STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Memorial Bridge	201 Fifth Avenue Penns Grove, 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed accommodate resident's need by not keeping the nurse's call bell within the resident's reach. This deficient practice was identified for 2 of 33 residents (Resident #27 and #45) reviewed for accommodation of need and was evidenced by the following: Upon initial tour of the A Wing Unit on 05/27/2025 at 11:07 AM, the surveyor observed the call bell of Resident #27 on the floor underneath the head of the resident's bed. On the same date and time, the surveyor observed the call bell of Resident #45 wrapped around the wall unit of the nurse's call bell system. While in the room with the residents, a Certified Nursing Assistance (CNA) who identified herself as an agency nurse confirmed that nursing call bells were to be located on the bed within resident's reach and further stated, I cant fix everything here. The surveyor reviewed the medical record for Resident #27. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Chronic Obstructive Pulmonary Disease (a chronic lung disease that causes breathlessness, coughing and mucus production) and Neurosyphilis (a complication of syphilis that affects the brain and spinal cord). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/17/2025 included the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident's cognition was severely impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 12/14/2021, that the resident was at risk for falls [related to] medication use, unsteady gait at times and use of assistive device during ambulation. Interventions included: Encourage [resident] to use call bell if she needs assistance. The surveyor reviewed the medical record for Resident #45 A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Alzheimer's Disease (a brain disorder that destroys memory and thinking skills) and Essential Hypertension (abnormally high blood pressure). A review of the resident's most recent comprehensive MDS dated [DATE] identified the resident has cognitively impaired. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's (ICCP) included a focus area, dated 12/16/2021, that the resident was at risk for falls, increased need for assistance with activities of daily living [ADL]/transfers, medication use, poor safety awareness, unsteady gait. Interventions included: Encourage [resident] to use call bell if she needs assistance. On 05/29/2025 at 11:19 AM, the surveyor interviewed CNA #1 who confirmed call bells are to be on the bed and easily accessible. On 05/30/2025 at 12:32 PM, during an interview with the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Director of Nursing (RCDON), confirmed that nursing call bells should be within reach of the resident and that anyone who walks by a room should ensure that the call bell is clipped to the blanket or bed. A review of the facility's undated Certified Nursing Assistant Job Function identified the following: [.] Keep the nurse's call system within easy reach of the resident[.]. A review of the facility's undated Answering the Call Light/Call bell policy identified the following under General Guidelines: When the resident is in bed or confined to a chair be sure the call light or call bell is within easy reach of the resident. NJAC 8:39-27.1 (a)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interviews, it was determined that the facility failed to maintain the most recent State of New Jersey inspection results in a place readily accessible to the residents, families, and the public. This deficient practice was evidenced by the following: During the Resident Council Meeting on 05/29/2025 at 10:31 AM, four of four alert and oriented residents said they were not aware of the location of the State Survey results and that the facility had not spoken to them about the results. During a tour of each unit, the surveyor observed signs that stated the State Survey results were in the lobby. The C-wing unit is a locked unit. In the lobby the surveyor observed a sign on a buffet cabinet that said State Survey results here. The binder was located inside the buffet cabinet where a door had to be opened outward. During an interview on 05/29/2025 at 11:06 AM with the surveyor, the Unit Manager (UM) of C-wing said the Survey Results were in lobby and all the residents had to do was ask to see them. When asked if the State Survey result were readily accessible to the residents on C-wing, the UM replied No During an interview with the surveyor on 05/30/2025 at 12:32 PM, the Licensed Nursing Home Administrator (LNHA) replied, No When asked if they considered if the results binder was readily accessible to the residents on the C- wing. A review of an undated facility provided policy titled Examination of survey Results revealed Survey reports and plans of correction are readily accessible to the residents and to the public. NJAC 8:39-9.4(b)

