI meeting monthly and the QA committee quarterly for 12 months by the director of nursing. 3. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0600 SS = D	Continued from page 6 NJ Exec Order 26.4b1 to a NJ Exec Orde staff member, and NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. NJAC 8:39-4.1(a) NJAC 8:39-9.4(f)	F0600		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.	F0605	Corrective Action Resident #5's use of NJ Exec Order 267 was reviewed immediately by the attending physician, psychiatrist and the Director of Nursing. Target behaviors were identified, defined, and documented on the clinical record. Resident #5's responsible party was notified of the medication review and updated on interventions. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change A new behavior monitoring tool was initiated on 8-8-25 and until completion date to ensure staff document specific behaviors that support the continued use, dose adjustment, potential discontinuation of medication. Licensed nurses were re-educated initiated on 8-8-25 and until completion date by staff development regarding: -residents rights to be free of unnecessary chemical restraints. -documentation of target behaviors for psychotropic medications -GDR process and prn psychotropic order regulations. Physicians and nurse practitioners were notified of the updated expectations and required documentation. Implementation of monthly psychotropic meetings. Implementation of a new GDR/ target behavior monthly psychotropic form to be utilized and reviewed by nursing team monthly during monthly psychotropic meetings.	09/08/2025

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F0605 SS = D	Continued from page 7 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is	F0605	Continued from page 7 Quality Assurance * Director of nursing or designee will review psychotropic medications records weekly for 8 weeks, then monthly for 10 months, to ensure target behaviors are consistently documented and GDR attempts are reviewed. *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the director of nursing. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0605 SS = D	Continued from page 8 necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record reviews, and policy review, the facility failed to monitor NJ Exec Order 26.4b1 for the use of NJ Exec Order 26.4b1) for one of five residents (Resident (R)5) reviewed for unnecessary medications out of a total sample of 33. This had the potential for R5 to receive medication without being assessed if NJ Exec Order 26.4 had improved or declined. Findings include: Review of R5's undated "Resident Face Sheet," found in the electronic medical record (EMR) under the "Profile" tab, indicated the resident was admitted to the facility on NJ Exec Order 26 with diagnoses including NJ Exec Order 26.4 Review of R5's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26 and located in the "EMR" indicated a "Brief Interview for Mental Status (BIMS)" score of NJ E out of 15, which indicated R5 was NJ Exec Order 26.4b1 . The assessment indicated the resident was not NJ Exec Order 26.4 during the assessment period but was taking an NJ Exec Order 26.4b1 medication. Review of R5's "Physician Order Report," dated NJ Exec Order 26 and found in the EMR under the "Orders" Tab, indicated R5 was to receive NJ Exec Order 26.4b1 one tablet by mouth twice daily for NJ Exec Order 26.4b1.	F0605		

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

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F0605 SS = D	Continued from page 9 Review of R5's "Medication Administration Record (MAR)," dated NJ Exec Order 26.4b1 and found in the EMR under the "Orders" tab, revealed no documented evidence to show which NJ Exec Order 26.4b1 were associated with the administration of the resident's NJ Exec Order 26.4b1 medications and required routine monitoring. Review of R5's "Nurse's Notes" located in the EMR under the "Notes" tab for NJ Exec Order 26.4b1 revealed no documented NJ Exec Order 26.4 related to the diagnosis of NJ Exec Order 26.4b1. During an interview on 08/06/25 at 11:29 AM, Unit Manager (UM)1 was asked if NJ Exec Order 26.4b1 were listed on the resident's monthly NJ Exec Or evaluation. She said if the resident were having any NJ Exec Order 26 during a shift it would be documented under progress notes, which she counts all NJ Exec Order 26.4 each month and those NJ Exec Order 26.4 are discussed during their weekly meetings. She stated the side effects were listed on the medication administration review to track but not specific NJ Ex Order 26.4(b)1 She was unable to state how any nurse would know what specific NJ Ex Order 26.4(b) were tracked for a resident if they were only listed on the monthly NJ Ex Orde evaluations. During an interview on 08/07/25 at 3:07 PM, the US FOIA (b)(6)) stated she expected staff to be monitoring specific NJ Exec Order 26.4b1 for residents with NJ Exec Order 26.4b1 medications. NJAC 8:39-4.1(a) NJAC 27.1(a)	F0605		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and	F0609	Corrective Action Resident #55's was immediately assessed following the incident on NJ Exec Order 2. No NJ Exec Order 26.4b1 were noted other than the NJ Exec Order 2 Appropriate treatment was provided. Resident #8 was NJ Exec Order 26 from Resident #55 and placed under NJ Exec Order 26.4b1. Both residents' care plans were updated to reflect interventions to minimize reoccurrence.	09/08/2025

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F0609 SS = D	Continued from page 10 misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to report an [NJ Exec Order 26.4] of NJ Exec Order 26.4b1 for two of three residents (Resident (R) 8 and R55) reviewed for [NJ Exec Or] out of 33 sampled residents. This failure had the potential to allow for continued [NJ Exec Orde] Findings include: 1. Review of R8's "Admission Record," located in the "Profile" tab of the EMR, revealed R8 was admitted to the facility on [NJ Exec Order 26] with diagnoses including [NJ Exec Or] [redacted] Review of R8's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26] revealed he scored [NJ E] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating [NJ Exec Order 26.4b1] [redacted]. 2. Review of R55's "Admission Record," located in the "Profile" tab of the EMR, revealed R55 admitted to the facility on [NJ Exec Order 26] with diagnoses including [NJ Exec Or] [redacted]	F0609	Continued from page 10 Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The facility's abuse, neglect, and exploitation policy has been reviewed and revised to ensure clear direction on reporting allegations of abuse immediately, but no later than 2 hours if abuse or serious bodily injury is suspected, or 24 hours if not involving abuse/serious injury. All licensed staff, nursing assistants and department heads were immediately re-educated on abuse reporting requirements by staff development initiated on 8-8-25 and until completion date. The administrator or designee will ensure all allegations are self-reported to the state agency within the required timeframes regardless of internal investigation status. Quality Assurance * Director of nursing or designee will audit all incident/accident reports daily in morning clinical on going to ensure that all allegations of abuse are reported to the state agency within the required timeframe. *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the director of nursing. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0609 SS = D	Continued from page 11 Review of R55's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4b] revealed he scored [NJ Exec O] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating [NJ Exec Ord] [redacted] Review of a "Nurse's Notes" located in the EMR under the "Notes" tab written by Licensed Practical Nurse (LPN) 4 dated [NJ Exec Order 26.4] revealed “nurse reported R8 [NJ Exec Order 26.4] R55 in [NJ Exec] and an incident report was needed. Upon investigation, residents were in dining room in activities and when R8 [NJ Exec Order 26.4b] of R55, R8 [NJ Exec Order 26.4] R55's [NJ Exec] When asked why R8 stated "I don't know." Residents [NJ Exec Order 26.4] immediately.” Review of the “Self-Report Form” provided by the facility, dated [NJ Exec Order 26.4] at 8:04 AM revealed the incident occurred on [NJ Exec Order 26.4] at 11:40 AM. During an interview on 08/06/25 at 12:07 PM, LPN4 said immediately after the incident occurred on [NJ Ex Order 26.4] she reported it to the corporate nurse and the [US FOIA (b)(6)] During an interview on 08/07/25 at 5:09 PM, the [US FOIA (b)(6)] stated they did not report the incident within two hours of becoming aware of it because the facility had to complete their investigation first. Review of the facility’s policy titled “Abuse, Neglect and Exploitation” undated revealed, “the facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.” NJAC 8:39-9.4(f)	F0609		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)	F0628	Corrective Action Residents # 25, #88, and #4 were reviewed written discharge/transfer notices were provided to the	09/08/2025

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F0628 SS = D	Continued from page 12 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628	Continued from page 12 resident representatives and a copy sent to the state long term care ombudsman. Bed hold policy information was issued and explained to the residents and/or their representatives. Each resident's medical record was updated to reflect the completed notices. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change Licensed nursing staff, social services, and unit clerks were provided by staff development initiated on 8-8-25 and until completion date regarding. -written notice requirements -immediately providing notices upon transfer -documentation of sending the notice to resident/resident representative and ombudsman. A transfer/discharge checklist was implemented to ensure all required elements are completed prior to resident transfer. A tracking log was implemented for social services regarding notification in writing to families of the bed hold. Quality Assurance *Social services will review all hospital transfers/discharges daily in morning clinical meeting for 12 months to confirm Notices of bed-hold policy were provided. Documentation is present in the resident's record and transfer packet is uploaded to To resident electronic medical record under miscellaneous. Ombudsman notification is complete.	

