STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Southgate	449 S Pennsville-Auburn Road Carneys Point, NJ 08069

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40041

Complaint #NJ 169844

Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident environment, equipment, and living areas in a safe, sanitary, and homelike manner.

This deficient practice was evidenced on 3 of 3 resident units (100, 200, and 300 Unit) and was evidenced by the following:

1.) On 2/20/25 at 9:58 AM, the surveyor, in the presence of Registered Nurse/Unit Manager (RN/UM) #1, observed the following in the pantry area on the 300 unit:

-A water cooler had a build-up of white streaks and grime.

-An ice cart that contained a plastic liner with multiple rips and brown stains.

-The black lid on a large gray trash can contained a build-up of white and brown substances.

At that same time in the day room, the following was observed:

-The black lid on a large gray trash can also contained a build-up of white and brown grime throughout.

On 2/20/25 at 10:14 AM , the surveyor interviewed Housekeeper (HSK) #5, who stated that when she cleaned the pantry area, she sweeps, checks for paper towels and soap, cleans next to and behind the refrigerator, makes sure there was nothing on top of the counter, takes out the trash, sweeps and mops the floor. She did not include cleaning the water cooler or trash can lids.

On 2/20/2025 at 10:20 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that the water cooler should be kept sparkling and should be cleaned twice a shift. She further stated that the ice cart should be taken to the kitchen daily to be cleaned by the dietary staff.