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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 - Many	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** On 05/27/2025 at 11:02 AM, Surveyor #2 observed the following on A Unit: the wall to left of Resident room [ROOM NUMBER]'s door had peeling paint. The wall to the left of Resident room [ROOM NUMBER] had paint peeling under the chair rail. There was missing floor tile to the right of the nurse's station. The shower room had multiple missing tiles on the wall. On 05/27/2025 at 01:43 PM, Surveyor #2 observed the following on A Unit: the paint under the heater in Resident room [ROOM NUMBER] was chipped. The ice machine at the nurse's station was missing a tile near the drainpipe and the black pad underneath the ice machine had a straw under it. On 05/28/2025 at 12:07 PM, Surveyor #2 observed the following on A Unit: there was black debris/discoloration next to the wardrobe and under the heater in Resident room [ROOM NUMBER]. There was peeling paint on the door to the smoking area. There was a broken cover on the thermometer in the dining room. There was chipped and peeling paint on the door jam and molding near the nurse's station. On 05/30/2025 at 12:03 PM, during an interview with the maintenance and housekeeping director, he acknowledged that A Unit requires housekeeping and repairs. He said he would get back to painting the units. He furthered that he will take care of it. On 5/27/2025 at 1:37 PM during the initial tour of the facility, Surveyor # 5 observed the B-Unit shower room. At that time, the shower room contained a duffel bag and a blazer jacket left on the chair. A nail clipper was also observed left out. On the same date at 11:12 AM during the initial tour of the facility, Surveyor # 5 onbserved room [ROOM NUMBER]. Upon observation of the bathroom, there was no bathroom mirror on the wall and no toilet paper available. 8:39-31.4 (a) 4. Upon initial tour of the A Wing Unit on 05/27/2025 at 11:24 AM, surveyor #4 observed approximately 5 resident wheelchairs, 2 geriatric reclining chairs, and one resident patient lift system that prevented the enjoyment and viewing of the A Wing fish tank. On 05/29/2025 at 11:19 AM, surveyor #4 interviewed CNA #3 who confirmed that resident and facility medical equipment was usually stored in corner somewhere when they are not in use. When asked if the equipment should be stored in front of the nurses by the fish tank CNA #3 responded, that's really the only spot to put them. At this time, CNA #3 confirmed that the medical equipment blocked the view of the A Wing fish tank and did not promote a homelike environment. On 05/30/2025 at 10:07 AM, during an interview with the Assistant Director of Nursing (ADON) confirmed that the residents in A Wing should be able to access all the activities and furnishings on the wing. Upon viewing the picture of the resident and medical equipment in front of the fish tank, the ADON acknowledged that the residents would not be able to access it and that it presented as an institutional like setting. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/30/2025 at 12:32 PM, during an interview with the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Director of Nursing (RCDON), confirmed that the area in front A Wing fish tank should have been empty and accessible for resident viewing. A review of the facility's undated Safe and Homelike Environment Policy identified the following under Policy Explanation and Compliance Guidelines: 1. The facility will create and maintain, to the extent possible, a homelike environment that deemphasizes the institutional character of the setting [.] Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment [.]. 3. During initial tour of C-Wing unit on 05/27/2025 at 10:03 AM, Surveyor # 3 observed the blue heaters in the hallway with peeling paint, a missing drawer in the dresser of room [ROOM NUMBER], a broken plastic covering on the door to room [ROOM NUMBER] and the thermostat box with dead bugs and cobwebs inside. During an interview on 05/30/2025 at 12:03 PM with surveyor # 3, the Maintenance and Housekeeping Director said that he does rounds on the units weekly and prioritizes safety concerns when making repairs to the units. He acknowledged the concerns on the C-wing and said they needed to be repaired. During and interview on 05/30/2025 at 12:32 PM with surveyor # 3, the LNHA acknowledge the concerns on C-wing unit and said, It's a little rougher of a unit due to the nature of the residents and the unit is next to a swamp. The LNHA also said they are working to make all repairs to the unit. Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to maintain a homelike environment that was clean, safe, and sanitary. This deficient practice was identified for 3 of 3 units (Units A, B, and C). This deficient practice was evidenced by the following: 1. On 05/27/2025 at 10:52 AM, Surveyor #1 observed several items in the C-Wing unit shower room. A loose, unsealed razor was in a basin on the shower bed. Hair was visible in the shower stall drain. An empty bodywash bottle was on the floor under the shower chair. A coffee cup with a red straw was sitting on the supply cart. An open container with a yellow substance inside was placed on top of the trash can liner in the trash can. On 05/27/2025 at 10:58 AM, Surveyor #1 observed a geriatric chair (specialized, high-backed reclining chair designed to provide comfort, support, and mobility for individuals with limited mobility) in the C-Wing female unit hallway with a ripped seat and a broken foot recliner. On 05/27/2025 at 11:10 AM, Surveyor #1 observed a plastic-framed picture on the wall with a crack in it, located in the hallway of the C-Wing female unit. On 05/27/2025 at 11:14 AM, Surveyor #1 observed a square-shaped hole in the wall near the window, a hole near bed B, a heater vent with brown spots, cracked windowsill molding, and cracked drywall on the ceiling in bedroom [ROOM NUMBER] on the C-Wing female unit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/27/2025 at 11:22 AM, Surveyor #1 observed a loose door handle in bedroom [ROOM NUMBER] on C-wing female unit. On 05/27/2025 at 11:24 AM, Surveyor #1 observed a cracked door panel in bedroom [ROOM NUMBER] on C-wing female unit. On 05/27/2025 at 11:30 AM, Surveyor #1 observed two drains on the C-Wing female unit hallway with missing floor tiles and brown residue surrounding them. During an interview with Surveyor #2 on 05/30/2025 at 12:03 PM, the Maintenance/Housekeeping Director (MHD) said that housekeeping staff clean the shower rooms on each unit daily. He also explained that Certified Nurse Aides (CNAs) are responsible for cleaning the shower room after each resident they bathe, and confirmed that the shower room should have been cleaned. During an interview with Surveyor #2 on 05/30/2025 at 12:04 PM, the Licensed Nursing Home Administrator (LNHA) said that C-Wing presents unique challenges due to the nature of its resident population, which often results in frequent maintenance issues. While efforts are made to address problems promptly, new issues tend to arise just as quickly. Additionally, the unit's proximity to a nearby swamp contributes to high moisture levels, which impact the building's condition and appearance.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Complaint: NJ184164 Based on interview, record review and document review it was determined that the facility failed to maintain documentation and ensure that a complete and thorough investigation was conducted for 1 of 2 residents (Resident #124) reviewed for abuse. This deficient practice was evidenced by the following: On 05/28/2025 at 11:19 AM, the surveyor observed Resident #124 in the Dining Room of C Wing sitting in a chair. The surveyor attempted to speak with the resident but was unable to do so due to cognitive impairment. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Metabolic Encephalopathy and Unspecified Dementia (Unspecified Severity) with Psychotic Disturbance. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 05/20/2025, identified that the resident was unable to complete the Brief Interview for Mental Status (BIMS). A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 02/24/2025, that the resident [Resident Name Redacted] has a diagnosis of Dementia with Psychotic Disturbances and takes medications to manager her diagnosis and behaviors (destructive behaviors, intrusive behaviors, verbal outbursts, refusal of meds, refusal of care). Interventions included: Attempt to redirect any negative behaviors with distractions; activities, 1:1 conversation, family contact, quiet environment and Monitor for changes in mood and behaviors such as increased agitation, increased aggression, hallucination, verbal outbursts. During the recertification survey, the surveyor reviewed a Facility Reported Event (FRE) Form submitted to the Department of Health (DOH) on 03/05/2025 in which the facility identified that an employee (a Certified Nursing Assistant {CNA}] was entering the room and [Resident #124] fell to the floor. The surveyor requested the full investigation of the incident. Per facility documentation, the incident occurred on 03/04/2025 during the evening hours. Upon review of the CNA statement that they, were trying to get [Resident #124] to let me in the [the room] [Resident #124] fell backwards onto the floor. Another employee statement reported that CNA was trying to get into residents [sic] room to check on residents [sic] roommate and resident was blocking the door and as she tried to get passed the resident [they] lost [their] balance and fell back hitting her head. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/29/2025 at 09:20 AM, the surveyor interviewed Licensed Nurse Practitioner Unit Manager (LPN/UM #1) who reported that as a unit manager she is responsible for gathering witness statements upon receiving notification of an alleged abuse. LPN/UM #1 indicated that she would gather a statement from aides, residents, any witnesses. Upon gathering all the information, she would also determine who was in the area at the time of the incident and make sure they provide a statement. LPN/UM #1 indicated that she reviewed the statements and if any further witnesses were identified in it a statement should be obtained from them. LPN/UM #1 confirmed that the Resident #124 resided in a room that has four beds but was unable to confirm who was present in the room at the time of incident. LPN/UM #1 further acknowledged that a care plan would be updated to identify the resident as a potential victim. When asked regarding the incident that occurred on 03/04/2024, LPN/UM #1 stated that she was not in the facility on that date but was informed that the CNA had possibly done something she wasn't supposed to do and was terminated. At this time, LPN/UM #1 advised that the incident may have been captured by the security camera that was located above the nursing station. On the same date at approximately 10:00 AM, the Director of Nursing (DON) confirmed that the video was reviewed the day after the event. On 05/29/2025 at 12:16 PM, the surveyor interviewed the DON in the presence of the Regional Clinical Director of Nursing and the Licensed Nursing Home Administrator, who confirmed that she was responsible for overseeing the investigation and ensuring that it was thoroughly conducted. The DON was provided the CNA's handwritten statement and her Investigation of Summary by the surveyor. Upon review, the DON acknowledged that the CNA identified a roommate as being present at the time of the incident but confirmed that her summary did not identify that any roommates were present at the time of the incident. When asked if any attempt was made to interview the roommates, the DON responded that she was unsure but that it should have been identified and investigated. When asked if it was possible that one of the residents could have provided some insight to the incident the DON agreed. When asked if Investigation of Summary identified that the wing of which the incident occurred had cameras and if it was viewed to assist in the incident conclusion, the DON denied. When asked if the resident's care plan should have been updated to reflect the allegation the DON denied. Upon review of the discussion and what was provided to the survey team, the surveyor inquired if a thorough investigation was completed. The DON responded that she believed it was completed but now is not sure. A review of the facility's undated Abuse Neglect, and Exploitation Policy identified the following under Policy Explanation and Compliance Guidelines and the Heading V. Investigation of Alleged Abuse, Neglect, and Exploitation: B. Written procedures for investigations include: [.]4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegations; [.] A review of the facility's undated Abuse Investigation and Reporting Policy identified the following under Role of the Investigator: Review the completed documentation forms; [.] Interview the resident's roommate, family members, and visitors [.]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan that identified furnished services to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being for 4 of 33 (Resident # 13, 80, 44, 47) residents reviewed for care plans, specifically a resident that required a hand orthotic (Resident 13), a resident with a Positive Pres-admission Screening and Resident Review (PASARR) Level 2, and a resident that required oxygen (Resident #80). This deficient practice was evidenced by the following: The deficient practice was evidenced by the following: On 05/27/2025 at 10:12 AM, Surveyor #1 observed Resident # 80 in bed receiving Oxygen via nasal cannula (a device used to deliver supplemental oxygen). Surveyor #1 reviewed Resident #80's medical record which reflected that the resident had a diagnosis which included asthma (narrowing and swelling of the airway). A review of the physician orders for Resident # 80 reflected an order dated 09/09/2024 for the resident receive Oxygen via nasal cannula. The minimum data set, an assessment tool, dated 05/07/2025 reflected that Resident #80 utilized Oxygen. Surveyor #1 reviewed the Resident # 80's care plans which revealed there was no care plan developed to address the use of Oxygen. On 05/30/2025 at 10:02 