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F0628 SS = D	Continued from page 13 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F0628	Continued from page 13 *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the director of nursing. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0628 SS = D	Continued from page 14 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F0628		

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F0628 SS = D	Continued from page 15 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and policy review, the facility failed to ensure written notice of the transfer to the hospital and the bed hold policy were provided to the resident and the resident's representative upon [redacted] for three (Resident (R)25, R88, and R4) of four residents reviewed for hospitalization out of a sample of 33 residents. This failure had the potential to [redacted] or [redacted] upon [redacted] and a lack of understanding of appeal rights or bed hold should the resident not be permitted to return or disagree with the reason for [redacted]	F0628		

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F0628 SS = D	Continued from page 16 Findings include: 1. Review of R25's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed he was admitted to the facility on [NJ Exec Order 26] with diagnoses including NJ Exec Order 26.4b1. Family Member (F) 1 was listed as [NJ Ex] only emergency contact. Review of R25's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26.] and located under the "MDS" tab of the EMR revealed a "Brief Interview for Mental Status (BIMS)" score of [NJ Exec O] out of 15 which indicated severely [NJ Exec Order 26] Review of "General Nurses Notes" dated [NJ Exec Order 26] and [NJ Exec Order 26] and located in the EMR under the "Progress Notes" tab revealed R25 was sent to the emergency department (ED) on [NJ Exec Order 26] due to a [NJ Exec Order 26.4b1]. F1 was informed by nursing of the [NJ Exec Order] to the ED. [NJ Ex] was admitted to the hospital on [NJ Exec Order 26]. Review of a copy of R25's "Notice of NJ Ex Order 26.4(b)(1) to [NJ Ex Order 26.4(b)(] and/or NJ Ex Order 26.4(b)(1)" dated [NJ Exec Order 26.] and provided by the facility revealed it was directed to R25. The transfer form was addressed: "To: _____" with "Residents Name" under the line where R25's name was handwritten. The [NJ Exec Order] form documented the location of the [NJ Exec Order 2] reason for the [NJ Exec Order 2] appeal rights, and contact information for appeals and the facility Ombudsman. There was no evidence that this written notice was provided to F1. Review of a copy of R25's "Notice A Bed Hold Form" dated [NJ Exec Order 26] and provided by the facility revealed it included the facility's policy on holding a bed and the cost. The form documented: "Sent to [NJ Ex Order 26.4(b)(1)] with the residents [NJ Exec Order] documentation on [NJ Exec Order 2] by [nursing]." There was no evidence that the form was provided to F1. During an interview on 08/05/2025 at 11:17 AM, F1 reported the facility called him when R25 was sent to the hospital. No verbal information was given regarding the bed hold policy, and no written notice of [NJ Ex Order 26] or bed hold policy were provided to [NJ Exec]	F0628		

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F0628 SS = D	Continued from page 17 2. Review of R88's "Admission Record" in the EMR under the "Profile" tab revealed R88 was admitted to the facility on [redacted] with diagnoses including [redacted] Review of "General Nurses Notes" dated [redacted] and located in the EMR under the "Progress Notes" tab revealed R88 was taken from an appointment to the hospital where [redacted]. Review of R88's quarterly "MDS" with an ARD of [redacted] and located under the "MDS" tab of the EMR revealed a "BIMS" score of [redacted] out of 15 which indicated [redacted] The facility was unable to locate a "Notice A Bed Hold Form" or "Notice of NJ Ex Order 26.4(b)(1) to [redacted] and/or NJ Ex Order 26.4(b)(1)" for R88's [redacted] discharge to the hospital. During an interview on 08/04/25 at 11:30 AM, R88 reported she had been hospitalized for [redacted] She did not recall receiving any written notice of [redacted] or the bed hold policy. During an interview on 08/06/25 at 12:37 PM, Licensed Practical Nurse (LPN) 1 reported that the facility had a packet of items which went to the hospital with the resident when they were sent to the ED. The packet included the "Notice A Bed Hold Form" and the "Notice of NJ Ex Order 26.4(b)(1) to [redacted] and/or [redacted]" both of which were triplicate forms. The white copy went with the resident, and the pink and yellow copies were kept by the facility. During an interview on 08/06/25 at 12:50 PM, the [redacted] reported she received the pink copies of the "Notice of NJ Ex Order 26.4(b)(1) to a [redacted] and/or NJ Ex Order 26.4(b)(1)" and "Notice A Bed Hold Form" and kept them to use for notifying the Ombudsman of the discharges. During an interview on 08/06/25 at 12:53 PM, the US FOIA (b)(6) stated it was the facility's policy to let the family know of the transfers to the hospital with a phone call. The US FOIA (b)(6)	F0628		

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F0628 SS = D	Continued from page 18 was not aware of any paper trail regarding the NJ Exec Order or bed hold policy. During an interview on 08/06/25 at 2:20 PM, LPN3 reported nursing called residents' responsible parties to let them know when a resident was sent to the hospital. She let the responsible party know where the resident went and why. The facility had a packet of items which went to the hospital with the resident. LPN3 said the original of the "Notice of NJ Ex Order 26.4(b)(1) [redacted] to NJ Ex Order 26.4(b) and/or NJ Ex Order 26.4(b)(1)" and "Notice A Bed Hold Form" was sent with the resident, and she thought the two copies went to the US FOIA (b)(6) [redacted], who notified the family. During an interview on 08/06/25 at 4:02 PM, the US FOIA provided the pink copies of the two forms for R25 but reported she was unable to locate them for R88. To the knowledge of the US FOIA no one in the facility followed up with the responsible party and provided the written forms to them. R25's responsible party was F1. R25 was NJ Exec Order 26.4b1 [redacted]. There were no forms for R88 because NJ Ex went directly from an appointment to the hospital, so the facility did not send them with NJ Ex During an interview on 08/07/25 at 2:50 PM, the US FOIA stated that nurses filled out the triplicate sheets for the emergency NJ Ex Order 26 to the NJ Ex Order 26 and for the bed hold policy. They sent one to the NJ Ex Order 26 with the resident, gave one to NJ Ex and one went to the US FOIA to notify family. 3. Review of R4's undated "Admission Record" found in the electronic medical record (EMR) under the "Profile" tab, indicated the resident was admitted to the facility on NJ Exec Order 26 with diagnoses of NJ Exec Order 26.4 [redacted] Review of R4's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26 located in the EMR under the "MDS" tab revealed the facility assessed R4 to have a "Brief Interview for Mental Status (BIMS)" score of NJ Exec out of 15 indicating NJ Exec Ord [redacted] Review of R4's "Progress Notes" dated NJ Exec Order 26 in the	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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F0628 SS = D	Continued from page 19 EMR under the “Progress Notes” tab revealed R4 was [redacted] to the [redacted] due to [redacted] R4 was [redacted] to the [redacted] During an interview on 08/07/25 at 1:43 PM, Licensed Practical Nurse (LPN)7 was asked about the Bed Hold. LPN7 stated, “The Bed Hold is in triplicate one copy goes to the hospital with the resident. Second goes to the to the [redacted]) and the third goes to the [redacted]). All we do is call the family member and notify of the hospital.” During an interview on 08/07/25 at 2:19 PM, Unit Manager (UM)2 stated the packet is put together and a copy of the Bed Hold is sent with resident, the [redacted] and the [redacted] UM2 stated the [redacted] will mail the Bed Hold to the family. During an interview on 08/07/25 at 2:44 PM, the [redacted] stated she was not aware of the family receiving the Bed Hold or [redacted] Review of the facility's undated "Bed Hold Prior to Transfer" policy revealed: "The facility will have policies that address holding the resident's bed during periods of absence, such as during hospitalization or therapeutic leave. The facility will provide written information about these policies to residents and/or resident representatives prior to and upon transfer for such absences. … The facility will provide this written information to all facility residents, regardless of their payment source." Review of the facility's undated "Transfer or Discharge, Emergency" policy revealed: "Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: … Prepare a transfer form to send with the resident; Notify the representative or other family member …" The policy failed to contain information regarding the notification to the representative or other family member needed to be in writing. NJAC 8:39-4.1(a) NJAC 8:39-5.1(a)	F0628		

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F0628 SS = D	Continued from page 20 NJAC 8:39-5.3(b)	F0628		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission	F0645	Corrective Action Residents # 8's NJ Exec Order 26.4b1 assessment was reviewed, the assessment was corrected and when indicated a referral for a NJ Exec Order 26.4b1 was submitted to the State Mental Health Authority. Resident#8's care plan was updated to reflect any NJ Exec Order 26.4b1 identified. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change *Social services will verify the PASARR level I is completed and accurate on admission and admission director will verify the PASARR level I is completed and upload it to electronic health record before admission. *If level I indicates possible mental illness or intellectual disability, Social Services will confirm that the referral to the State authority for Level II is completed and documented. *A checklist has been added to the admission packet to ensure PASARR compliance is reviewed and signed by social services and Director of Nursing. *Staff involved in admissions (admission coordinator, director of nursing, social services, nursing supervisors and unit managers) were re-educated by staff development initiated on 8-8-25 and until completion date regarding the PASARR process and regulatory requirements. Quality Assurance The Director of Nursing/designee will audit all new admissions daily ongoing to ensure PASARR level 1 is complete accurate, and referrals for level II are made as required.	09/08/2025

