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	11/18/2025

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 - Some	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** Based on observations, interviews, record reviews, and review of pertinent facility documents, it was determined that the facility failed to implement a system for staff to consistently check the function of wander guards used on residents at risk for wandering/elopement. This deficient practice was identified for 3 of 3 residents (Resident #19, #43, and #79) reviewed for wander guards. The deficient practice was evidenced by the following:1.On 9/19/25 at 10:54 AM, during an initial tour on A-wing, the surveyor observed Resident #79 lying on their bed with a beige colored band around their right ankle. The surveyor reviewed the EMR for Resident #79. A review of the admission Record reflected that Resident #79 was admitted with diagnoses which included but were not limited to; major depressive disorder, anxiety disorder, cerebral infarction (lack of blood flow to the brain causing brain tissue damage), and metabolic encephalopathy. A review of the Quarterly MDS dated [DATE] reflected that Resident #79 had a BIMS score of 12 out of 15, which indicated the resident had moderate cognitive impairment. A Wandering/Elopement Assessment with an effective date of 7/5/25 revealed a score of 10, which indicated that Resident #79 was at risk to wander. A review of the ICCP included a focus area, with revision on 2/4/25, which indicated that Resident #79 is an elopement risk/wanderer. is confused at times and can be impulsive. has a wander guard on right ankle. Interventions/Tasks included .wander alert placed to right ankle, expiration date 9/2027. A review of the eTAR reflected an order dated 2/4/25 to check right ankle wander guard for function and placement every shift for elopement monitoring. On 9/23/25 at 9:17 AM, the surveyor interviewed the receptionist, who stated that if a resident had a wander guard, once they got close to the front door, the alarm beeped and the front door locked. She added if she saw a resident she did not recognize, she would call nurse's station to ask if it was ok if the resident went outside alone. The receptionist stated that pictures of all the residents with a wander guard were at the front desk. At that time, the surveyor observed Resident #79's picture was posted at the desk.On 9/23/25 at 9:45 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 on A-wing, who stated that resident #79 had an alarm on their ankle, a wander guard, which alerted staff if the resident tried to leave the building. LPN #1 stated that by signing the electronic Treatment Administration Record (eTAR) to check the wander guard placement and function, she was confirming she checked if it's there or not. She could not answer to how the function of the wander guard was checked.On 9/23/25 at 10:00 AM, in the presence of the surveyor and LPN #1, the A-wing Unit Manager (UM) stated that the nurses checked the placement of the wander guards. The UM stated the function of the wander guards was checked by the unit clerk (UC) on B-wing, who had a machine and scanned it [the wander guard] like at a grocery store. The UM stated this was done weekly, or maybe monthly. On 9/23/25 at 10:15 AM, the surveyor interviewed the UC on B-wing. The UC produced a binder which she referred to as the elopement binder. The UC opened the binder to a page titled Residents with Wander guards. A table on this page listed the room number, resident name, original date, expiration date, and location [area of the resident's body] of the wander guards for four residents, which included Residents #19, #43, and #79. The UC acknowledged that she was responsible for checking the function of the wander guards, (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 - Some	and they were to be checked every day on every shift. The UC stated that when she was not working, a nursing supervisor was supposed to check the wander guard function. The UC added that regardless of who checked the function, the date and time would be noted on a calendar in the elopement binder. The UC stated that to check the wander guard function, a hand-held scanner was used [showed the surveyor a portable electronic device]. The UC stated that the scanner does not need to touch the wander guard, you can just put it near it, and a green light goes on. The UC was unable to show the surveyor the calendar that revealed the wander guard function was checked for the above mentioned residents.On 9/24/25 at 8:56 AM, the surveyor interviewed Resident #79 in their room. Resident #79 pointed to the band around their right ankle and stated that is an alarm system. They say it's in case I escape. 2. The surveyor reviewed the EMR for Resident #43. A review of the admission Record reflected that Resident #43 had diagnoses including but not limited to; metabolic encephalopathy and Alzheimer's Disease. A review of the Quarterly MDS dated [DATE], reflected the resident had a BIMS score of 6 out of 15, which indicated severe cognitive impairment. A review of the Wandering/Elopement Assessment with an effective date of 8/15/25 revealed a score of 12, which indicated that Resident #43 was at a high risk to wander. A review of the ICCP revealed a Focus indicating that the resident was an elopement risk/wanderer, disoriented to place, impaired safety awareness, wanders aimlessly. 