AM, Surveyor #1 interviewed the Assistant Director of Nursing (ADON) who said that the nurse manager or any nurse were responsible for ensuring care plans were completed. The ADON said that Oxygen use should be included on the care plan. The ADON and surveyor reviewed the care plans of Resident #80 together. She confirmed that there was no care plan addressing the use of Oxygen. A review of the facility's undated Comprehensive Care Plan policy identified the following: it is the policy of this facility to develop and implement a comprehensive person centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. NJAC 8:39-27.1(a) 3. Upon initial tour of the facility on 05/27/2025 at 11:00 AM, the surveyor observed Resident #44 in bed. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Chronic Obstructive Pulmonary Disease with Acute Exacerbation (COPD- a common lung disease causing restricted airflow and breathing problems) and Unspecified Psychosis not due to a Substance or Known Physiological Condition. (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 resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 05/15/2024, identified under Section A, Question A1500, of the MDS that Resident #44 had state level 2 Preadmission Screening and Resident Review (PASRR) process to have serious mental illness. A review of the PASARR Level II Determination Notification letter by the New Jersey Department of Human Services Division of Mental Health and Addiction Services dated 05/26/2016 revealed that Resident #44 had mental health treatment needs that could be met in a nursing facility. A review of the resident's individual comprehensive care plan (ICCP) included a focus area that [the resident had] a [diagnosis] of depression and anxiety, dated 12/14/2021, but did not identify the resident's positive PASARR Level 2. During an interview with the surveyor on 05/29/2025 at 01:05 PM, the Social Worker (SW #1 and SW #2) explained that a positive PASARR Level 2 is assigned by a State of New Jersey PASARR Coordinator and will identify the resident with a mental disability. SW #1 and SW #2 further advised that when a PASARR Level 2 is confirmed it will remain until the State of New Jersey removes it. The surveyor requested that SW #1 and SW #2 review the care plan for Resident #44 and confirm if the PASARR Level 2 is identified. SW #1 and SW #2 acknowledged that Resident #44 had a care plan for Depression and Anxiety, but it did not identify that the resident had a positive PASARR Level 2. When asked if it should be identified, SW #1 and SW #2 stated that they could see the rationale behind identifying it on the care plan but we've never done it. On 05/29/2025 at 12:16 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Regional Clinical Director of Nursing and the Licensed Nursing Home Administrator, who confirmed that the PASARR Level 2 should be identified on the care plan and that the Social Workers would be responsible for updating. A review of the facility's undated Comprehensive Care Plan policy identified the following: [.]3. The comprehensive care plan will describe, at a minimum, the following: [.]c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations [.]. NJAC 8:39-27.1 (a) A review of Resident # 13's admissions record revealed that, Resident # 13 was admitted with but not limited to Osteomyelitis (an infection in a bone), Cerebral Infarction (when blood flow is blocked to part of the brain causing dead tissue in the brain) and, Seizures. A review of Resident #13's Electronical Medical Record revealed a physician's order with a start date of 11/01/2024 for Handroll to left hand every day shift. A review of the current Care Plan (CP) for Resident #13 did not include documentation of a CP focus area or interventions for the use of a hand roll. A review of Resident # 47's admissions record revealed that, Resident # 47 was admitted with but not limited to Benign Prostatic Hyperplasia (a condition where the prostate gland is enlarged), and Type 2 Diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels.) (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 Resident #47's admission Minimum Data Set (MDS) dated [DATE] revealed under section H that the resident was frequently incontinent of bowel and bladder A review of the current Care Plan (CP) for Resident #47 did not include documentation of a CP focus area or interventions for incontinence. During an interview on 05/30/2025 at 09:04 AM with surveyor #2 the Unit Manger (UM)# 1 on C-wing said that care plan consists of focus areas for medication, care that is pertinent, recent incidents and any information that other departments would need to know. When asked if resident is incontinent is that something that should be on the care plan, the UM # 1 stated, yes I would but it under skin assessment. When asked about a