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F0645 SS = D	Continued from page 21 screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure that an accurate NJ Exec Order 26.4b1 [redacted] assessment was completed after admission for one resident (Resident (R)8) out of 33 sampled residents. This failure increased the risk for the resident not receiving NJ Exec Order 26.4b1 as determined by a NJ Exec O [redacted] Findings include: Review of R8's ''Admission Record,'' located in the ''Profile'' tab of the EMR, revealed R8 admitted to the facility on NJ Exec Order 26 with diagnoses including NJ Exec Order [redacted] Review of R8's annual ''Minimum Data Set (MDS)'' with an Assessment Reference Date (ARD) of NJ Exec Order 26 revealed a score of NJ E out of 15 on the ''Brief Interview for Mental Status (BIMS),'' indicating NJ Exec Order 26.4b1	F0645	Continued from page 21 *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the director of nursing. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0645 SS = D	Continued from page 22 NJ Exec Order 26.4b1 Review of the Facility Reportable Investigation dated NJ Exec Order 26 revealed he was NJ Exec Order 26.4b1 towards another resident and was sent out for a NJ Exec Order 26.4b1 evaluation. Review of R8's "NJ Exec Order 26.4b1 located under the "Resident Documents" tab in the EMR dated NJ Exec Order 26 revealed it did not indicate the resident's diagnosis of NJ Exec Orde [redacted]. Further review revealed it did not indicate R8 was sent out for NJ Exec Order 26.4b1 [redacted]. During an interview on 08/07/25 at 11:52 AM, the US FOIA (b) [redacted]) revealed R8's NJ Exec Order 26.4b1 was not completed correctly and based on NJ Ex diagnosis and NJ Exec Order 26.4b1 R8 should have been referred for a NJ Exec Order 26.4b1. NJAC 8:39-5.1(a)	F0645		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure the medical staff documented the correct indication for the use of an NJ Exec Order 26.4b1 medication and instead documented a diagnosis of NJ Exec Order 26.4b1 in the medical record for one resident (Resident (R) 6) out of five residents reviewed for unnecessary medications out of a total sample of 33 residents. This failure had the potential to cause NJ Exec Order 26.4b1 and impact treatment. Findings include: Review of R6's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed NJ E was admitted to the facility on NJ Exec Order 26	F0658	Corrective Action Residents # 6's medical record was immediately reviewed, the incorrect diagnosis of NJ Exec Order 26.4b1 was removed from the electronic medical record. The provider updated the medical record to reflect the accurate NJ Exec Order 26.4b1 as documented by the hospital discharge summary. Resident #6 and/or their representative were notified of the correction to ensure accurate communication of diagnoses. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change *The admission nurse and MDS coordinator were re-educated on the requirement that diagnoses must be based on physician/provider documentation and clinical justification not entered solely on to resolve MDS alerts. *Providers (MD/PA/NP) will approve all new diagnoses prior to being entered into the electronic medical	09/08/2025

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F0658 SS = D	Continued from page 23 with diagnoses including NJ Exec Order 26.4b1 . Review of the "Care Plan" tab revealed a focus area, "[R6] uses NJ Exec Order 26.4b1 medications r/t [related to] NJ Exec Order 26.4b1 " NJ Exec Order 26.4b1 The "Care Plan" did not reflect a diagnosis of NJ Exec Order 26.4b1 Review of a "General Nurses Note" dated NJ Exec Order 26 and located in the EMR under the "Progress Notes" tab revealed R6 was sent to a NJ Exec Order for a NJ Exec Order 26.4b1 Review of an "Admission Note" dated NJ Exec Order 26. and located in the EMR under the "Progress Notes" tab revealed R6 returned to the facility but medications were unable to be verified because NJ E returned without a medication list. The facility was waiting for a NJ Exe Review of a hospital "Discharge Summary" dated NJ Exec Order 26 , faxed to the facility on NJ Exec Order 26. and located under the "Misc" tab of the EMR revealed: NJ Exec Order 26.4b1]" under the heading of NJ Exec Order 26.4b1 " The hospital records did not document a diagnosis of NJ Exec Order 26.4b1 Review of an "Order Audit Report" for NJ Exec Order 26.4b1) ordered NJ Exec Order 26., located under the "Orders" tab, revealed the medication order was entered by Licensed Practical Nurse (LPN) 4 and was indicated "for NJ Exec Order 26.4b1 The order was signed by a US FOIA (b)(6) on NJ Exec Order 26. Review of R6's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26. and located under the "MDS" tab of the EMR revealed a "Brief Interview for Mental Status (BIMS)" score of NJ E out of 15 which NJ Exec Order 26.4b1 . The "MDS" indicated R6 had NJ Exec Order 26.4b1 Review of the "Med Diag [Medical Diagnoses]" tab of the EMR revealed a diagnosis of NJ Exec Order 26.4b1 was created on NJ Exec Order 26 with an effective date of NJ Exec Order 26 . During an interview on 08/04/25 at 3:43 PM, R6 reported NJ E had NJ Exec Or but NJ Exec Orde having NJ Exec Order 26.4b1 During an interview on 08/05/25 at 3:18 PM, the US FOIA stated she entered the diagnosis of NJ Exec Order 26.4b1 into the EMR while she completed the NJ Exec Order 26 quarterly "MDS" assessment. She clicked the "Verify" button as directed after completing the "MDS" to review coding inconsistencies for quality measures. An alert showed up: "QM [quality measures] Alert: Resident is receiving NJ Exec Order 26.4b1]	F0658	Continued from page 23 record. *Nursing, admissions, and MDS staff were in-serviced initiated on 8-8-25 and until completion date by staff development regarding: Proper documentation of diagnoses Requirements for antipsychotic use Compliance with professional standards of quality Quality Assurance The Director of Nursing/designee will audit 5 charts of residents on antipsychotic medications weekly for 3 months, then biweekly for 3 months then monthly for 6 months, to verify that each has an accurate and provider documented diagnosis. *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the director of nursing. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0658 SS = D	Continued from page 24 without a diagnosis of NJ Exec Order 26.4b1 NJ Exec Order 26.4 [redacted]. This QM is included in the Five Star calculation." The US FOIA (b)(stated she saw that R6 had an order for NJ Exec Order 26.4b1 " and so used that diagnosis for the MDS and entered the diagnosis in the EMR under the "Med Diag" tab. During an interview on 08/05/25 at 3:50 PM, the US FOIA (b)(6) [redacted] reported the US FOIA (b [redacted] who signed the NJ Exec Order 26 order was on emergency medical leave and unavailable for interview. During an interview on 08/06/25 at 9:25 AM, the US FOIA (b)(6) stated the NJ Exec Order 26.4b1 diagnosis was an error on admission. During an interview on 08/06/25 at 4:16 PM, the US FOIA [redacted] stated she looked over R6's documentation and verified NJ E [redacted] should not have had a NJ Exec Order 26.4b1 diagnosis. During an interview on 08/07/25 at 3:15 PM, LPN4 reported she knew that NJ Exec Order 26 [redacted] was "tricky" to receive from pharmacy without a correct diagnosis. When asked if she saw a NJ Exec Order 26.4b1 diagnosis in NJ Ex [redacted] hospital documentation, LPN4 stated she was unable to say she saw it, but she had glanced through R6's records and saw that NJ E [redacted] had NJ Exec Order 26.4b1. LPN4 said she went with her clinical judgment to be able to get the NJ Exec Order 26 [redacted] from the pharmacy. Review of the facility's "Medication and Treatment Orders" policy, dated July 2024, revealed: "Orders for medications must include: … clinical condition or symptoms for which the medication is prescribed … " NJAC 8:39-27.1(a)	F0658		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by:	F0684	Corrective Action Resident # 80's NJ Exec Ord [redacted] treatment order was reviewed with the attending physician and NJ Exec Ord [redacted] care was immediately resumed per physician order. The NJ Exec Order 2 [redacted] was NJ Exec Order 26 [redacted] immediately, and the NJ Exec Ord [redacted] was assessed by the NJ Exec Order 26.4b1 and determined there were no NJ Exec Order 26.4b1 to the NJ Exec Orde [redacted] Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice.	09/08/2025