3. The surveyor reviewed the EMR for Resident #19. A review of the admission Record (an admission summary) reflected that Resident #19 had diagnoses which included but were not limited to; metabolic encephalopathy (impairment of brain function due to a chemical imbalance in the blood) and dementia. A review of the Quarterly Minimum Data Set (MDS) dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated severe cognitive impairment. A review of the Wandering/Elopement Assessment with an Effective Date: 09/12/2025 revealed a score of 11, which indicated Resident #19 was at a high risk to wander. A review of the individual comprehensive care plan (ICCP) reflected a Focus revised on 12/16/22 that the resident is an elopement risk/wanderer, disoriented to place. Interventions/Tasks included wander alert placed to left ankle, expiration date 9/2027. Check placement and function every shift. Date Initiated: 02/20/2023 Revision on: 04/10/2025. A review of the electronic Treatment Administration Record (eTAR) revealed a physician's order to monitor left ankle wander guard for function and placement every shift for elopement monitoring, dated 2/4/25. On 9/25/25 at 10:10 AM, the surveyor requested the UC to demonstrate the use of the scanner to check the function of a wander guard. The UC stated It [the scanner] isn't working. The UC stated that after a new system was installed a few months ago, the scanner did not work. The UC stated that she took the residents with wander guards to the front door, and if the alarm went off, this confirmed that the wander guard was functioning. The UC stated that she asked the UM to check the wander guards yesterday. The UC stated that each unit has an elopement binder, and added, Remember I told you yesterday about the calendars we write on? I'll show you. The UC, with the surveyor, walked to the nurse's station. The UC picked up a white binder and stated it was the elopement binder for that unit. The UC was unable to locate a calendar in the binder. The UC, with the surveyor, walked to the front desk where the receptionist was seated. The UC picked up a binder from the desk and stated to the receptionist, in the presence of the surveyor, from now on when someone comes up and the wander guard alarms you need to write it in here [the UC pointed to the binder]. That's what we are going to start doing now. At that time, the surveyor observed pictures of Residents #19, #43, and #79 posted at the front desk. On 9/25/25 at 11:33 AM, the surveyor interviewed LPN #1, who stated that someone else checked the function of the wander guards. She was not sure who checked them, nor how often they were checked. On 9/25/25 at 11:35 AM, in the presence of the surveyor, the UM reviewed the EMR for Resident #79 which revealed a physician's orders to check for wander guard function and placement every shift. The UM stated that if she wanted to check the function of the resident's wander guard, she would take them to the front door. Then the door makes a sound like a suction, like a magnet click, and it won't open. The UM stated if the resident got closer to the door, the door would (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alarm. The UM stated that the nurses do not always check the function of the wander guards, that me or somebody else might do it if they [the nurses] were busy. But the nurses were expected to sign the eTAR order that the function was checked. The UM stated that the nurse would know the function of the wander guard had been checked because It's the way we communicate. We have huddles every morning and we know the expectations. The UM stated On the overnight shift, I don't think they're going to wake them up to walk them out the front door. I will have to check. The UM stated that she was ultimately responsible to ensure the residents' wander guard function and placement was checked. On 9/25/25 at 11:47 AM, the surveyors observed Resident #79 return to the facility, wearing a wander guard to their right ankle. When the resident was transported into the facility, the alarm sounded at the front door and the receptionist had to cancel the alarm. On 9/25/25 at 12:20 PM, the surveyor interviewed the Maintenance Director (MD), who acknowledged that a new wander guard system was put in about January, and that the wander guard scanner on B-wing was not compatible with the new system. On 9/25/25 at 1:37 PM, the MD produced an invoice from [company redacted] dated 10/02/2024. The invoice contained Completion Notes: Run cable and install upgraded [name redacted] patient wander control system. Patient transmitters will also have to be upgraded. The MD was not able to provide any additional information regarding the wander guard system. On 9/25/25 at 2:50 PM, the surveyor conducted a phone interview with Registered Nurse (RN) #1. RN #1 stated she worked as a night shift nurse on A-wing. RN #1 stated her process to check the function of a wander guard was, if a resident with a wander guard was up walking around at night, she took them to the door, and the door made a sound. RN #1 stated, All doors take the alarm, and that the resident could be taken to any door. RN #1 stated, You get about two feet away [from the door] and the alarm goes off. RN #1 stated if a resident with a wander guard was in bed all night, honestly I don't check the function of their wander guard. On 9/26/25 at 9:59 AM, the surveyor interviewed RN #2, who was working on A-wing. She stated that to check the placement and function of a resident's wander guard, she would check their legs to make sure it was there. RN #2 stated If it's not working, I'm not sure how I would know. RN #2 stated I think the alarm on their ankle beeps. I'm not sure. I never heard it. RN #2 stated that if a resident with a wander guard tried to go outside, the wander guard would beep. On 9/26/25 at 10:41 AM, the survey team met with the Regional Director of Nursing (RDON) and the Administrator. The RDON stated, The transmitter [for the wander guard system] was ordered, after surveyor inquiry. The RDON stated that residents with wander guards had to be taken to the door to check the wander guard function. The RDON stated the wander guard system alarms at every door. She stated that if a resident with a wander guard was taken near a door, you hear it click. That means the door locks. She added that if the resident with a wander guard tried to open the door, then it will alarm. The Administrator stated the wander guard alarm was at the front door. The surveyor reviewed the facility provided Policy Elopements and Wandering Residents updated October 2024. This policy reflected that the facility ensures that residents who . are at risk for elopement . receive care in accordance with their person-centered plan of care. Under the heading Policy Explanation and Compliance Guidelines: Number 3 reflected, The facility shall establish and utilize a systematic approach for monitoring and managing residents at risk for elopement or unsafe wandering, including . monitoring for effectiveness and modifying interventions when necessary. Number 4, letter e, reflected Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. NJAC 8:39-27.1(a)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of medical records, other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 2 of 25 residents reviewed (Resident #7 and Resident #93). This deficient practice was evidenced by the following: 1.On 9/19/2025 at 10:35 AM, the surveyor observed Resident #7 lying in bed with tube feeding infusing via a pump at 65 cc/hr (cubic centimeters per hour). On 9/23/2025 at 10:17 AM, the surveyor reviewed the electronic medical record (EMR) which revealed a physician order, dated 9/2/25, for continuous feeding of Glucerna 1.5 @ 65ml/hr (milliliters per hour) for a total volume of 1170 mls.A review of the individual comprehensive care plan (ICCP) included a focus area dated 9/2/25, that the resident required a tube feeding.A review of the medical provider note dated 9/2/25, includes diagnosis of diabetes (high blood sugar) and dysphagia (difficulty swallowing).A review of the comprehensive admission Minimum Data Set (MDS), an assessment tool, dated 9/5/25, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment, no diagnoses were indicated in section I, and tube feeding was not indicated in section K. On 9/24/2025 at 1:22 PM, the surveyor interviewed the MDS Coordinator (MDSC) regarding no diagnoses and no tube feeding coded on the MDS. She stated she wasn't sure what happened with Resident #7, that it was her error. 2.On 9/19/2025 at 10:28 AM, the surveyor observed Resident #93 in a wheelchair and the resident stated all was well. The staff indicated presence of a colostomy (surgically placed opening in the abdomen for the release of stool from the body).On 9/23/2025 at 12:29 PM, the surveyor reviewed the EMR which revealed a physician order dated 5/30/25 to check colostomy bag every shift and if filled 3/4, change for new one.A review of the ICCP included a focus area initiated 9/30/22 addressing the presence of a colostomy. A review of the Treatment Administration Record (TAR) for July 2025, indicated that colostomy check, and care were performed every shift, every day of the month.A review of the most recent quarterly MDS dated [DATE], revealed a BIMS score of 9, indicating moderately impaired cognition, diagnoses including atrial fibrillation (an irregular and often rapid heart rhythm), and section H did not indicate the presence of an ostomy.On 9/24/2025 at 1:27 PM, the surveyor interviewed the MDSC regarding Resident #93's ostomy. She stated ostomy should have been checked and it was her error. On 09/25/2025 at 2:42 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Corporate Director of Nursing (DON) and made them aware of the above concerns. No further information was provided. A review of facility provided policy, MDS 3.0 Completion reviewed 10/24, which included:Policy Statement:Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Policy implementation and interpretation:1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State.4. Care Plan Team Responsibility for Assessment Completion: ^a. Interdisciplinary Responsibility for Completion of MDS Sections:ii. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections.^^b. Coding of Assessment:^^^i. All disciplines shall follow the guidelines in chapter 3 of the current RAI manual for coding each assessment. N.J.A.C 8:39-11.1