resident with a splint or hand roll, the UM stated, Yes I usually put that under skin assessment as well. During an interview on 05/30/2025 at 12:32 PM with surveyor #2 the Director of Nursing said, there should be a focus for incontinence and on the use of splints or hand rolls on the resident's care plan. A review of the facility's undated policy titled Comprehensive Care Plan revealed under Policy Explanation and Compliance Guidelines that, 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. NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 173841 Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility failed to ensure that proper incontinence care was provided to 1 of 1 resident reviewed for Bowel and Bladder (Resident # 47) and 3 of 11 resident reviewed for incontinence rounds. (Resident # 6, Resident #113, and Resident # 402) This deficient practice was evident by the following: On 05/27/2025 at 09:59 during initial rounds Resident # 47 was observed in bed in a t-shirt with the covers at the bottom of the bed. Resident # 47 was observed to have a saturated incontinent brief. Resident # 47 was unsure of the last time he/she was changed. A review of Resident # 47's admissions record revealed that, Resident # 47 was admitted with but not limited to Benign Prostatic Hyperplasia (a condition where the prostate gland is enlarged), and Type 2 Diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels.) A review of Resident #47's admission Minimum Data Set (MDS) dated [DATE] revealed under section H that the resident was frequently incontinent of bowel and bladder. On 05/28/2025 at 08:14 AM surveyor #1 accompanied the C-wing Unit Manger (UM) # 1 conducted incontinence tour on the C-wing. Four random residents who were identified by UM#1 as being dependent on staff for care, were observed. Surveyor # 1 and the UM entered Resident #6 room. Resident # 6 was in bed wearing a hospital style gown. At the time, the resident granted permission for the survey to observe his/her incontinent brief. Surveyor # 1 observed the incontinent brief to be saturated and soaked through to his/her gown. Resident # 6 said he/she was waiting for someone to come in. The UM said they were just getting done breakfast and are starting to get residents ready. A review of Resident # 6's admissions record revealed that, Resident # 47 was admitted with but not limited to Type 2 Diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels.) and muscle weakness. A review of Resident #6's admission Minimum Data Set (MDS) dated [DATE] revealed under section H that the resident was occasionally incontinent of bowel and bladder. During an interview on 05/29/2025 at 01:08 PM with Surveyor #1, the Certified Nursing Assistant #1 (CNA) said that incontinence care should be done at least every 2 hours. The CNA also said that residents that are heavy wetter's should be checked more often and should not be soaked through. During an interview on 05/30/2025 at 09:04 AM with surveyor # 1, the UM #1 said that incontinence rounds are done two to three times a shift and as needed. The UM # 1 also said that residents should not be soaked through, however sometimes it takes a while to get to all the residents. During an interview on 05/30/2025 at12:32 PM with surveyor #1, the Director of Nursing (DON) said that incontinent rounds should be done every two hours or as needed. When asked if residents should be soaked through their briefs, the DON replied, No (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an undated policy titled Incontinent Care revealed, It is the policy of [facility name] that incontinent residents will be maintained clean and dry. NJAC 8:39- 27.2 (h) On 05/28/2025 at 8:53 AM, Surveyor #2 completed an incontinence round with Licensed Practical Nurse/Unit Manager #1 (LPN/UM #1) on B-Wing for Resident #402. The adult incontinent brief was visibly soiled with urine, which was confirmed by LPN/UM #1. The LPN/UM #1 said that she would have the Certified Nurse Aide (CNA) assigned to the resident complete the incontinence care. On 05/28/2025 at 8:59 AM, Surveyor #2 completed an incontinence round with LPN/UM #1, on B-Wing, for Resident #113. The adult incontinent brief was visibly soiled with urine and feces and confirmed with LPN/UM #1. The LPN/UM #1 said that she would have the CNA assigned to the resident complete the incontinence care. On 05/28/2025 at 9:22 AM, Surveyor #2 observed that the call light for Resident #113 on B-Wing was flashing. After knocking on the resident's door and receiving permission to enter, Surveyor #2 was informed by Resident #113 that the call light had been on for 20 minutes, he/she needed to be changed, and no staff had responded to the call bell. On 05/28/2025 at 9:24 AM, Surveyor #2 completed another incontinence round for Resident #113 with CNA #1. The adult