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F0684 SS = D	Continued from page 25 Based on observation, interview, and record review, the facility failed to provide NJ Exec Ord treatments as ordered by the physician for one (Resident (R) 80) of 33 sampled residents Findings include: Review of R80's "Admission Record" located in the electronic medical record (EMR) under the "Admission" tab revealed R80 was admitted to the facility on NJ Exec Order 26 with diagnoses including NJ Exec Order of other NJ Exec Order 26.4b1 . During an observation and interview on 08/04/25 at 11:15 AM, revealed R80 had an NJ Exec Order 26.4b1 on NJ Exec Order 26 NJ Exec Order 26 R80 stated the NJ Exec Order 26 had not been NJ Exec Order 26 since NJ Exec Order 26 and it was supposed to be NJ Exec Order 26 daily. During an observation and interview on 08/04/25 at 11:23 AM, Licensed Practical Nurse (LPN1) revealed R80 had a NJ Exec Order 26.4b1 under an NJ Exec Order 26.4b1 dated NJ Exec O with LPN1's initials. LPN1 also stated she did NJ Exec Ord on R80's NJ Exec Order 26.4b1 . She further stated R80's NJ Exec Ord care was supposed to be done daily. Review of the physician order dated NJ Exec Order 26 and located in the EMR "Orders" tab revealed : NJ Exec Order 26 with normal NJ Exec Order 26.4b1 apply NJ Exec Order 26.4b1 followed by NJ Exec Order 26.4b with NJ Exec NJ Exec Order 26 every day shift for NJ Exec Order 26.4. Record review of the "Treatment Administration Record (TAR)" located in R80's EMR under the "Orders" tab revealed the following: 'NJ Exec Order 26.4b1 followed by NJ Exec Order 26.4b1 everyday shift for NJ Exec Order 26 Order date NJ Exec Order 26, discharge date NJ Exec Order 26.4. During an interview on 08/07/25 at 2:03 PM, the US FOIA (b)(6) stated if the resident's NJ Exec Order 26 was ordered to be NJ Exec Order 26 every day, NJ E expectation was the NJ Exec Order 26.4b1 every day. During an interview on 08/07/25 at 2:19 PM, the US FOIA (b)(6)) stated the resident's NJ Exec Order 26	F0684	Continued from page 25 Systemic Change *Nursing staff initiated re-educated on 8-8-25 and will continue through to completion date by staff development regarding Following physician orders as written Documentation requirements on the treatment administration record Reporting to charge nurse/director of nursing if a treatment is missed. *The identified nurse received 1:1 counseling and re-education. *A new process was implemented requiring the Unit Managers/designee to review the treatment administration record daily to ensure wound treatments are documented as completed. *The unit manager will round weekly during weekly measurement days with nursing staff to validate wound orders are current and treatments as performed as ordered. Quality Assurance The Director of Nursing/designee will audit 5 charts of residents with wound treatments weekly for 3 months, then biweekly for 3 months then monthly for 6 months, to ensure treatments are provided and documented as ordered. *The Unit managers will monitor daily that treatments are signed and dressings have the appropriate date during daily rounding. The findings will be reported to the director of nursing daily. *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The director of nursing and unit manager wound audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the director of nursing.	

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F0684 SS = D	Continued from page 26 should have been changed every day until the order was discharged according to the physician's order.. Review of the facility's policy and procedure titled "Wound Care," undated, revealed the following: “It is the policy of this facility center to provide wound care as directed by physician order to promote healing.” NJAC 8:39-3.2(a)	F0684	Continued from page 26 * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	
F0695 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 observation, record review, interviews, and policy review, the facility failed to ensure a resident NJ Exec Order 26.4b1 (Resident (R) 65) had orders and a plan of care for its use and a resident (R31) had NJ Exec Order 26.4b1 out of two residents reviewed for NJ Exec Order use out of a total sample of 33 residents. This NJ Exec Or had the potential to cause NJ Exec Order 26.4b1 . Findings include: 1.Review of R65's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed she was admitted to the facility on NJ Exec Order 26. with diagnoses including NJ Exec Order 26.4b1 . Review of the hospital "Discharge Summary" dated NJ Exec Order 26. and located under the "Misc" tab of the EMR revealed: "Patient received NJ Exec Order 26.4b1, … and we NJ Exec Order 26.4b1] as NJ Exec Order 26. Patient has been	F0695	Corrective Action Resident # 65 A physician’s order for NJ Exec Order 26.4b1 was obtained and entered into the electronic medical record. Resident #65’s care plan was immediately updated to include NJ Exec Order use. Resident #31’s NJ Exec Order 26.4b1 was replaced and equipment cleaned immediately. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change *Licensed nursing staff were re-educated by staff development initiated on 8-8-25 and until completion regarding Requirement for active physician orders for supplemental oxygen Updating the comprehensive care plan to include oxygen use Following manufacturer guidelines for concentrator filter cleaning and replacement *Oxygen filter cleaning order has been added to oxygen order set in point click care. The filters will be checked and documented weekly by nursing staff. *The unit managers will audit all residents with oxygen weekly for accurate order for oxygen administration and verify that oxygen concentrator filters are clean and free of dust.	09/08/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0695 SS = D	Continued from page 27 weaned from NJ Exec Order 26.4b1 , NJ Exec Order 2 is NJ Exec Order 2 … Will discharge with NJ Exec Order 26 It also stated to 'NJ Exec Order 26 as NJ Exec Order 26 If NJ Ex requirements NJ Exec Order 26 can consider NJ Exec Order for NJ Exec Order 26.4b1]." Review of R65's "Baseline Care Plan" dated NJ Exec Order 26 and located under the "Evaluations" tab of the EMR revealed the box for NJ Exec Order 26.4b1 was not checked. It included no information regarding NJ Exec Order 26.4b1 Review of R65's "Brief Interview for Mental Status (BIMS)" dated NJ Exec Order 26 and located under the "Evaluations" tab of the EMR revealed NJ Exe scored a NJ Exec Or out of 15, which indicated NJ Exec Order 26.4b1 Review of "Medical Visits" dated NJ Exec Order 26 and NJ Exec Order 26 and located under the "Evaluations" tab of the EMR revealed R65 was: "Seen at bedside today. … continues with NJ Exec Order 26.4b1]." Review of the "Order Recap Report" dated NJ Exec Order 26.4b1 and located under the "Orders" tab of the EMR revealed an order dated NJ Exec Order 26 to consult NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 requiring NJ Exec Order 26.4b1 . There were no orders regarding NJ Exec Order 26.4b1 use to include the amount of NJ Exec Orde required or the checking of NJ Exec Order 26.4b1 . Review of a "Medical Visit" dated NJ Exec Order 26 and located under the "Evaluations" tab of the EMR revealed directions to: 'NJ Exec Order 26.4b1 If NJ Exec Order 26.4b1 remains above NJ E NJ Exec Order 2 patient may not need NJ Exec Order 26.4b1 Review of the unfinished "Care Plan" on NJ Exec Order 26 revealed no documentation of R65's use of NJ Exec Order 26.4b1 Review of the 'NJ Exec Order 26.4b1] Summary" dated NJ Exec Order 26 revealed five documented NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 and none after NJ Exec Order 26 .	F0695	Continued from page 27 Quality Assurance The Director of Nursing/designee will audit 5 residents on oxygen weekly for 2 months, then bi-weekly for 2 months then monthly for 8 months to verify orders, care plan accuracy, and equipment maintenance including filter clean. *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The findings of the oxygen audits will be report by the Director of Nursing to the QAPI committee monthly and the QAA committee quarterly. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0695 SS = D	Continued from page 28 Review of the "Progress Notes" tab of the EMR revealed no documentation regarding R65's NJ Exec Order 26.4b1. During an observation on 08/04/25 at 12:23 PM, R65 had a NJ Exec Order 26.4b1, connected to NJ Exec Order, with the NJ Exec Order 26.4b1 on the floor and not connected to any NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was turned on and set at NJ Ex. R65 did not appear in NJ Exec Order 26.4b1 During an observation on 08/04/25 at 1:08 PM, R65 held the NJ Exec Order 26.4b1 with it not NJ Exec Order 26.4b to NJ Exec Order 26.4b1. During an interview on 08/04/25 at 2:14 PM, Licensed Practical Nurse (LPN) 1 stated she recalled R65 needed NJ Exec Order when she was first admitted to the facility. She felt R65 had orders on admission to NJ Exec Order 2 the NJ Exec Order and to consult NJ Exec Order 26.4b1 if NJ Exe continued to need NJ Exec Order. LPN1 reviewed the EMR "Orders" tab and located the NJ Exec Order 26.4b1 order but no orders indicating the use of NJ Exec Order. She then went into R65's room and noted NJ Ex on the back of NJ Exe wheelchair, which was set at NJ Ex. LPN1 said sometimes when R65 was in bed NJ Exe did not use NJ Exec Order and NJ Exec Order 26.4b1. LPN1 felt R65 used the NJ Exec Order more with NJ Exec Order During an interview on 08/06/25 at 3:44 PM, the US FOIA (b)(6)) reported R65 needed NJ Exec Order during NJ Exec Order. The therapists checked NJ Exec Order 26.4b1 NJ Exec Or before and during NJ Exec Order to determine NJ Ex needs. R65's NJ Exec Order 26.4b1 sometimes NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 During an interview on 08/06/25 at 4:06 PM, the US FOIA (b)(6) voiced the expectation that if a resident used NJ Exec Order there were orders for it in the EMR to include the rate and to check a NJ Exec Order 26 every shift. If there was no order, the nurses were expected to call the provider to obtain one. The nurses were to document NJ Exec Order use in the "Baseline Care Plan" evaluation. Review of the facility's undated "Oxygen Administration" policy revealed: "Oxygen is administered under orders of a physician, except in the case of an emergency. … Staff shall document the	F0695		