(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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/25 at 10:06 AM, the surveyor interviewed the Food Service Director (FSD) who stated that the kitchen staff was responsible for cleaning the ice carts and they should be cleaned once per week. She further stated, when they bring them to us, we clean them. Some units never brings them to us at all. 41072 2.) On 2/20/25 at 10:30 AM, the surveyor conducted resident council with five (5) oriented residents (Resident #5, #14, #28, #44 and #64). Resident # 28 stated that the windows have not been washed and there were cobwebs in the windows. Resident #28 further stated that the housekeeping department was short staffed. Four (4) out of five (5) residents verbalized agreement that the windows were not clean, and there were cobwebs present on both the inside and the outside of the windows at the facility. On 2/21/25 at 10:46 AM, the surveyor observed the following on the 200 Unit: -The large atrium windows with a large windowsill in the resident lounge had large cobwebs located in each corner. One large window had a large crack. The doors and windows that led to a courtyard had a film on the inside and black debris at the edge of the doors that met the flooring. -Resident #89's shower located the resident's bathroom had a black substance on the floor and a shower chair with washcloths hanging on the chair. On 2/21/25 at 10:49 AM, the surveyor observed the following on the 100 unit: -The window and doors located at the end of the hallway by room [ROOM NUMBER] had large number of cobwebs on the outside of the window and the door. -The window located in Resident #28's room had a film on the window and a dark colored cobweb outside in the right corner of the window. -In the resident lounge, the large atrium window located above the doors had several large cobwebs in the corners. On 2/21/25 at 11:00 AM, the surveyor observed the following in the 300-Unit lounge: -Cobwebs in the corners of the large atrium window -A white substance with black dots on the ceiling in the middle of the vaulted ceiling. On 2/21/25 at 11:03 AM, the surveyor interviewed Housekeeper (HSK) #1 on the 200 Unit who stated she had been employed with the facility for about three weeks. She stated her responsibilities included to clean both resident hallways, including the resident's rooms, the lounge, and offices. She further stated that every day the lounge was swept and mopped, the tables were wiped, and the inside windows were cleaned. HSK #1 stated dusting was done where needed, but she doesn't dust up high by the atrium windowsills. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/25 at 11:10 AM, the surveyor interviewed HSK #2 on the 100 Unit who stated she had been employed with the facility for one month. She stated she was responsible to clean both hallways including the resident rooms and the lounge. HSK #2 further stated that everyday she swept and mopped the lounge and wiped the tables and countertops before breakfast. She stated that she does not dust up high by the atrium windowsills. On 2/21/25 at 11:26 AM, the surveyor interviewed the Interim Director of Housekeeping (IDH) who stated he had been employed at the facility in the housekeeping department since 1994. The IDH stated that each unit was supposed to have two housekeepers each but at this time each unit only had one housekeeper. The IDH further stated the housekeeping department had one laundry aide and one floor technician on the 3-11 PM shift. The IDH explained the floor technician would empty trash, mop the floors, and would clean a resident's room on occasion if needed for an admission. The IDH further stated that housekeeping was responsible for cleaning the units, the resident's rooms, the lounge, and inside and outside windows. The IDH stated the outside windows have not been cleaned in over five years. He also stated that housekeeping was responsible for dusting the atrium windowsills in the unit lounges, but it has been over five years since they were cleaned because a ladder would be needed to clean the atrium windowsills. The IDH stated that cobwebs should not be in the lounges where the residents eat and do activities. He explained that it was important that the facility be kept clean because the facility should be kept like it is their home. On 2/21/25 at 12:25 PM, the surveyor was accompanied by the Licensed Nursing Home Administrator (LNHA) and toured the 100, 200, and 300 units. The LNHA stated that he completes environmental rounding of the building and looked for cleanliness and safety maintenance. At that time, residents were eating lunch in all three lounges. The LNHA confirmed the presence of the cobwebs in each unit lounge and the cobwebs outside the facility on the windows and doors. The LNHA stated, about the window located at the end of the 100-unit hallway, it's a beautiful window you want to look out of it. The LNHA stated that he will have someone clean all the cobwebs in the windows that day and clean the outside of the building. The LNHA stated it's hard to keep up with the outside of the building and we try to do what's needed. On 2/21/25 at 12:25 PM, the surveyor interviewed the Director of Maintenance (DM) who stated he had been the director for [AGE] years. The DM stated that the facility should be kept in good repair. He further stated that the housekeeping department was responsible for dusting the lounges, A review of the facility's Trashcan [sic.] Receptacle Management and Disinfection Procedures policy, updated January 2025, included Trash cans and surrounding areas must be disinfected at least once daily or more frequently if soiled or contaminated. A review of the facility's Ice Machines and Ice Storage Chests policy, updated January 2025 included To help prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow these precautions: clean and sanitize the chest and ice scoop daily; Regular cleaning of ice chests or coolers, especially before use and when contaminated or soiled. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Routine Cleaning and Disinfection policy, undated, included that the facility is 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 Clean from top to bottom (bring dirt from high levels down to floor levels Horizontal surfaces with infrequent hand contact (window sill and hard surface flooring) in routine resident care area should be cleaned on a regular basis and when soiling and spills occur Area around the buildings shall be maintained in a safe and orderly manner. NJAC 8:39-4.1 (a)11; 31.2(e)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43308 Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to implement the facility's abuse policy to ensure reference checks were completed for 10 of 10 employee files reviewed. This deficient practice was evidenced by the following: On 2/25/25 at 11:00 AM, the surveyor reviewed the 10 randomly selected employee files, which revealed the following: 1. Registered Nurse (RN #1), with a hire date of 4/16/24, did not have a previous employee reference on file. 2. Licensed Practical Nurse (LPN #5), with a hire date of 1/21/25, did not have a previous employee reference on file. 3. Certified Nursing Assistant (CNA #5), with a hire date of 1/7/25, did not have a previous employee reference on file. 4. Housekeeper (HSK #8), with a hire date of 1/30/25, did not have a previous employee reference on file. 5. CNA #6, with a hire date of 10/15/24, did not have a previous employee reference on file. 6. LPN #6, with a hire date of 6/12/24, did not have a previous employee reference on file. 7. Dietary Aide (DA #4), with a hire date of 6/13/23, did not have a previous employee reference on file. 8. RN #2, with a hire date of 3/14/23, did not have a previous employee reference on file. 9. HSK #9, with a hire date of 3/19/24, did not have a previous employee reference on file. 10. [NAME] #3, with a hire date of 9/14/24, did not have a previous employee reference on file. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/25 at 11:59 AM, the surveyor interviewed the Director of Human Resources (DHR) who stated she completed the reference checks, but a lot of times she was not successful with reaching the references. The DHR stated she normally attempted three times if not successful. She then stated that most of the hires were re-hires, or they knew a current employee whom she obtained the reference from. The DHR stated that the references would be documented on the reference form or on the back page of the application. She stated if the employee was a re-hire, then she did not complete the reference check unless it was more than a year. The DHR stated most of the references were current employee references, and so they were a verbal conversation. She stated she was the only one that did the reference checks. At that time, the DHR confirmed the verbal references were not documented. She stated it was important to document to ensure it was done and to know if there were any issues in their prior jobs. The DHR stated that was one of her weaknesses not documenting after she talked to someone. The surveyor continued to interview the DHR who stated that RN #1, CNA #5, HSK #8, and HSK#9 were all re-hires; LPN #5 and DA #4 had verbal references from current employees; CNA #6 and LPN #6 were agency staff they liked and became employees; and for RN #2 she did not call the references. The DHR then stated she utilized the Health Care Facility Inquiry Regarding Health Care Professional form as part of the reference check for RN #2. She stated she was unsure where it was, but confirmed it was not in the folder; and [NAME] #3 she stated the reference check sheet was accidentally shredded. On 2/25/25 at 12:31 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the DHR kept him in the loop regarding new hires and that the reference checks were done as needed. He then stated that the DHR oversaw the reference checks. When asked did employees that were re-hired, or hired from agency need a reference check, the LNHA stated he would have to ask the DHR regarding if reference checks were needed. On 2/25/25 at 12:38 PM, the LNHA stated that for an agency staff who became their staff, they obtained the reference checks from the current staff. He stated he was not sure if those reference checks were a verbal conversation or documented. The LHNA stated for employees that were re-hired, then it was based on their prior history at the facility in a short period of time. The LNHA stated that it was important to ensure reference checks were done for the safety of the residents. On 2/25/25 at 12:42 PM, the DHR provided her job description and an applicant employment verification form. At that time, the DHR confirmed she did not have any documented evidence that the 10 employees reference checks were completed. On 2/25/25 at 2:00 PM, the DHR confirmed she did not complete an applicant employment verification form and provided blank forms for the 10 of 10 employees reviewed. A review of the DHR's job description, included check applications and references of prospective employees. A review of the facility's Abuse, Neglect and Exploitation policy undated, included, 1. Screening: a. potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property .reference checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. NJAC 8:39-9.3(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45589 Complaint #: NJ167424, NJ169906, NJ170986 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to develop an individual comprehensive care plan (ICCP) to include a.) tube feeding, b.) risk for pain, and c.) oxygen use. This deficient practice was identified in 3 of 28 residents (Resident #85, #108, and #391) reviewed and was evidenced by the following: 1.) On 2/25/25 at 10:14 AM, the surveyor reviewed the medical record for Resident #85. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, encounter for surgical aftercare following surgery on the digestive sysytem and gastrostomy (a flexible tube inserted through the abdominal wall and into the stomach). A review of the Minimum Data Set (MDS), an assessment tool, dated 2/3/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS in Section K -Swallowing/Nutritional Status indicated the resident had a feeding tube on admission and while a resident. A review of the physician's orders (PO) revealed the following: -A PO, dated 1/31/25, for enteral feed (a method of providing nutrition directly into the stomach through a tube) every shift for percutaneous endoscopic gastrostomy (PEG- a flexible, thin tube inserted through the abdominal wall into the stomach) tube maintenance. Check residual and hold if greater than 100 millitiers (ml) -A PO, dated 2/3/25, for enteral feed one (1) time a day start (nutritional supplement) at 65 cubic centimeters (ccs)/hour (hr) until total volume (TV) 800ccs infused. -A PO, dated 2/12/25, enteral feed four (4) times a day flush peg tube with (w/) 240 ccs water (H20). -A PO, dated 2/15/25, for enteral feed four (4) times a day flush peg tube w/ 240ccs H20 -A PO, dated 2/18/25, for enteral feed four (4) times a day flush peg tube with w/ 240 ccs of H2O A review of the individualized comprehensive care plan (ICCP) did not include a focus area for the peg tube. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/25 at 11:11 AM, the surveyor interviewed the Director of Nursing (DON) who stated that a baseline care plan was done upon admission and that the ICCP was placed sometime after. The DON stated that care plans should be reviewed upon admission or re-admission. The DON stated she was unable to state the importance of keeping the care plan up to date. On 2/25/25 at 11:43 AM, during tour of the 200 Unit's dining room, Resident #85 was observed awake and alert, sitting in a wheelchair. At that time, the surveyor interviewed Resident #85 who stated they did not have any concerns with the tube feeding. On 2/25/25 at 12:25 PM, the surveyor interviewed the Regional Nurse, who stated that the care plan should be updated to reflect care for the peg tube and tube feeding, however, the timing depended on if the MDS was due. The Regional Nurse also stated that the DON was responsible for the ICCP. 41260 2.) On 2/19/25 at 10:05 AM, during the initial tour, the surveyor observed Resident #108 lying in bed. At that time, a nurse entered the room to administer the resident's medications and asked the resident if he/she had pain. The resident complained of nine out of 10 pain to his/her back. When the nurse left the room to get the resident pain medication, the resident stated his pain was not being managed properly. The resident explained that he/she had pain in his/her back from a prior surgery and that he/she had esophageal cancer as well. On 2/21/25 at 9:35 AM, the surveyor reviewed the medical record for Resident #108. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, multiple fractures of ribs, encounter for other orthopedic aftercare, and malignant neoplasm (cancer) of the esophagus. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/27/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident frequently had pain that limited his/her day-to-day activities and rated the pain level as moderate. A review of the Medical Visit evaluation, dated 10/8/24, revealed the resident had recently fell , sustained right sided rib fractures, and had surgery to correct the fractures. Further review of the evaluation included a recommendation from the Nurse Practitioner (NP) for a pain management appointment. A review of the Order Summary Report, dated as of 2/25/25, included the following physician's order (PO): -A PO, dated 11/20/24, for oxycodone 10 milligrams one tablet every eight hours as needed for pain. A review of the February 2025 Medication Administration Record revealed the above order for oxycodone was administered 31 times from 2/1/25 through 2/25/25 for a pain level ranging from five to nine out of 10 on the pain scale. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the individual comprehensive care plan (ICCP) did not include a care plan related to the resident's pain. On 2/25/25 at 10:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the Unit Managers (UM) were responsible for creating resident care plans right away so that staff know the needs of the resident, the resident's history, and how to accommodate the resident. The LPN further stated that interventions for a resident with pain included adjusting pain medications, making sure pain was not affecting activities of daily living, assessing pain level, and notifying the physician of any issues with pain management. The LPN added that pain should be included on the care plan for a resident with pain. On 2/25/25 at 10:52 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated care plans were created collaboratively by the nursing, social services, activities, and dietary departments within 24 hours of the initial care conference which takes place within the first two weeks of the resident's admission. The LPN/UM added that if there was a change in the resident's condition, the care plan would be updated within 48 hours. The LPN/UM further stated that interventions for a resident with pain included monitoring pain levels, attempting non-pharmacological interventions, providing pain medication as ordered, and notifying the physician of inadequate pain management. The LPN/UM also stated that pain should be included on the care plan for a resident with pain. On 2/25/25 at 1:54 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team, the Regional Nurse, and the Licensed Nursing Home Administrator. The DON stated that the comprehensive care plans were created within 21 days of the resident's admission and updated quarterly and as needed. When asked about Resident #108, the DON stated the resident should have had a care plan related to pain. 3.) On 2/20/25 at 10:01 AM, the surveyor reviewed the closed medical record for Resident #391. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and acute and chronic respiratory failure. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/14/23, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident received oxygen therapy. A review of the September, October, November, and December 2023 Treatment Administration Records revealed the resident was receiving oxygen at a rate of two to three liters continuously via nasal cannula. A review of the individual comprehensive care plan (ICCP) did not include a care plan related to the resident's oxygen use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/25 at 10:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the Unit Managers (UM) were responsible for creating resident care plans right away so that staff know the needs of the resident, the resident's history, and how to accommodate the resident. The LPN further stated that interventions for a resident with oxygen included ensuring the resident was wearing the oxygen as ordered, ensuring the oxygen equipment was functioning properly, and checking the resident's pulse oximetry (measures oxygen saturation in the blood) every shift and as needed. The LPN added that oxygen use should be included on the care plan for a resident who wears oxygen. On 2/25/25 at 10:52 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated care plans were created collaboratively by the nursing, social services, activities, and dietary departments within 24 hours of the initial care conference which takes place within the first two weeks of the resident's admission. The LPN/UM added that if there was a change in the resident's condition, the care plan would be updated within 48 hours. The LPN/UM further stated that interventions for a resident with oxygen included monitoring pulse oximetry, ensuring oxygen tanks were not empty, and following the physician's order for oxygen use. The LPN/UM also stated that oxygen use should be included on the care plan for a resident who wears oxygen. On 2/25/25 at 1:54 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team, the Regional Nurse, and the Licensed Nursing Home Administrator. The DON stated that the comprehensive care plans were created within 21 days of the resident's admission and updated quarterly and as needed. When asked about Resident #391, the DON stated the resident should have had a care plan related to oxygen use. A review of the facility's Comprehensive Care Plans policy, updated 10/17/23, included the following: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. NJAC 8:39-11.2 (e)(f)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40041 Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for bilateral heel boots (a pressure-relieving device) for a resident at risk for developing pressure ulcers. This deficient practice was identified for 1 of 1 resident (Resident #7) reviewed for positioning and mobility and was evidenced by the following: On 2/20/25 at 12:37 PM, the surveyor observed Resident #7 resting in bed. The resident was awake and stated that he/she was not wearing heel boots at that time and would like to wear them. The resident's feet were noted to be resting on two green pillows. There were no heel boots observed in the resident's room. The surveyor reviewed the medical record for Resident #7. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, hemiplegia and hemiparesis, morbid obesity, mild protein calorie malnutrition, and restless leg syndrome. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/11/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS revealed the resident was at risk for developing pressure ulcers. A review of the resident's individual comprehensive care plan (ICCP) included a focus area that the resident was at risk for skin breakdown. Interventions included: heel boots. A review of the Order Summary Report (OSR), dated 2/24/25, included a physician's order for bilateral (B/L) heel boots when in bed as tolerated every shift for prevention. On 2/20/25 at 12:44 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #7) who stated Resident #7 wears B/L heel boots and the caretaker would put them on and take them off. She also stated that the resident did not refuse them and was always offered them. LPN #7 further stated that the heel boots were used to prevent heel pressure ulcers. On 2/20/25 at 12:48 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) #8 who stated, the resident had pads on, and I put those under her feet. She further stated that Resident #7 did not decline treatment. She further stated the nurse would be notified if the resident declined any treatment. The surveyor, accompanied by the CNA #8, returned to the resident's room and CNA #8 stated this is what I use, and pointed to a green pillow. On 2/20/25 at 1:05 PM, the surveyor asked the Director of Nursing (DON) to show the surveyor a pair of heel boots. The DON presented a pair of heel boots and stated, This is what we use. At that time, the surveyor accompanied the DON and the CNA into the resident's room. The DON and CNA both applied the B/L heel boots. The resident accepted the heel boots and stated, It feels fine. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Southgate	449 S Pennsville-Auburn Road Carneys Point, NJ 08069