incontinent brief remained visibly soiled with urine and feces. CNA #1 said that she would complete the incontinence care. On 05/28/2025 at 9:28 AM, Surveyor #2 completed another incontinence round for Resident #402 with LPN #2. The adult incontinent brief remained visibly soiled with urine. LPN #2 said that she would complete the incontinence care. On 05/29/2025 at 11:06 AM, Surveyor #2 reviewed the electronic medical records (EMR) for Resident #113 as follows: According to the admission record, the resident was admitted to the facility with diagnoses including, but not limited to, cerebral infarction, which occurs when blood flow to a part of the brain is blocked, leading to tissue death due to a lack of oxygen and nutrients. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 04/02/2025, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Further review of the MDS revealed that Section GG- Functional Abilities was coded as 1, reflecting impairment on one side of both the upper and lower extremities, and Section H- Bladder and Bowel was coded as 3, meaning the resident is always incontinent of both urine and bowel. The resident's comprehensive care plan, dated 04/10/2025, included a focus area indicating that he/she is at risk for skin breakdown related to decreased mobility. Interventions included, but were not limited to, keeping the resident's skin as clean as possible and checking for incontinence and assist with changes routinely and as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/29/2025 at 11:30 AM, Surveyor #2 reviewed the electronic medical records (EMR) for Resident #402 as follows: According to the admission record, the resident was admitted to the facility with diagnoses including, but not limited to, cerebral infarction. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 04/02/2025, included a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severely impaired cognition. Further review of the MDS revealed that Section GG- Functional Abilities was coded as 1, reflecting impairment on one side of the upper extremities, and Section H- Bladder and Bowel was coded as 3, meaning the resident is always incontinent of urine. The resident's comprehensive care plan, dated 04/29/2025, included a focus area indicating that he/she has bowel and bladder incontinence related to cerebral infarction. Interventions included, but were not limited to, checking the resident as required for incontinence. During an interview with Surveyor #2 on 05/28/2025 at 9:26 AM, CNA #1 said that she tries to respond to call lights immediately but was unaware that Resident #113's call light was on because she was assisting another resident in a different room. She reported that incontinent care is provided every two hours or as needed and that she feels she has enough time to complete her assigned duties. During an interview with Surveyor #2 on 05/28/2025 at 9:30 AM, LPN #2 said that she is an agency nurse and not directly employed by the facility. She explained that she tries to answer call lights immediately and that incontinent care at the facility is provided every two hours or as needed. She also expressed that she feels she has enough time to complete her assigned duties. During an interview with Surveyor #2 on 05/30/2025 at 12:04 PM, the Director of Nursing (DON) said that incontinence rounds should be completed every two hours, as needed, and upon resident request. She also confirmed that call lights should be answered immediately. A review of the undated facility policy, titled, Incontinent Care, revealed that, It is the policy of the facility that incontinent residents will be maintained clean and dry. NJAC 8:39-27.1 (a), 27.2 (h)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint: NJ184164 Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to provide appropriate safety interventions to a cognitively impaired resident (Resident #124) with a history of refusal of care. On 3/4/25, Resident #124 fell when a Certified Nursing Assistant (CNA #4) refused to allow the resident to close his/her door causing the resident to fall and hit the back of their head causing a laceration. Resident #124 was sent to the hospital for evaluation. This deficient practice was identified for 1 of 2 Residents, (Resident # 124), reviewed for falls and evidenced by the following: On 5/28/25 at 11:19 AM, the surveyor observed Resident #124 in the C-wing dining room sitting in a chair. The C-wing unit was a locked unit for residents with behaviors. The surveyor attempted to speak with the resident but was unable due to cognitive impairment. On 5/29/25 the surveyor reviewed the admission Record, an admission summary, that revealed Resident #124 had diagnoses which included, but were not limited to: Metabolic Encephalopathy (a brain dysfunction caused by problems with metabolism) and