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F0695 SS = D	Continued from page 29 initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, … " 2.Review of R31's "Admission Record," located under the "Resident" tab of the electronic medical record (EMR), revealed R31 was admitted on NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 . Review of R31's quarterly "Minimum Data Set (MDS)," located in the EMR under the "RAI (Resident Assessment Instrument)" tab with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1 out of 15, indicating R31 had NJ Exec Order 26.4b1 . Review of R31's "Physician Order Sheet," located in the EMR under the "Resident" tab, revealed the following order dated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 every shift check every shift." During observations on 08/04/25 at 10:59 AM, R31's NJ Exec Order 26.4b1 had two NJ Exec Order 26.4b1 located on each side of the NJ Exec Order 26.4b1 During an interview on 08/05/25 at 3:48 PM, US FOIA (b)(6) were responsible for cleaning NJ Exec Order 26.4b1 . During an interview and observation on 08/05/25 at 3:50 PM, LPN1 went into R31's room and brought out the NJ Exec Order 26.4b1 and showed them to this surveyor on the 100 hall. LPN1 stated both NJ Exec Order 26.4b1 were dusty and dirty. LPN1 further stated maintenance were responsible for cleaning NJ Exec Order 26.4b1 During an interview on 08/05/25 at 3:57 PM, the US FOIA (b)(6)) were responsible for cleaning NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . During an interview on 08/05/25 at 3:57 PM, the	F0695		

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F0695 SS = D	Continued from page 30 US FOIA (b)(6)) stated the nurses were responsible for cleaning the NJ Exec Order 26.4b1 She further stated the NJ Exec O should be cleaned weekly. During an interview on 08/07/25 at 2:03 PM, the US FOIA (b)(6) stated his expectation was for the filters to be cleaned weekly. Review of the facility's policy and procedure titled "Departmental (Respiratory Therapy Equipment) – (Prevention of Infection)," undated, revealed the following: "9. Wash filters from oxygen concentrators as needed with soap and water. Rinse and squeeze dry." NJAC 8:39-27.1(a)	F0695		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure documentation of assessment prior to, and upon return from, NJ Exec Order and failed to ensure communication forms were used between the facility and the NJ Exec Order center for one of one resident reviewed for NJ Exec Order (Resident (R) 2) out of 33 sampled residents. This had the potential to affect the health of residents receiving NJ Exec Order 2 Findings include: Review of R2's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed she was admitted to the facility on NJ Exec Order 26. with diagnoses including NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . Review of the "Care Plan" tab revealed a focus area, "[R2] needs NJ Exec Order 26.4b1 " dated NJ Exec Order 26. with interventions including to check the NJ Exec and	F0698	Corrective Action Resident #2 nursing staff completed a full assessment prior to NJ Exec Order and immediately upon return from NJ Exec Order or NJ Exec Orde. Communication forms between the facility and the NJ Exec Order were reviewed and a new NJ Exec Order communication was implemented to ensure accurate transfer of resident information. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change *Licensed nursing staff were re-educated by staff development initiated on 8-8-25 and until completion date regarding facility policy for dialysis care, and including Pre and post dialysis assessments were completed Communication forms were used consistently between the facility and the dialysis Center Use of new standardized communication form with dialysis center	09/08/2025

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F0698 SS = D	Continued from page 31 NJ Exec Order 26.4b1 per protocol, observe/document/report any NJ Exec Order 26.4b1, any signs of NJ Exec Order 2 to the NJ Exec Order 26.4b1. Review of the "Order Summary Report" revealed orders to check vital signs every day shift order date NJ Exec Order 26, NJ Exec Order 26.4b1 every shift dated NJ Exec Order 26, remove NJ Exec Order 26.4b1 from NJ Exec Order day dated NJ Exec Order 26, and 'NJ Exec Order 26.4b1 center phone number is: xxx-xxx-xxxx NJ Exec Order days: Monday, Wednesday, Friday. Time for pick up: 4:45 AM, return time 10:30 AM. Transport to: NJ Exec Order center] via wheelchair. … " with order date NJ Exec Order 26. Review of R2's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26. and located under the "MDS" tab of the EMR revealed a "Brief Interview for Mental Status (BIMS)" score of NJ E out of 15 which indicated NJ Exec Order 26.4b1. The "MDS" indicated R2 received NJ Exec Order 2 Review of R2's "Evaluations" tab of the EMR revealed no NJ Exec Order 26.4b1 evaluations. Review of R2's "Medication Administration Record (MAR)" dated NJ Exec Order 26.4b1 and located under the "Orders" tab of the EMR revealed vital signs were recorded daily by day shift but not by night shift when NJ Exe went out to NJ Exec Order 2 Review of R2's 'NJ Exec Order 26.4b1" and "Progress Notes" tabs of the EMR revealed inconsistent documentation of NJ Exec Order 26.4b1 assessments, to include vital signs. Review of R2's "Misc" tab of the EMR revealed no scanned communication forms between NJ Exec Order and the facility. Review of R2's paper chart, located at the nursing desk, revealed "Nursing Home Communication Sheets" from dialysis to the facility with recorded NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 and NJ Exec Order 26.4 by NJ Exec Order 2 There were forms for dates: NJ Exec Order 26.4b1 In addition, the facility was able to provide communication sheets from NJ Exec Order 26.4b1. There were no communication forms between NJ Exec Order 26.4b1 During an interview on 08/05/25 at 8:46 AM, R2 reported she went to NJ Exec Order via transport from the facility	F0698	Continued from page 31 Any missing documentation was obtained immediately, and the nurse responsible was re-educated. Quality Assurance The Director of Nursing/designee will audit 100% of dialysis residents weekly to ensure Pre and post dialysis assessments are completed. Communication forms are consistently used. weekly for 12 months. The unit managers will audit 100% dialysis residents daily to ensure communication sheets are done post every dialysis. *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The findings of the dialysis audits will be reported by the Director of Nursing to the QAPI committee monthly and the QAA committee quarterly. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0698 SS = D	Continued from page 32 around 4:00 AM on Mondays, Wednesdays, and Fridays. R2 was unable to recall if the facility staff checked NJ Exec vital signs, to include NJ Exec, NJ Exec Order 26.4b1, NJ Exec Orde and NJ Exec Order 26.4b1. NJ Exec knew they were checked at the NJ Exec Order center. R2's NJ Exec Order 2 over NJ Exec Order 26.4b1 NJ Exec on NJ Exec Order 26.4b1 remained intact from NJ Exec Order 26.4b1 the day prior. R2 removed the NJ Exec Order 2 during the conversation and stated, "Sometimes when I NJ Ex Order 26.4(, NJ Exec Order 26.4b1." During an interview on 08/06/25 at 2:20 PM, Licensed Practical Nurse (LPN) 3 reported R2 left for NJ Exec Order on night shift. When R2 returned on day shift, LPN3 got a paper sent from NJ Exec Order with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 recorded on it. LPN3 stated she put a note in the EMR about what was recorded on the paper from NJ Exec Order2 and the paper went into R2's paper chart. There were no orders for an assessment upon R2's return from NJ Exec Order2 During an interview on 08/06/25 at 4:02 PM, the Unit Manager (UM) 1 reported that nursing checked residents' vital signs before they left for NJ Exec Order2 If there was anything NJ Exec Order 26.4 or anything NJ Exec Order 26 with the residents, nursing called the NJ Exec Order center. NJ Exec Order sent a paper communication form back with R2. They were in the paper chart at the desk. In addition, UM1 located three more communication forms from NJ Exec Order at the desk that were not in the chart. During an interview on 08/06/25 at 4:05 PM, the US FOIA (b)(6)) reported she was used to facilities using communication sheets that went out with residents to NJ Exec Order with pertinent information from the facility about the resident's status prior to NJ Exec Order as well as the communication from the NJ Exec Order center, but she did not think the facility did that. A review of R2's paper chart was completed with the addition of the three NJ Exec Order papers provided by UM1, and the US FOIA acknowledged many days were not accounted for. Review of the facility's undated "Dialysis" policy located in the facility's "Survey Binder" revealed the facility "will send a Dialysis Communication book with communication sheets to be completed and returned." Review of the facility's "End Stage Renal Disease, Care of a Resident with" policy, updated June 2024, revealed: "Staff caring for residents with ESRD [End Stage Renal Disease], including residents receiving dialysis care outside of the facility shall be trained in the care and special needs of these residents. … Initiate communication sheets which will be sent and	F0698		

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F0698 SS = D	Continued from page 33 received from the dialysis unit to have routine communication. The communication sheet will be kept on unit and/or in resident medical record. … The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis." NJAC 8:39-27.1(a)	F0698		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails and that assessments were completed for the risk of NJ Exec Order 26.4b1 for one of four residents (Resident (R)59) reviewed for NJ Exec Order 26 out of 33 sampled residents. The lack of NJ Exec Order 26.4b1 and proper assessment/consent could lead to NJ Exec Order 26 Findings include:	F0700	Corrective Action Resident #59's NJ Exec Order 26.4b1 was immediately reviewed. A complete NJ Exec Order risk assessment was conducted, including evaluation for NJ Exec Order 26.4b1 and documented in the medical record. Alternatives to NJ Exec Orde use were reviewed with resident/resident representative, and informed consent was obtained and filed in resident's chart. Bed was inspected to ensure appropriate size and weight compatibility. Manufacturer's recommendations for installation and maintenance were verified and documented. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. A facility wide audit of all residents with bed rails was completed to ensure Assessment of risk of entrapment prior to installation Documentation of alternatives attempted prior to bed rail use. Informed consent obtained. Bedrail compatibility and manufacturer guidelines followed. Any missing assessments, documentation, or consents were immediately corrected. Systemic Change *Licensed nursing staff were re-educated by staff development initiated on 8-8-25 and until completion date regarding facility policy for bed rails	09/08/2025