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/25 at 1:38 PM, the surveyor conducted a follow-up interview with the DON, who stated that if there was an order in place for heel boots, it should be followed. A review of the facility's Physician Orders policy, updated April 2024, included All nurses will follow physician orders and recommendations. NJAC 8:39-27.1(e)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40041 Complaint #: NJ167424 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow a physician's order for a resident who required continuous oxygen. This deficient practice was identified for 1 of 3 residents (Resident #31) reviewed for respiratory care and was evidenced by the following: On 2/19/25 at 9:57 AM, during the initial tour of the facility, the surveyor observed Resident #31 resting in bed with their eyes closed and receiving oxygen via nasal cannula (N/C; a device that delivers extra oxygen through a tube and into the nose). On 2/20/25 at 9:02 AM, the surveyor observed Resident #31 resting in bed with their eyes closed. At that time, the surveyor observed the resident wearing a N/C which was connected to an empty portable oxygen tank on the back of the resident's wheelchair. At 9:06 AM, the surveyor interviewed Certified Nurse Aide (CNA) #4 who stated that she was assigned to care for Resident #31. She stated that the resident had not yet gotten out of bed that morning. At 9:10 AM, the surveyor returned to the resident's room accompanied by Licensed Practical Nurse (LPN) #3, who confirmed that the N/C that the resident was using was connected to an empty portable oxygen tank. LPN #3 connected the N/C to the oxygen concentrator (a medical device that filters nitrogen out of air to deliver oxygen-enriched air) and replaced the portable oxygen tank. At 9:28 AM, the surveyor conducted a follow-up interview with LPN #3 who stated that the resident required checks to ensure that the resident was receiving oxygen. He further stated that upon entering the room, normally he would check to ensure that everything was connected properly and the portable tank had oxygen in it. LPN #3 stated that it was important for Resident #31 to get oxygen to maintain safe oxygen levels. At 9:38 AM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #1 who stated, Resident #31's oxygen should be administered continuously as per the physician's order. She stated that everyone was responsible for ensuring that the resident was receiving oxygen. She then stated that the portable oxygen tanks did not last too long, therefore, every person that went in the resident's room should be checking to ensure there was oxygen in the tank. On 2/20/25 at 11:00 AM, the surveyor reviewed the medical record for Resident #31. A review of the Admission Record, an admission summary, revealed Resident #31 had diagnoses which included chronic obstructive pulmonary disease (COPD) with acute exacerbation and anxiety disorder. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated 12/12/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS revealed the resident experienced shortness of breath or trouble breathing when lying flat and received continuous oxygen therapy. A review of the Order Summary Report (OSR) revealed a physician's order (PO), dated 1/31/25 at 11:00 PM, for oxygen at two liters via N/C continuously. A review of the resident's individualized comprehensive care plan (ICCP) revealed a focus area of oxygen therapy and nebulizer use related to ineffective gas exchange due to chronic obstructive pulmonary disease (COPD) via concentrator and portable oxygen tank (E tank). Interventions included: oxygen via N/C at two liters continuously. On 2/21/25 at 1:30 PM, the surveyor interviewed the Director of Nursing (DON), who stated that Resident #31's oxygen should be administered continuously as per the physician's order. She stated that the staff should be aware that it was in place and the resident was receiving it. She further stated that the resident was ambulatory and should have a portable oxygen tank containing oxygen readily available. A review of the facility's Physician Orders policy, updated April 2024, included All nurses will follow physician orders and recommendations. NJAC 8:39-27.1(a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 41260 Complaint #: NJ169906 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to follow-up on a healthcare provider's recommendation for a pain management appointment in a timely manner for 1 of 2 residents (Resident #108) reviewed for pain management. This deficient practice was evidenced by the following: On 2/19/25 at 10:05 AM, during the initial tour, the surveyor observed Resident #108 lying in bed. At that time, the nurse entered the room to administer the resident's medications and asked the resident if he/she had pain. The resident complained of nine out of 10 pain to his/her back. When the nurse left the room to get the resident pain medication, the resident stated his pain was not being managed properly. The resident explained that he/she had pain in his/her back from a prior surgery and that he/she had esophageal cancer as well. The resident further stated that he/she had been asking to see a pain management specialist, but that nothing is being done about it. On 2/21/25 at 9:35 AM, the surveyor reviewed the medical record for Resident #108. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, multiple fractures of ribs, encounter for other orthopedic aftercare, and malignant neoplasm (cancer) of the esophagus. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/27/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident frequently had pain that limited his/her day-to-day activities and rated the pain level as moderate. A review of the individual comprehensive care plan (ICCP) did not include a care plan related to the resident's pain. A review of the Order Summary Report, dated as of 2/25/25, included the following physician's order (PO): -A PO, dated 11/20/24, for oxycodone 10 milligrams one tablet every eight hours as needed for pain. A review of the February 2025 Medication Administration Record revealed the above order for oxycodone was administered 31 times from 2/1/25 through 2/25/25 for a pain level ranging from five to nine out of 10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Medical Visit evaluation, dated 10/8/24, revealed the resident had recently fell , sustained right sided rib fractures, and had surgery to correct the fractures. Further review of the evaluation included a recommendation from the Nurse Practitioner (NP) for a pain management appointment. A review of the Appointment/Outing Note, dated 10/28/24, included, Resident needs pain management consult r/t [related to] chronic pain. A review of the Medical Visit evaluation, dated 11/04/24, revealed the NP again recommended a pain management appointment related to the resident's chronic pain. Further review of the Appointment/Outing Notes revealed the next note regarding the pain management appointment was on 12/26/24, which was written by Unit Clerk (UC) #1 and included the following: called [pain management specialist] and they did not take [his/her] insurance. A review of the census tab in the resident's electronic medical record (EMR) revealed the resident's room was switched from the 300 unit to the 100 unit on 1/7/25. Further review of the Appointment/Outing Notes revealed the next note regarding the pain management appointment was on 1/27/25, which was written by UC #2 and included that she spoke with the NP who gave the okay to send the resident to a pain management appointment. The note further indicated that she called a pain management specialist (the same one UC #1 called on 12/26/24) and that they did not take the resident's insurance. The note also included that UC #2 asked the Admissions Director (AD) to call the resident's insurance company to see where the resident could go for pain management. There were no further Appointment/Outgoing Notes related to the resident's pain management appointment after 1/27/25 through 2/25/25. On 2/25/25 at 10:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that when a recommendation was made for a resident to be scheduled for an appointment, the UC was notified to set up the appointment and transportation. The LPN further stated that it was the Unit Manager's (UM) responsibility to ensure that resident appointments were being scheduled as recommended. The LPN added that it was important to ensure resident appointments were scheduled for the resident's progress and overall health, and that the resident, should live the same here as at home. On 2/25/25 at 10:52 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated when an appointment was recommended, the nurse would notify the UC to set up the appointment and transportation. The LPN/UM further stated that it was the UM's responsibility to ensure appointments were being made as recommended. The LPN/UM added that it was important for resident appointments to be scheduled because, if the physician recommends a specialist, it is something they feel the resident needs. When asked about Resident #108, the LPN/UM stated the UC was handling his/her pain management appointment and was trying to find one that takes his/her insurance. The LPN/UM was unsure when the process for finding a pain management specialist had started. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/25 at 11:02 AM, the surveyor interviewed the UC for the 100 unit (UC #2) who stated she was made aware of appointment recommendations through the Appointment/Outings Notes in the residents' EMR. The UC stated that appointments should be scheduled right away to ensure the resident is healthy. When asked about Resident #108, the UC stated she had to find a pain management specialist that took the resident's insurance. The UC added that she received a prescription from the NP on 1/27/25, for the resident to consult pain management related to chronic pain and that she was given a list of pain management specialists that took the resident's insurance. The UC was unable to recall when she received the list or who gave the list to her. The UC removed the list from the bottom of her drawer designated for scheduling appointments, and the 1/27/25 prescription for pain management was paperclipped to the list. The surveyor reviewed the list with the UC and observed there were 16 pain management specialists highlighted. The UC explained that the highlighted offices took the resident's insurance. When asked which offices the UC had already attempted to call, the UC stated she had not yet tried to schedule the resident for any of the highlighted offices. On 2/25/25 at 11:18 AM, the surveyor interviewed the UC for the 300 unit (UC #1) who stated appointment recommendations were communicated to her verbally or through the Appointment/Outings Notes in the EMR. The UC stated that appointments should be scheduled within 24-72 hours of receiving the recommendation and that she documented when she called the doctors' offices in the Appointment/Outing Notes. The UC stated it was important to schedule recommended appointments to continue the resident's care, and that it's part of the resident's treatment. When asked about Resident #108, the UC could not recall any specifics related to his/her pain management appointment. On 2/25/25 at 11:21 AM, the surveyor interviewed the NP who stated she was managing Resident #108's pain at the facility. She further stated that the facility was having difficulty finding a pain specialist office that would take the resident's insurance and that the issue had been ongoing. At that time, the surveyor informed the NP that UC #2 had a list of pain management specialists that accepted the resident's insurance, and the NP verified that Resident #108 should still be scheduled to see a pain management specialist. On 2/25/25 at 12:06 PM, the surveyor interviewed the Admissions Director (AD). The surveyor asked the AD about the Appointment/Outings Note, dated 1/27/25, which indicated UC #2 had asked the AD to call the resident's insurance to find a pain management specialist that will accept the resident's insurance. The AD stated that the note was not accurate and that he never called the resident's insurance. On 2/25/25 at 1:54 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team, the Regional Nurse, and the Licensed Nursing Home Administrator. The surveyor informed the DON that the NP recommended Resident #108 see a pain management specialist on 10/8/24, and that the first documented attempt to schedule the appointment was on 12/26/24 (approximately two months later). The surveyor also informed the DON that UC #2 had since received a list of pain management specialists to call, but had not yet made any attempts to contact their offices. The DON confirmed that whoever obtained the recommendation from the NP should have notified the UC to schedule the appointment in a reasonable amount of time, within three to four days. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medical Follow-Up Appointments policy, updated 1/2025, included, Medical follow-up appointments will be scheduled as per the recommendations made by the attending physician or other healthcare provider during initial assessments, hospital discharges, or routine evaluations. Further review of the policy revealed, A consulting physician/practitioner may include, but not limited to a resident's . specialists. NJAC 8:39-27.1(a)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45589 Based on observation, interview, and review of facility documents, it was determined that the facility failed to ensure a palatable temperature of food for 1 of 1 lunch meals observed on 1 of 3 nursing units (300 Unit). This deficient practice was evidenced by the following: On 2/20/25 at 10:35 AM, the surveyor conducted a Resident Council Meeting with five residents (Resident #5, #14, #28, #44, and #64). Four out of five residents stated that if meals were served in the resident's room the meals were cold, that only the dining room received warms meals, and that the eggs were always cold. Resident #28 stated that the meals were delivered on open racks that did not keep the food warm and that the last unit served, nursing unit 100, was served cold food. On 2/21/25 at 11:34 AM, the surveyors observed [NAME] #1 testing the temperatures of the food on the steam table. The temperatures were as follows: Pureed baked fish (tilapia) 173 F (degrees Fahrenheit) Pureed rice 144.9 F Mashed potatoes 143.4 F Green beans 199 F Pureed green beans 192 F Yellow rice 202 F Baked fish (tilapia) 168 F. Upon interview, [NAME] #1 stated that the desired temperature of the food on the steam table was 150 F, however [NAME] #1 stated that the preferred temperature was 180 F. The Regional Food Service Director (RFSD) who was present, stated that food items should be held above 135 F on the steam table. On 2/21/25 at 11:57 AM, the surveyors requested to have a regular meal tray and a pureed tray prepared and placed on the food truck for nursing unit 300 as a test tray. The surveyor requested that the RFSD record temperatures of the food in the presence of the surveyors on the nursing unit using a calibrated (procedure used to confirm accuracy) thermometer. On 2/21/25 at 12:15 PM, the surveyors observed the lunch meal service for the unit 300 A tray line prep in the kitchen, in the presence of [NAME] #1, Dietary Aides (DA) #2, DA #4, DA #5, and DA #6. Dinner plates were observed being picked up by hand by [NAME] #1 who portioned food from the steam table onto the plates. The plates were covered with a plastic insulated dome and were placed on the trays. The completed trays were placed on an uncovered food truck at the end of the line. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:24 PM, the surveyor and the RFSD accompanied DA #6 and the 300 A food cart to the unit. At 12:26 PM, DA#6 arrived on nursing unit 300 and the nursing staff proceeded to deliver meal trays to the residents in the dining room. At 12:30 PM, the RFSD confirmed the last tray was delivered on nursing unit 300 and the surveyors observed the RFSD obtain the temperatures using a calibrated thermometer of the lunch meal trays. The temperatures were as follows: Pureed baked fish 125 F Pureed green beans 127.2 F Pureed rice 129 F Pureed pears 61 F Milk 40 F Regular baked fish 150 F Regular rice 141 F Regular green beans 147 F Regular pears 62 F At that time, the RFSD stated that the puree foods were not meeting the desired temperatures of 135 F for hot foods, and that the cold items should be 41 F or below. The RFSD also stated that if the temperature fell out of range it may cause bacterial growth in the food and that food items were in the temperature danger zones. Review of the undated facility's, Record of Food Temperatures policy included: .Policy Explanation and Compliance Guidelines: 1. Food temperatures will be checked on all items prepared in the dietary department. 2. Hot foods will be held at 135 degrees Fahrenheit greater 4. Potentially hazardous cold food temperatures will be kept at 41 degrees Fahrenheit .8. If food temperature falls into an unsafe range, immediately follow procedures for previously cooked food .11. No food will be served that does not meet the food code standard temperatures. NJAC 8:39-17.4(a)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Based on observations, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 2/19/25 from 9:26 AM to 10:55 AM, the surveyor observed the following in the presence of [NAME] #1: 1. The Receptionist was observed exiting the walk-in refrigerator with a tray of food items and proceeded to give the tray to Dietary Aide (DA) #3. When interviewed, DA #3 stated that he was instructed to throw eight containers of the pudding in the trash. [NAME] #1 who was present, then proceeded to reach into the trash can and retrieved a single container which she identified as butterscotch pudding, and she stated that it was not labeled or dated. The surveyor interviewed DA #1, who was also present, stated that it was important to label and date food items to ensure that they were not out of date. 2. The surveyor observed [NAME] #1 wash her hands for nine seconds out of the stream of running water prior to resuming the tour of the kitchen. 