STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315195	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Berkeley Heights	35 Cottage Street Berkeley Heights, NJ 07922

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Date: 01/20/2025Complaint #: 2712991Census: 92 Based on interviews, medical record review, and review of other pertinent facility documentation on 01/21/2026 it was determined that the facility failed to follow their protocol and policy to prevent the elopement of a resident (Resident #2) who exited the facility through the lobby, got a ride to the train station, and took public transportation out of town. The resident missed the return bus and spent the night in a hospital lobby before returning to the facility the next day. This deficient practice was identified for 1 of 3 residents reviewed for elopement (Resident 2).This deficient practice was evidenced by the following: According to the admission Record (AR) Resident #2 was admitted to the facility with diagnoses including but not limited to: other lack of coordination; schizophrenia (mental health condition that results in hallucinations, delusions, and disorganized thinking and behavior), unspecified; unspecified abnormalities of gait and mobility; anxiety disorder (intense, excessive and persistent worry and fear about everyday situations), unspecified; and depression (persistent feeling of sadness and loss of interest), unspecified. A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated 01/09/2026, revealed that Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. A Facility Reportable Event (FRE), a document used to report events to the New Jersey Department of Health, dated 01/08/2026 was reviewed. The FRE revealed that on 01/07/2026 at approximately 7:00 PM, the Director of Nursing (DON) was notified that Resident #2's dinner tray was untouched, and that Resident #2 was not in their room during staff rounds. A search was conducted, police were notified, and the resident's family was notified. Resident #2 returned to the facility on [DATE] at approximately 9:05 AM. A review of Resident #2's progress notes (PN) revealed a PN written by the Nursing Supervisor (NS) dated 01/07/2026 at 11:55 PM, which indicated that the resident was not seen in their room or the facility during the 3:00 PM - 11:00 PM shift. The PN further revealed that an elopement alert was initiated; the facility and neighborhood were searched; and police, doctor, and resident family were notified. A PN written by Licensed Practical Nurse (LPN) #1 dated 01/08/2026 at 1:32 AM, revealed that Resident #2 was not seen in their room at 3:15 PM, 5:00 PM, and 5:30 PM. At 5:30 PM LPN #1 searched for the resident and did not find them. At 6:00 PM, LPN #1 notified the NS. The PN further revealed that at 7:15 PM, it became clear that Resident #2 was not in the facility and had left without notifying anyone. A PN written by the Unit Manager (UM) dated 01/08/2025 at 9:46 AM, revealed that Resident #2 returned to the facility that morning and complained of leg pain and had redness to their leg. The physician was notified and advised that Resident #2 be evaluated in the emergency room (ER). A PN written by the UM dated 01/08/2025 at 11:36 AM, revealed that Resident #2 refused to go to the ER. An interview was conducted with Resident #2 on 01/20/2026 at 10:16 PM. Resident #2 stated that on 01/07/2026 they left the facility and were picked up by a friend, then took public transportation to their hometown to handle some personal (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	errands. The resident stated that they missed the last two busses that would have brought them to the train back to the facility. Resident #2 stated that they then went to a nearby hospital, were given food, and slept in the lobby. Resident #2 stated that the next day they took public transportation back to the facility. Resident #2 stated that when they returned to the facility they were checked by a nurse and refused to be evaluated in the ER. During the same interview Resident #2 stated that in the past when they wanted to leave the facility, they would inform their nurse, and the nurse would sign them out. Resident #2 stated that on 01/07/2026 they told a Certified Nursing Assistant (CNA) that they wanted to go out but did not inform a Nurse or get signed out. Resident #2 further stated that they stayed out of the facility overnight by mistake due to missing the bus. A telephone interview was conducted with Registered Nurse (RN) #1 on 01/20/2026 at 1:08 PM. RN #1 cared for Resident #2 on day shift on 01/07/2026. RN #1 stated that she last saw Resident #2 at 11:00 AM, or 12:00 PM on 01/07/2026. RN #1 stated that she did not see Resident #2 again before the end of her shift at 3:00 PM, but this was not unusual. RN #1 stated that she endorsed care of Resident #2 to LPN #1 at 3:00 PM, and did not endorse that she had not seen Resident #2 after 12:00PM. The Surveyor attempted to reach LPN #1 for a telephone interview but was unsuccessful. A telephone interview was conducted with CNA #1 on 01/20/2026 at 2:33 PM. CNA #1 stated that she delivered at tray to Resident #2's room at approximately 5:00 PM. CNA #1 stated that when she returned to pick up the tray, it was untouched. CNA #1 stated that she informed LPN #1 that the resident did not eat. CNA #1 stated that she thought the resident was out smoking but she became concerned later when she learned that the resident was missing. An interview was conducted with the Regional Director of Nursing (RDON) on 01/20/2026 at 3:33 PM. The RDON stated that usual process when Resident #2 went out of the facility was for the resident to inform their nurse and sign out. The RDON stated that Resident #2 followed that process most of the time, but on 01/07/2026 the resident did not tell anyone they were leaving. The facility policy, Elopements and Wandering Residents, updated 10/2024, was reviewed. The policy revealed under Policy; that residents who were at risk for elopement received adequate supervision to prevent accidents. Under, Policy Explanation and Compliance Guidelines: the facility policy revealed, 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering [.] d. adequate supervision will be provided to help prevent accidents or elopements. NJAC 8:39-33.1(d)