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F0700 SS = D	Continued from page 34 Review of R59's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR), revealed he was admitted to the facility on NJ Exec Order 26 with diagnoses including NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . Review of R59's annual "Minimum Data Set (MDS)" located under the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec Order 26, revealed a "Brief Interview for Mental Status (BIMS)" score of NJ E out of 15 indicating NJ Exec Order 26.4b1 . Review of R59's "Care Plan," located under the "Care Plan" tab of the EMR and dated NJ Exec Order 26, revealed no intervention related to NJ Exec Order 26.4b1 . Review of R59's "Physician Orders," located under the "Orders" tab in the EMR and dated NJ Exec Order 26, revealed, "…may have NJ Exec Order 26.4b1 while in bed for NJ Exec Order 26.4b1 . Review of R59's "Resident Evaluation/Bedrail Assist Device," located under the "Observations" tab in the EMR and dated NJ Exec Order 26, revealed no evidence of alternatives explored and no assessment for risk for NJ Exec Order 26.4b1 . During an interview on 08/06/25 at 11:29 AM, Unit Manager (UM)1 revealed that on admission staff determine if residents need NJ Exec Order 26 for NJ Exec Order 26.4b1 and if so, they get a consent form signed. She said NJ Exec Order 26 were considered a NJ Exec Order 2 unless they were used for NJ Exec Order 26.4b1 and NJ Exe They got a physician order and care planned it and residents were reevaluated quarterly. She said they offer residents alternatives on admission but most of the time they do not want the alternatives, so they are offered the NJ Exec Order 2 UM1 said they do not explore alternates prior to NJ Exec Order 2 being used for residents. She said risk for NJ Exec Order 26.4b1 was done with the consent form, but she did not want to say there was a process to assess for risk of NJ Exec Order 26.4b1 She said nursing and nursing assistant staff do a visual observation of the bed and NJ Exec Order During an interview on 08/07/25 at 11:24 AM, the US FOIA (b)(6) stated there was not a process to assess for risk of entrapment for NJ Exec Orde use. During an interview on 08/07/25 at 3:07 PM, the US FOIA (b)(6)) said sometimes the family would request bedrails and/or therapy would say if there was a need for NJ Exec Order 2 She said it would be on the care plan, and they got informed consent. She said	F0700	Continued from page 34 Updated bed rail audit tool implemented to track compliance. Bed rails will not be installed without director of nursing/designee approval and signed documentation checklist. Quality Assurance The Director of Nursing/designee will audit 10% of residents with bed rails weekly x 8 weeks, then monthly x 10 months to ensure Alternatives considered and documented Assessments completed Informed consent obtained Bedrail compatibility and manufacturer requirements are met. *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The findings of the bed rail audits will be reported by the Director of Nursing to the QAPI committee monthly and the QAA committee quarterly. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0700 SS = D	Continued from page 35 she was unsure if they are accessing for risk of entrapment or exploring alternatives prior to use. Review of the facility policy titled “Siderails” undated revealed, “each resident has the right to be free from restraints imposed for purposes of convenience or discipline. Siderails will be applied and monitored within the context of individualized care planning after alternative methods for treating the resident's medical symptoms have been found to be ineffective. On admission all residents will be evaluated for side rail use. Maintenance will do side rail entrapment assessment of the bed and equipment.” NJAC 8:39-27.1(a)	F0700		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, 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	F0755	Corrective Action Resident #113's NJ Exec Order 26.4b1) was obtained and administered as ordered by the provider on NJ Exec Order 26.4b1 resident #113 received NJ Exec Orde which was documented as effective. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change *Licensed nursing staff were re-educated by staff development initiated on 8-8-25 and until completion date regarding admission/readmission medication reconciliation policy. A new admission medication checklist has been implemented and must be signed by the admitting nurse and reviewed by the nurse supervisor within 2 hours of admission. The pharmacy consultant was instructed to include admission medication reconciliation during their medication review. The pharmacy consultant was directed to provide additional consultation on reconciliation procedures and to assist in staff education initiated on 8-8-25	09/08/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	Continued from page 36 §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 interview, record review, and policy review, the facility failed to ensure a medication was ordered upon admission from the hospital for one resident (Resident (R) 113) out of a total sample of 33 residents. This failure increased the risk that the resident would have NJ Exec Order 26.4b1. Findings include: Review of R113's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed she was admitted to the facility on NJ Exec Order 26 with diagnoses including NJ Exec Order 26.4b1 and encounter for other NJ Exec Order 26.4b1 Review of R113's hospital "Discharge Documentation" dated NJ Exec Order 26 and provided by the facility from the resident's paper chart revealed NJ Exec Order 26.4b1 on NJ Exec Order 26 and NJ Exec Order 26.4 R113 had an NJ Exec Order 26.4b1) on NJ Exec Order 4. Discharge medications included acetaminophen NJ Exec Order 2 every six hours as needed (PRN) for NJ Exec Order 26 and NJ Exec Order 26.4b1 every four hours as needed for NJ Exec Order 26.4b1) for up to five days. Review of R113's "Order Recap Report" for her admission located under the "Orders" tab of the EMR revealed orders on admission (NJ Exec Order 26) for NJ Exec Order 26.4b1 included NJ Exec Order 26.4b1 every six hours PRN for NJ Exec Order 26 as well as for NJ Exec Order 26.4b1 every four hours PRN for NJ Exec Order 26. The NJ Exec Order 26.4b1 every four hours for NJ Exec Order 26.4b1 ordered on the hospital's discharge medication list was not ordered by the facility staff. Review of R113's "Medication Administration Record (MAR)" dated NJ Exec Order 26.4b1 and located under the "Orders" tab of the EMR revealed she received NJ Exec Order 26.4b1 at 10:20 PM for NJ Exec rated as 'NJ E on a NJ Exec Order 26.4b1, which indicated NJ Exec Order 26.4b1 for which NJ Exec Order 26.4b1 was ordered per the hospital "Discharge Documentation." Review of the “MAR” revealed the NJ Exec Orde was effective with a NJ Exec Order 26.4b1.	F0755	Continued from page 36 and until completion date regarding controlled drug access from the emergency supply. All new admissions/ readmissions will be reviewed next morning post admission during the clinical morning meeting to verify accurate reconciliation of medications, Quality Assurance The Director of Nursing/designee will audit 100% of admissions/readmissions daily in morning clinical meeting for 12 months to ensure all medications are correctly transcribed, ordered and obtained timely. *Any trends or non-compliance will result in immediate staff re-education and corrective counseling. *The findings of the admission/readmission audits will be reported by the Director of Nursing to the QAPI committee monthly and the QAA committee quarterly. * The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	Continued from page 37 Review of NP1's "General Note" dated [NJ Exec Order 26] and located under the "Progress Notes" tab of the EMR revealed R113 "appears in [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] States she has only had [NJ Exec Orde] for [NJ Exec] and was taking [NJ Exec Order 26.4b1] in the hospital." Review of R113's "Order Recap Report" located under the "Orders" tab of the EMR revealed that on [NJ Exec Order 26] at 11:35 AM, NP1 ordered [NJ Exec Order 26.4b1] every six hours PRN. Review of R113's discharge "Minimum Data Set (MDS)" located under the "MDS" tab of the EMR with an "Assessment Reference Date (ARD)" of [NJ Exec Order 26] revealed a score on the "Brief Interview for Mental Status (BIMS)" of [NJ E] out of 15 which indicated [NJ Exec O] During a telephone interview on 08/05/25 at 2:20 PM, R113 stated [NJ Exec Order 26.4b1] prior to [NJ Exe] admission to the facility. She stated she had to wait for [NJ Exec Order 26.4b1] because the pharmacy closed at a certain time the day [NJ Exe] arrived. R113 reported [NJ Exe] was in [NJ Exec] and [NJ Exec Order 26.4b1] or [NJ Ex] for three days. The [NJ Exec Order 26.4b1] finally arrived, and the [NJ Exec Order 26.4b1] helped “a little bit.” During an interview on 08/05/25 at 12:37 PM, Licensed Practical Nurse (LPN)1 reported the process for ordering medications was that nurses entered the admission orders into the EMR off of the hospital's discharge summary after confirming all medications with the nurse practitioner. If medications were awaiting delivery by the pharmacy, there were back up boxes of medications in the medication room. If a medication was not available in the back-up supply, nurses were to call the doctor or nurse practitioner about changing the medication to one the facility had access to. During an interview on 08/06/25 at 2:20 PM, LPN3 also reported that the facility was able to get medications from the back-up box in the medication room. If a medication was not in the back-up supply, nurses called to see if a different medication was available. During an interview on 08/07/25 at 2:55 PM, the [US FOIA (b)(6)]) reported nurses called and reviewed medication orders with the provider for all new admissions. Then nurses entered the medication orders into the EMR. The [US FOIA] said she was unsure why the [NJ Exec Order 26.4b1] order from the hospital was not transcribed into the EMR. The nurse who entered the order was no longer employed by the facility, and NP1	F0755		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	Continued from page 38 was unavailable due to emergency medical leave. During an observation on 08/07/25 at 3:30 PM, the medication room had a locked cupboard of back-up medications. A list of available medications included in the back-up supply included both NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 During an interview on 08/07/25 at 5:55 PM, the US FOIA (b)(6) stated that when a resident was admitted to the facility, the nursing staff called the nurse practitioner to confirm the medications. The nurse practitioner conferred with the US FOIA (b)(6). Nursing staff entered the orders into the EMR for the nurse practitioner to sign. The US FOIA (b)(6) stated he expected that a resident who had a NJ Exec Or of the NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 days prior to admission, who received NJ Exec Order 26.4b1 in the hospital, and who had it ordered on discharge from the hospital, to have NJ Exec Order 26.4b1 ordered by the facility. Review of the facility's "Medication and Treatment Orders" policy, dated July 2024, revealed, "Drug and biological orders must be recorded on the physician's order sheet in the resident's chart…" Review of the facility's undated "Pharmacy Services Overview" policy revealed that pharmaceutical services consisted of: "The processes of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, … Pharmacy services are available to residents 24 hours a day, seven days a week. Residents have sufficient supply of their prescribed medications and receive medications [routine, emergency or as needed] in a timely manner." NJAC 8:39-27.1(a)	F0755		
F0812 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.	F0812	Corrective Action On 8-8-25_the dietary manager (DM) did an Inservice on hand hygiene, changing gloves before and after each task, with all dietary staff. The potholder attached to the ceiling was permanently removed and the ceiling was completely cleaned. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The dietary manager re-educated all her staff on 8-8-25	09/08/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = F	Continued from page 39 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure the kitchen was clean and staff performed handwashing between glove use and task changes. These failures had the potential to affect 103 residents who consumed food prepared by the facility's kitchen. Findings include: During observation of the kitchen on 08/04/25 at 10:02 AM, dust was noticed on the potholder above the steam table where meals were served and on the ceiling around the vent areas above the sink and shelving. During observation on 08/06/25 at 11:56 AM, lunch was served from the steam table that sat directly beneath the potholder that had dust on it. And staff were observed to use tongs that had been hanging on the potholder. Also, the trays and plates were set up under the vent area where dust was hanging from the ceiling. During the meal service on 08/06/25, the following was observed: At 11;:6 AM, Cook1 was observed to take off gloves and went over to the stove and touched the knob on the front of the stove. Cook1 went to the sink and started grabbing utensils that hung above the sink and moving them over to the steamtable for serving. At 11:58 AM, Cook1 was observed to put gloves on and took dirty dishes to the dish area and returned to the main kitchen wearing the same gloves and went to the sink and began wiping it down. At 12:01 PM, Cook1 was observed to take off gloves and	F0812	Continued from page 39 regarding hand hygiene including before and after glove use. The ceiling tile was completely cleaned on 8-8-25 Quality Assurance 1. The DM, or designee, will monitor hand hygiene for proper procedure daily. Any trends of non-compliance identified will receive corrective counseling and re-education immediately. The Dietary manger will monitor the ceiling for cleanliness during weekly sanitation rounds. 2. The audit findings for hand hygiene and sanitation rounds will be reported to the QAPI meeting monthly and the QA committee quarterly by the DM or designee. 3. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F0812 SS = F	Continued from page 40 wash hands. There were no paper towels in the dispenser, and she left the kitchen area and went to the storeroom with wet hands and grabbed some napkins. She returned with the napkins and placed them at the sink area. At 12:03 PM, Cook1 was observed to pick up a paper towel off the floor and put it in the trash. Cook1 went over to the stove and adjusted knobs and then reached into a box of gloves and pulled out a pair. During an interview on 08/06/25 at 12:51 PM, Cook1 was asked about the different observations made during the meal service. Cook1 agreed with the observations and admitted her hands should have been washed after taking off gloves and before putting on new gloves. Cook1 stated she should have washed hands after picking up the paper towel and placing it in the trash. Cook1 also confirmed the dust on the ceiling and potholder above the food service area. Cook1 was asked who should be cleaning the ceiling. Cook1 stated she did not know. During an interview on 08/06/25 at 12:55 PM, the US FOIA (b)(6) was shown the ceiling. The US FOI confirmed the dust and grease was over the food service area. The US FOI was asked who should clean it and she stated it was maintenance that should clean the ceilings. The US FOI was also asked about the hand washing observations for Cook1. The US FOI stated hands should be washed when gloves are removed and before putting on another pair. The US FOI also stated hand washing should have occurred after picking up the paper towel off the floor. During an interview on 08/07/25 at 12:22 PM, the US FOIA (b)(6)) was asked who should clean the ceilings in the kitchen and he stated it was maintenances responsibility. Review of the facility policy titled, “Routine Cleaning and Disinfection” dated August 2025 revealed, “Policy Statement: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. . . Policy Explanation and Compliance Guidelines. . . 4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas	F0812		