3. In the walk-in freezer, on the second shelf from the top of a four-tiered wired rack, there were ten pounds of frozen meatballs that were opened and exposed to air. [NAME] #1 stated that it should have been fully covered. 4. When the surveyor asked where the temperature logs were for the walk-in refrigerator and walk-in freezer [NAME] #1 stated that they were in the office. The surveyor reviewed the temperature logs and noted that there were no temperatures recorded on 2/19/25. [NAME] #1 stated that they should have been done, but she worked short staffed today. 5. In the walk-in refrigerator, on the third shelf from the top of a four-tiered wired rack, there were three six-inch pans which each had two ten-pound logs of meatloaf wrapped in parchment paper in them that were surrounded by a thick coating of a white and brown substance. [NAME] #1 stated that she started to cook them yesterday but she left the facility around 3:00 PM, before they were finished cooking. [NAME] #1 stated that there were no temperature logs to demonstrate the cooling process that was used. Cook #1 then proceeded to remove a tray of meatloaf from the walk-in refrigerator and used a calibrated thermometer to obtain the temperature of the meatloaf which was 48.6 F (Fahrenheit). [NAME] #1 stated that items in the refrigerator should be held at a temperature of 41 F or less. [NAME] #1 stated that the meatloaf should have been taken out of their juices, drained and placed in separate pans for the cool down process. [NAME] #1 further stated that meatloaf was on the menu for lunch today and it was safe to serve. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 10:25 AM, the Regional Food Service Director (RFSD) described the cooling process for meatloaf. The RFSD stated that the meatloaf should have been cooled within two hours to get the temperature from 135 F to 70 F, and then from 70 F to 41 F within four hours, but not greater than six hours to cool. The RFSD stated that the meatloaf should be 41 F and it was unacceptable for the meatloaf to be 48 F at this time. The RFSD stated and there was a potential for bacterial growth if the meatloaf was not properly cooled as it was a potentially hazardous food. The RFSD stated that the meatloaf would have to be discarded and replaced with another meal. 6. In the galley of the kitchen, the surveyor observed DA #1 use a table mounted can opener to open a seven pound can of vanilla pudding. [NAME] #1 pulled the can opener out of the sheathe when requested by the surveyor, which revealed that the tip of the can opener had a thick, dried, black substance on it. [NAME] #1 stated that the can opener should be cleaned after every use. 7. In the galley of the kitchen, there was a pink coat, a travel mug, and a 24 ounce coffee cup in the food preparation area. [NAME] #1 stated that the coat and drinks should not be in the galley of the kitchen. 8. There was a thick layer of dried food particles on the side of the tilt skillet next to the deep fryer and both a thick, black shiny substance and food particles were noted on the floor beneath and around the deep fryer. [NAME] #1 stated that there were was only an AM [NAME] and a PM [NAME] here to clean. [NAME] #1 stated that the floor was cleaned every night, but grease dripped onto the floor from the deep fryer. 9. In the galley of the kitchen, in the reach-in refrigerator, there was a package of hot dogs in a hotel pan that was opened to the air and was not labeled or dated. There was a hotel pan with grape jelly in it that was not labeled or dated. There was no thermometer inside of the refrigerator. [NAME] #1 stated that everything should be labeled and dated. [NAME] #1 further stated that there should have been a thermometer inside of the refrigerator. 10. In the galley of the kitchen, there was a double steamer which had cleaning solutions, and cleaning supplies stored in both the upper and lower units. [NAME] #1 stated that the steamer did not work, but they should not store stuff in there. 11. In the galley of the kitchen, there was a plunger under the prep area beside a drain on the floor. [NAME] #1 stated that the plunger was kept there because the drain gets clogged sometimes. 12. In the galley of the kitchen, on the third shelf from the top of a rolling rack, there was a cutting board with cuts in it, and a personal drinking cup was on top of it. [NAME] #1 stated that they should not use the cutting board. 13. In the galley of the kitchen, [NAME] #1 placed a plastic cutting board on the prep area with multiple cuts in it beside the meatloaf pan. [NAME] #1 stated that this is what we have until we get new ones. [NAME] #1 then placed parchment paper over the cutting board surface. 14. In the dry storage area, on the canned goods rack, there was a six pound container of creamed corn that was dented at both the top and the bottom of the can. [NAME] #1 stated that it should not have been in the rack. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Southgate		STREET ADDRESS, CITY, STATE, ZIP CODE 449 S Pennsville-Auburn Road Carneys Point, NJ 08069	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	15. On the second shelf from the top of a four-tiered wired rack, there was an opened bag of acine de [NAME] pasta that was opened to the air. [NAME] #1 removed it from the storage area. 16. On the lower shelf, second shelf, and third shelf of a four-tiered drying rack, a reddish-brown substance was noted on the racks where cookware had been placed in direct contact of the substance to dry. 17. A three-tiered rolling cart was noted in front of the drying rack and there were serving trays noted on top of the cart which was soiled with dried food particles. DA #1 was interviewed, and she stated that the serving trays were cleaned in the dish washer and were then placed on the rolling cart which was dirty. DA #1 stated that the trays could become contaminated. 18. On the third shelf from the top of a four-tiered drying rack, there was a white hot beverage carafe that had a dried brown substance around the outer edge. DA #1 then proceeded to wipe the brown stain off with her finger and she stated that the staining came off. DA #1 then proceeded to place the hot beverage carafe in the dish machine. 19. In the dish machine area, the surveyor reviewed the dish machine log which instructed that the minimum wash and rinse temperature was 140 F and should the temperature drop below, inform the manager. The log also indicated that the test strip for chemical sanitizer should register 50-100 parts per million (PPM). The wash temperature was recorded as 143 F, and the rinse temperature was recorded as 130 F, and the chemical sanitizer level was recorded as 100 PPM. The surveyor interviewed DA #2 in the presence of the RFSD. DA #2 agreed to demonstrate the dish machine usage. A laminated data strip affixed to the dish machine indicated: low temp wash 140 F, rinse 140 F. DA #2 stated that both the wash and rinse cycle values should be 140 F. DA #2 ran a tray of dishes through the dish machine and the gauges for both the wash and rinse cycles did not move and were fixed in place at 146 F for the wash cycle and 130 F for the rinse cycle. DA #2 stated that the gauges moved sometimes during use. DA #2 ran a second tray through the dish machine and the RFSD stated that she did not see the dish machine gauges move and stated that she planned to shut down the dish machine. The RFSD stated that the dishes were not properly sanitized if the the gauges were not functional. 20. In the paper storage area, two ceiling tiles were observed to have black circular stains surrounded by outer brown stains. An insect was observed flying around the black stain. On 2/19/25 at 11:15 AM, the surveyor interviewed [NAME] #2 in the presence of the survey team. [NAME] #2 stated that he worked yesterday from 10 AM to 6:30 PM. [NAME] #2 stated that [NAME] #1 prepared the meatloaf between 2:00 PM and 2:30 PM, and he removed it from the oven around 3:30 PM. [NAME] #2 stated that he opened the oven door and allowed the meatloaf to cool for five to ten minutes. Then he put it on the speed rack (an open rolling rack) on the side of the oven and let it cool for 20 to 30 minutes before he placed it on the middle rack of a covered rolling rack and then placed it in the middle of the walk-in refrigerator. (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Cook #2 further stated that he did not normally document the cooling of the meat during the cooling process. [NAME] #2 further stated that the only temperatures that he obtained were for the tray line during meal service. [NAME] #2 stated that if meat were not properly cooled before it were placed in the refrigerator, bacteria could result. [NAME] #2 stated that the temperature of the meatloaf after being in the refrigerator over night should have been 41 F. [NAME] #2 stated that the importance of keeping a food temperature log for cooling meat was to ensure that residents did not get sick.

