STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. Building B. Wing	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, NJ 08079

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 unrelieved pain.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 [DATE] with diagnoses including spondylosis (degenerative changes of the spine) and encounter for other orthopedic aftercare (surgery).Review of R113's hospital Discharge Documentation dated 10/17/24 and provided by the facility from the resident's paper chart revealed she underwent fusion of the spine (back surgery) on 10/08/24 and 10/14/24. R113 had an unplanned cage migration (movement of hardware used during the surgeries, which can cause pain) on 10/15/24. Discharge medications included acetaminophen 1000mg every six hours as needed (PRN) for mild pain and oxycodone 5mg every four hours as needed for moderate pain (pain scale four to seven) 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 [DATE]) for pain management included acetaminophen 1000mg every six hours PRN for mild pain as well as for acetaminophen 650mg every four hours PRN for mild pain. The oxycodone 5mg every four hours for moderate to severe pain ordered on the hospital's discharge medication list was not ordered by the facility staff.Review of R113's Medication Administration Record (MAR) dated 10/01/24 - 10/31/24 and located under the Orders tab of the EMR revealed she received acetaminophen 1000mg on 10/17/24 at 10:20 PM for pain rated as 5 on a zero to ten pain scale, which indicated moderate pain, for which oxycodone was ordered per the hospital Discharge Documentation. Review of the MAR revealed the Tylenol was effective with a pain scale rating of zero.Review of NP1's General Note dated 10/18/24 and located under the Progress Notes tab of the EMR revealed R113 appears in obvious pain and restlessness. States she has only had Tylenol for pain and was taking oxycodone 10mg in the hospital.Review of R113's Order Recap Report located under the Orders tab of the EMR revealed that on 10/18/24 at 11:35 AM, NP1 ordered oxycodone 10mg 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 10/26/24 revealed a score on the Brief Interview for Mental Status (BIMS) of 15 out of 15 which indicated intact cognition.During a telephone interview on 08/05/25 at 2:20 PM, R113 stated she had major surgery on her back a week prior to her admission to the facility. She stated she had to wait for her oxycodone because the pharmacy closed at a certain time the day she arrived. R113 reported she was in pain and unable to sleep or eat for three days. The oxycodone finally arrived, and the Tylenol (acetaminophen) 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 Director of Nursing (DON) reported nurses called and reviewed medication orders with the provider for all new admissions. Then nurses entered the medication orders into the EMR. The DON said she was unsure why the oxycodone 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 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 oxycodone 5mg and oxycodone 10mg.During an interview on 08/07/25 at 5:55 PM, the Medical Director 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 Medical Director. Nursing staff entered the orders into the EMR for the nurse practitioner to sign. The Medical Director stated he expected that a resident who had a fusion of the vertebrae from lumbar five to sacral one with a biomedical cage/bone graft nine days prior to admission, who received oxycodone in the hospital, and who had it ordered on discharge from the hospital, to have