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F0812 SS = F	Continued from page 41 to include, but not limited to. . . o. Ceiling vents, tiles and ceiling surfaces should be inspected and cleaned when visibly soiled or as part of scheduled deep- cleaning protocols to minimize dust and microbial buildup. . . 13. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. Ceiling tiles and air vents should be dusted and cleaned as needed or as part of scheduled preventive maintenance. . .” Review of the facility policy titled, “Hand Hygiene” dated April 2023 revealed, “Policy Statement: All staff perform proper hand hygiene procedures to prevent the spread of infection to the other personnel residents, and visitors. This applies to all staff working in allocations within the facility. Policy Explanation of Compliance Guidelines. . . immediately before putting on gloves and after glove removal. NJAC 8:39-17.2(g)	F0812		
F0814 SS = F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure the dumpsters’ lids were closed, the plugs were in place, and used gloves and debris was picked up off the ground. This failed practice had the potential to allow trash and animals to enter and leave the dumpster and cause sanitary issues. Findings include: Observation of the dumpster on 08/04/25 at 10:10 AM, revealed two dumpsters for refuse. Both dumpsters’ lids were open and when the US FOIA (b)(6)) shut the lids a liquid substance splashed on the US FOIA There were gloves and other debris lying on the ground around the dumpsters. Neither dumpster had plugs in the holes at the bottom of the container. During an interview on 08/04/25 at 10:10 AM, The US FO was asked whose responsibility it was to clean up the area and maintain the dumpsters. The US FO stated the maintenance department.	F0814	Corrective Action Both dumpster lids were closed, with the plugs replaced, and all used gloves and debris were removed from the ground on 8/8/25. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change Laminated signage was displayed on the dumpsters ensuring that all lids must be closed at all times. The dietary staff were in serviced by the Environmental Services (EVS) Manager on 8/8/25 to ensure that they are aware to keep the dumpsters closed, to keep the area around the dumpsters clean, and to report if they see a loose or removed plug at the bottom of the dumpsters. Quality Assurance 1. The EVS Manager, or designee, will audit the dumpsters weekly x 12 weeks then biweekly for 12 weeks then monthly for six months. Any trends of non-compliance identified will receive corrective counseling and re-education immediately. 2. The dumpster audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by	08/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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

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F0814 SS = F	Continued from page 42 During an interview on 08/07/25 at 12:22 PM, the US FOIA (b)(6) stated it was maintenance responsibility. Review of the facility policy titled, “Preventive Maintenance Program” dated 12/28/22 revealed, “Policy: A preventive Maintenance Program shall be developed and implemented to ensure the provision of safe, functional, sanitary, and comfortable environment for residents, staff, and the public. . .” NJAC 8:39-19.7	F0814	Continued from page 42 the EVS Manager or designee. 3. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061703	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		08/29/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/22/2025

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

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/22/2025 in relation to the 8/7/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/06/25 and 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. Autumn Lake Healthcare at Salem County is a one-story building built in 1964. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator powers 100% of the building per the Maintenance Director. The current occupied beds are 105 of 116.	K0000		08/29/2025
K0222 SS = F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs	K0222	The vendor (current technologies) installed a new magnetic lock system (Mag Lock system) with egress. The facility determined that all residents have the potential to be affected by this deficient practice. All staff received re-education on 8-8-25 by the environmental services manager regarding the 15 second delay to open alarmed egress after alarms sounds. The Environmental Services manager/designee, will check the egress doors weekly for 12 weeks then bi-weekly for 12 weeks then monthly for 6 months. Any trends of non-compliance identified will receive corrective counseling and re-education immediately. The alarmed egress audit findings will be reported to the QAPI meeting monthly and the QAA committee quarterly by the environmental services manager. The administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	08/29/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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

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K0222 SS = F	Continued from page 1 of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that the egress doors with delayed egress would release when pushed upon in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.2.2.2.4.(2). This deficient practice had the potential to affect all 105 residents and was evidenced by the following: An observation on 08/06/25 at 1:28 PM revealed the double egress exit doors with delayed egress near the	K0222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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