On 2/19/25 at 11:44 AM, in a later interview with the RFSD, she stated that [NAME] #1 should have washed her hands vigorously for twenty seconds out of the stream of running water or cross contamination could result.

On 2/21/25 from 11:26 AM to 12:24 PM, the surveyor observed the following in the presence of the RFSD:

1. During the tray line lunch meal service, Dietary Aide (DA) #5 wore a hair net that did not fully cover her hair and left a large part of the back of her head exposed.

2. During the tray line lunch meal service, DA #2 and DA #5 were observed returning from the dining room with trays and lids and placed them back on the tray line. When interviewed, DA #2 confirmed that both the trays and lids were previously used to serve residents in the dining room and were then brought back to the kitchen to be reused. DA #5 stated that lids should not be reused once taken out to the dining room because of the potential for germs.

3. The surveyor requested to see the temperature log book and noted that during the month of February 2025, meal temperatures were not obtained from the meal service tray line as follows:

-On 2/3/25, A Daily Food Temperature Log was not found.

-On 2/6/25, the dinner meal section of the form was not completed.

-On 2/9/25, the dinner meal section of the form was not completed.

-On 2/10/25, the dinner meal section of the form was not completed.

-On 2/12/25, both the breakfast and lunch meal sections of the form were not completed.

-On 2/13/25, a Daily Food Temperature Log was not found.

-On 2/14/25, both the breakfast and lunch meal sections of the form were not completed.

-On 2/18/25, both the breakfast and lunch meal sections of the form were not completed.

-On 2/18/25, both the breakfast and lunch meal sections of the form were not completed.

-On 2/19/25, both the breakfast and lunch meal sections of the form were not completed.

The RFSD stated that temperatures were supposed to be checked at every meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/21/25 at 1:08 PM, the surveyor observed the 300 Unit Nourishment Room in the presence of Registered Nurse/Unit Manager (RN/UM) #1. 1. There was a lunch bag in the refrigerator that RN/UM #1 stated belonged to a staff nurse. 2. There was a prepackaged frozen lasagna in the freezer that was not labeled and dated. When interviewed, RN/UM #1 referred to signage on the refrigerator door which indicated, Please label and date all food items and beverages with the following: name, room number, date and discard after three days. Any items not having the above information is to be discarded on the 11-7 shift. On 2/21/25 at 1:24 PM, the surveyor observed the 100 Unit Nourishment Room in the presence of Licensed Practical Nurse/Unit Manager (LPN/UM) #1. 1. A lunch bag was noted within the refrigerator. LPN/UM #1 stated that it should not have been in the refrigerator if did not belong to a resident. 2. There was a dried brown liquid on top shelf of the interior door of the refrigerator. 3. There was pink matter on the bottom of the freezer. LPN/UM #1 stated that Housekeeping was responsible to clean it. On 2/21/25 at 1:37 PM, the surveyor observed the 200 Unit Refrigerator in the presence of Licensed Practical Nurse (LPN) #4. 1. A lunch bag as noted within the refrigerator. LPN #4 reviewed the contents which included containers of food that were not labeled and dated. LPN #4 stated that the food was brought in today. LPN #4 further stated that you would not know if the contents were safe to eat if it were not labeled and dated. On 2/25/25 at 9:43 AM, the surveyor interviewed the Food Service Director (FSD) who stated that there should be no personal items in the unit nourishment room refrigerators because it was a resident refrigerator and the staff had been told about that before. The FSD stated that the kitchen staff did not adhere to a cleaning schedule. The FSD stated, Cleaning was done by word of mouth when delegated and when we have enough staff. The FSD further stated that staffing has been a real challenge. A review of the facility's undated Nutrition and Dining Services policy, included: Cooling food .Never cool large amounts of hot food in a cooler. Transfer cooked product to a container (s) with a depth no greater than two inches. Label and date the container(s). Leave container uncovered or loosely covered during the cooling process. Take temperature of product. Document temperature on cooling log. The food must be cooled from 135 * to 70* within 2 (two) hours and cooled from 70*F to 41*F within 4 (four) more hours .Record action taken to achieve proper temperature on cooling log. When temperature reaches 41*F, cover tightly and store in refrigerator or freezer .Danger Zone 41*F and 135*F. A review of the facility's undated Record of Food Temperatures policy, included: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Southgate		STREET ADDRESS, CITY, STATE, ZIP CODE 449 S Pennsville-Auburn Road Carneys Point, NJ 08069	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature (s) before trays are assembled. Potentially Hazardous Food (PHF) .means food that requires time/temperature control for safety to limit the growth of pathogens such as bacterial or viral organisms capable of causing disease. Food temperatures will be checked on all items prepared in the dietary department. .Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit. A review of the facility's Sanitization policy, reviewed and updated January 2025, included: The food service area shall be maintained in a clean and sanitary manner. All kitchens, kitchen areas and dining areas shall be kept clean . .Once cutting boards has scars from knife usage they must be replaced. Dishwashing machines must be operated using the following specifications: Low-temperature Dishwasher (Chemical Sanitization) Wash temperature (120*F) Final rinse with 50 parts per million (PPM) hypochlorite (chlorine) for at least 10 seconds . .The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas A review of the facility's Hair Restraint (Net) Policy updated January 2025, included: Hair restraints must cover all head hair completely. This includes securing bangs and other loose strands that might escape from primary restraints. .Hair restraints (Net) help maintain standards of hygiene and safety in food handling, crucial for patient health and compliance with health regulations. A review of the facility's Dented Can Policy for Dietary Services policy, updated April 2024, included: .Dented cans that are deemed unsafe must be disposed of in accordance with the facility's waste management policies . A review of the facility's Unit Refrigerators policy, updated April 2024, included: .Housekeeping staff should clean the refrigerator daily and as needed. Nursing staff should discard any foods that are out of compliance and clean up spills as needed, or refer to housekeeping staff .No staff food personal food to be in refrigerator . A review of the facility's Hand Hygiene policy accessed 2023, included: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility .Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers . A review of the facility's Dating and Labeling Policy updated January 2025, included: It is the policy of this facility for the kitchen to assure food safety by maintaining proper dates and labels to all ready to eat food products . NJAC 8:39-17.2(g), 19.4