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K0222 SS = F	Continued from page 2 laundry would not open when pushed upon. Signage on the door stated, "PUSH UNTIL ALARM SOUNDS - DOOR CAN BE OPENED IN 15 SECONDS." The U.S. FOIA (b) (6) pushed on the door for 25 seconds; however, the audible alarm did not sound, and the door did not open after 15 seconds. An observation on 08/06/25 at 1:38 PM revealed that the double egress exit doors with delayed egress near Rehabilitation would not open when pushed upon. Signage on the door stated, "PUSH UNTIL ALARM SOUNDS - DOOR CAN BE OPENED IN 15 SECONDS." The U.S. FOIA (b) (6) pushed for 25 seconds; however, the audible alarm did not sound, and the door did not open after 15 seconds. During an interview at the time of observations, the US FOIA (b)(6) confirmed that the double doors with delayed egress hardware near the laundry room and Rehabilitation would not open when pushed upon. NJAC 8:39-31.1(c), 31.2(e)	K0222		
K0351 SS = F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	K0351	Corrective Action Parts to replace the conduit and electrical box were immediately ordered. The parts arrived on 8/25/25 and were installed on 8/25/25. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The conduit and electrical box replaced on 8/25/25, and the panel is properly marked also on 8/25/25. Quality Assurance 1. The Environmental Services (EVS) Manager will check the conduit and electrical box weekly for 12 weeks, then biweekly for 12 weeks then monthly for 6 months to ensure that there are no loose wires. 2. The conduit and electrical box audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the EVS Manager, or designee.	08/29/2025

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K0351 SS = F	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on document review and interview, it was determined that the facility failed to ensure non-metallic sheath cable was not exposed for fire sprinkler equipment in the sprinkler room in accordance with NFPA 70 National Electrical Code (2011 Edition) section 334.10 (5). This deficient practice had the potential to affect all 105 residents and was evidenced by the following: Observations on 08/06/25 at 12:20 PM of the sprinkler system room revealed non-metallic sheath cable was exposed in the sprinkler system room connected to the compressor for the dry sprinkler system going through the wall and into the electrical panel in the boiler room (panel was not marked). During an interview at the time of observation, the US FOIA (b)(6) confirmed that the non-metallic sheath cable was exposed from the dry sprinkler compressor to the electrical panel in the boiler room. NJAC 8:39-31.2(e) NFPA 70	K0351	Continued from page 3 3. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K0353	Corrective Action The EVS (Environmental Services) Manager consulted the fire protection contractor about proper code and reviewed the deficiency to ensure proper inspection is done up to code on 8/8/25. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The EVS Manager will go over the inspection reports and ensure the contractor is up to code weekly for 12 weeks, then biweekly for 12 weeks then monthly for 6 months. Quality Assurance 1. The fire protection proper code audit findings will	08/29/2025

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K0353 SS = F	Continued from page 4 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on document review and interview, it was determined that the facility failed to ensure the fire department connection (FDC) was hydrostatic tested every five-years in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) section 6.3.2.1. This deficient practice had the potential to affect all 105 residents and was evidenced by the following: A review of the facility's untitled sprinkler system records revealed no documented evidence the FDC was hydrostatic tested within the last five years. During an interview on 08/06/25 at 1:05 PM, the US FOIA (b)(6) confirmed that fire department connection had not been hydrostatic tested. At 4:10 PM the US FOIA (b)(6) contacted the contracted fire sprinkler company who stated that it was on page three of the report. A review of the report indicated that the FDC was back flushed and not hydrostatic tested. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K0353	Continued from page 4 be reported to the QA committee quarterly by the EVS Manager, or designee. 2. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	
K0355 SS = F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on document review and interview, it was determined that the facility failed to ensure the placard for the class K fire extinguisher was located near the class K fire extinguisher in accordance with NFPA 10 Standard for Portable Fire Extinguishers (2010 Edition) section 5.5.5.3. This deficient practice had the potential to affect all 105 residents and was	K0355	Corrective Action The EVS (Environmental Services) Manager relocated the fire extinguisher away from the pull station on 8/8/25 and added a placard stating, “To Allow System to activate before using the extinguisher” also on 8/8/25. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change All dietary staff received re-education, by the EVS Manager, on 8/8/25, on the proper use of ANSUL fire extinguisher as indicated by the placard. Quality Assurance	08/29/2025

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K0355 SS = F	Continued from page 5 evidenced by the following: An observation on 08/06/25 at 12:05 PM revealed that the portable K-Type fire extinguisher was not provided with a placard stating that the suppression system shall be activated first, then the portable K-Type may be used as a secondary. During an interview at time of observation, the US FOIA (b)(6) confirmed that placard was not present at the K-Type fire extinguisher. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96	K0355	Continued from page 5 1. The Environmental Services Manager, or designee, will check the extinguisher and placard weekly for 12 weeks then biweekly for 12 weeks then monthly for 6 months. 2. The fire extinguisher and placard audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the EVS Manager, or designee. 3. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	
K0511 SS = F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure non-metallic sheath cable wiring was concealed in walls or conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) section 334.10 (5). This deficient practice had the potential to affect all 105 residents and was evidenced by the following: An observation on 08/06/25 at 12:29 PM revealed non-metallic sheath cable wiring was exposed in the boiler room from the electrical switch to the pump for the boiler. During an interview at the time of observation, the US FOIA (b)(6) confirmed the non-metallic sheath cable wiring was exposed.	K0511	Corrective Action Parts to replace the conduit and electrical box were immediately ordered. The parts arrived on 8/25/25 and were installed on 8/25/25. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The conduit and electrical box were replaced on 8/25/25, and panel is properly marked on 8/25/25. Quality Assurance 1. The Environmental Services (EVS) Manager will check the conduit and electrical box weekly for 12 weeks then biweekly for 12 weeks then monthly for 6 months to ensure that there are no loose wires. 2. The conduit and electrical box audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the EVS Manager, or designee. 3. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the	08/25/2025

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K0511 SS = F	Continued from page 6 NJAC 8:39-31.2(e) NFPA 70	K0511	Continued from page 6 implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	
K0741 SS = F Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure ashtrays were installed in the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.4. (5) and smoking refuse was disposed of in a safe manner. This deficient practice had the potential to affect all 105 residents and was evidenced by the following: Observations on 08/06/25 at 12:53 PM of the facility designated smoking area, revealed no ashtrays were	K0741	Corrective Action The smoking receptacles were immediately replaced in the designated smoking area alongside the Justrite Oily Waste can metal receptacle where both are used for cigarette butts on 8/8/25. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change Signage was put at the smoking area so that residents who smoke are aware of using the metal receptacles for cigarette butts and not for garbage on 8/8/25. The Environmental Services (EVS) Manager, or designee, will have the housekeeping staff clean the smoking receptacles daily and ensure the receptacles remain in place. The EVS Manager, or designee, will check the receptacle weekly for 12 weeks then biweekly for 12 weeks then monthly for 6 months to ensure that they are being used properly. Quality Assurance 1. The smoking receptacle audit findings will be reported to the QAPI meeting monthly and the QA committee quarterly by the EVS Manager, or their designee. 2. The Administrator will be responsible for overseeing the completion and continuation of all audits and findings. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	08/29/2025

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K0741 SS = F Bldg. 01	Continued from page 7 provided in the smoking area. Over 150 cigarette butts were located on the patio concrete and in the grass area around the smoking pavilion. Three self-closing fire rated trash cans were in the smoking pavilion with mixed cigarette butts and trash in the cans. During an interview at the time of the observations, the US FOIA (b)(6) stated the ashtrays were removed from the smoking pavilion. The US FOIA (b)(6) stated at the Life Safety Code exit conference that the last surveyor told the facility to remove the ashtrays and put in the fire rated metal trash cans. NJAC 8:39-31.2(e), 31.6(e)	K0741		

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/06/25. The facility was found to be in compliance with 42 CFR 483.73.	E0000		08/29/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

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K0000	INITIAL COMMENTS An on-site revisit was conducted on 11/20/2025 to verify the facility's Plan of Correction for the 8/7/2025 Recertification survey. The facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: REPEAT DEFICIENCY from the 08/07/2025 Re-Certification survey. Based on document review on 11/202025 in the presence	K0353		08/29/2025

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

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

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K0353 SS = F Bldg. 01	Continued from page 1 of the facility's US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure the fire department connection (FDC) was hydrostatic tested every five-years in accordance with NFPS 25 standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition section 6.3.2.1. This deficient practice had the potential to affect the103 Residents and was evidence4d by the following: On 11/20/2025 during the survey entrance at approximately 9:18 AM, a request was made to the US FOIA (b)(6) [redacted] to provide the last three quarterly (every 3 months) sprinkler inspections for the year 2025 and the five-year Hydrostatic testing for the FDC which had been cited during the 08/07/2025 Re-Certification survey. A review of the facility provided quarterly fire sprinkler inspections identified the following,Quarterly sprinkler 10/29/2025 reads in part, Deficiencies: Fire Department Connection Damaged Piping and Fittings in outside outside Pit needs to be replaced. Replace 4" Butterfly (GRV) on C and D Wing Fire Sprinkler System that does not close properly. System C and D losing Air-Pressure this should be investigated and corrected. Replace damaged 3/4" Angle Valve on "B" system.The facility failed to correct the deficiency with a completion date of 08/29/2025.The DEVSM confirmed the findings. The US FOIA (b)(6) [redacted] were informed of the repeat deficiency during the Life Safety Code survey exit at approximately 1:05 PM. NJAC 8:39 -31.1 (c), 31.2 (e).	K0353		