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37547 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to minimize the spread of infection to residents during incontinence care rounds. This deficient practice was identified on 1 of 3 nursing units (100 Unit) and was evidenced by the following: On 2/21/25 at 9:09 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #7 who stated that she was assigned to eight residents and had four residents who still awaited incontinence care. On 2/21/25 at 9:11 AM, the surveyor accompanied CNA #7 into Resident #17's room with the resident's permission. Resident #17 stated that he/she was wet and needed to be changed. CNA #7 donned (put on) gloves. CNA #7 then proceeded to unfasten the resident's brief and adjusted the resident's linens to demonstrate the resident's incontinence status. The resident's brief was mildly wet and it was not soaked through. When finished, CNA #7 then proceeded to doff (remove) her gloves and washed her hands out of the stream of running water for 10 seconds before rinsing her hands and drying them on a paper towel. On 2/21/25 at 9:19 AM, the surveyor accompanied CNA #7 to Resident #35's room. There was a sign posted on the outside of the door which indicated that the resident was on Enhanced Barrier Precautions [EBP; a set of infection control practices that used gowns and gloves to reduce the spread of multi-drug resistant organisms (MDROs)] and CNA #7 stated that a gown and gloves were required to be worn when direct care was provided to the resident. CNA #7 then proceeded to donn a gown and gloves before she entered the room. CNA #7 stated that Resident #35 had a tracheostomy tube [a tube inserted into the trachea (windpipe) through a surgically created opening in the neck] and he/she did not respond verbally when CNA #7 requested to check his/her brief. CNA #7 unfastened the resident's brief and stated that the resident's brief was dry and then proceeded to fasten the residents brief. When finished, CNA #7 doffed both her gown and gloves and used ABHR (alcohol based hand rub) to clean her hands afterward. On 2/21/25 at 9:26 AM, the surveyor accompanied CNA #7 to Resident #1's room. There was a sign posted on the outside of the door which indicated that the resident was on EBP. CNA #7 then proceeded to donn a gown and gloves before she entered the room. CNA #7 stated that Resident #1 had a gastrostomy tube (a feeding tube that is surgically inserted through the abdominal wall into the stomach). Resident #1 did not respond verbally when CNA #7 requested to check his/her brief. The resident's brief was mildly wet, and was not soaked through. When finished, CNA #7 doffed both her gown and gloves. CNA #7 then proceeded to wash her hands out of the stream of running water for nine seconds before rinsing her hands and drying them on a paper towel. When interviewed at that time, CNA #7 stated that she was supposed to wash her hands for 20 to 30 seconds out of the stream of running water and she sang happy birthday once to ensure that she had washed her hands long enough. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/25 at 10:07 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that the process for hand washing was to scrub your hands for at least 20 seconds. LPN/UM #1 further stated that if hand washing was not performed for a full 20 seconds it was an infection control issue and could spread germs around. On 2/25/25 at 11:00 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that staff should sing at least two rounds of the happy birthday song to ensure they washed their hands for the required 20 to 30 seconds. The IP stated that if hands were washed for less than 20 seconds, you were not killing any bacteria. The IP further stated that it could be a potential disaster if hands were only washed for nine seconds during incontinence care. On 2/25/25 at 2:27 PM, the surveyor interviewed the Director of Nursing (DON) who stated that it was her expectation that staff followed the protocol to wash their hands for a minimum of 20 seconds otherwise their hands were not clean. A review of the facility's Hand Hygiene policy, accessed April 2023, included: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . Hand hygiene technique when using soap and water: .Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers . NJAC 8:39-19.4

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 41260 Based on observation, interview, and review of facility documents, it was determined that the facility failed to maintain dryer machines in a safe operating condition for 2 of 4 dryer machines observed. This deficient practice was evidenced by the following: On 2/21/25 at 12:20 PM, the surveyor, accompanied by the Interim Housekeeping Director (IDH), toured the facility's laundry room. The IDH explained that the laundry staff clean the dyer lint traps every two hours and sign off the completion in a logbook. The IDH retrieved the dyer lint trap cleaning log binder, opened the binder to review it, and stated the laundry staff had not completed the logs per the facility's policy. When asked when the logs were last completed, the IDH opened the binder and turned to the last page that was filled out which contained the dates for 8/20 and 8/21. The dates did not indicate the year it was completed. At that time, the surveyor requested to see the lint traps for the four dryer machines which revealed two out of the four dryer machines had a moderate amount of lint accumulation in the lint traps. The IDH then stated, there should not be that much lint in the trap if it was cleaned two hours ago. The IDH further stated the staff should be following the facility's policy for dryer lint trap cleaning to prevent fires. At that time, the IDH removed a policy that was hanging up on the wall of the laundry room. A review of the policy titled, Laundry Drain and Dryer Lint Trap Cleaning, effective 1/28/11, included, Lint traps are to be cleaned of debris every (2) two hours, and, Document cleaning in the laundry activity log book (Lint Trap Cleaning Tracking Form). On 2/25/25 at 12:38 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated he expected the laundry staff to clean the lint traps every two hours to prevent fires. At that time, the surveyor informed the LNHA of the two dryer machine lint traps observed and the LNHA stated he was concerned about the lack of documentation related to the lint trap cleaning. A review of the facility's Lint Cleaning Policy for Dryers in Long-Term Care Facilities, updated, 1/2025, included the following: 1. Daily Maintenance: -Staff must inspect and clean lint traps in all dryers every two hours. This helps to prevent lint buildup, which can pose a fire risk and reduce the efficiency of the dryer. 4. Record Keeping: -Maintain a log of all cleaning and maintenance activities. This log should include dates of lint trap cleaning, inspections, and any maintenance work performed on the dryers. NJAC 8:39-31.2(e) (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-31.7(e)