Dementia with Psychotic Disturbance. On 5/29/25 the surveyor reviewed the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/20/25, that documented Resident #124's Brief Interview for Mental Status (BIMS) score was 3 out of 15 indicating severe cognitive impairment. On 5/29/25 the surveyor reviewed the resident's Individual Comprehensive Care Plan (ICCP) which included a focus area, dated 2/24/25, regarding Resident #124 receiving medications to manage his/her Dementia with Psychotic Disturbances and behaviors. The ICCP documented that the resident's behaviors included: destructive and intrusive behaviors; verbal outbursts; and refusal of medications and care. Interventions included: Attempt to redirect any negative behaviors with distractions; activities, 1:1 conversation, family contact, quiet environment. An additional focus area of the ICCP, revised on 12/5/24, indicated that the resident was at risk for falls related to medication use and poor safety awareness. Interventions included to monitor for changes in gait status. On 5/29/25, the surveyor reviewed the 3/4/25 . Fall Risk Evaluation which documented that Resident #124 was at moderate risk of falls. On 5/29/25, the surveyor reviewed the facility's fall investigation file regarding Resident #124's 3/4/25 fall. Per the investigation, Resident #124 fell and hit the back of their head causing a 3 x 4 centimeter laceration after CNA #4 would not allow the resident to close their door. The resident complained of a headache and was sent to the hospital for evaluation after neurological checks were started and the laceration was cleaned. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The surveyor reviewed CNA #4's written statement regarding the 3/4/25 incident. CNA #4 documented that she tried to check on Resident #124 but the resident kept refusing and tried to shut the door. CNA #4 documented that she told Resident #124 that he/she had to let CNA #4 in but Resident #124 would not allow it. CNA #4 wrote that as I was trying to get (Resident #124) to let me in (Resident #124) fell backwards onto the floor. A review of LPN #2's written statement reflected that she was called to Resident #124's room and observed the resident standing in the doorway with blood coming from the back of the resident's head. LPN #2 wrote that CNA #4 told her that she was trying to get into the resident's room but the resident was blocking the door. CNA #4 tried to get passed the resident when the resident lost their balance and fell hitting the back of their head. On 5/29/25 at 09:20 AM, the surveyor interviewed the Licensed Practical NurseUnit Manager (LPN/UM #1) who stated that employees received abuse training monthly and upon hiring. When asked about the 3/4/25 incident, LPN/UM #1 stated that she was not in the facility at the time, but was informed that CNA #4 had possibly done something she wasn't supposed to do and was terminated. On 5/29/25 at 12:16 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Regional Clinical Director of Nursing (RCDON) and the Licensed Nursing Home Administrator (LNHA). The DON stated that based on the facility's investigation, CNA #4's actions of pushing through the door triggered Resident #124 to lose their balance and fall resulting in a laceration to the back of the head and an emergency room evaluation. On 5/30/25 at 9:03 AM, the surveyor interviewed CNA #2 who confirmed that upon hiring she received training about how to approach and care for residents with a dementia diagnosis. When asked, based on her training, if a resident refused care what should she do, CNA #2 stated that she would stop whatever she was doing, contact the nurse, and go back at a later time. CNA #2 identified that the resident's right to privacy should never be violated. Lastly, the surveyor asked if she was engaged with a resident that was pushing or pulling on an object what would she do. CNA #2 responded that she would stop because being combative is part of the disease behavior and, as a result, the resident and she could fall or get hurt. On the same date at 9:09 AM, the surveyor interviewed LPN #1 who confirmed that upon hiring and on a regular basis staff received regular in-services on how to care for residents with cognitive impairments. LPN #1 confirmed that a resident's privacy, regardless of their cognition, is not to be violated, and that they have the right to refuse care. When asked how to proceed with a resident that is refusing care, LPN #1 stated that she would give the resident time and possibly switch with another staff member to see if they could proceed with care. LPN #1 stated that she was familiar with Resident #124 and that he/she is very particular with what he/she wants and how to receive it. When asked if the resident was combative, LPN #1 stated that she had not seen that, but Resident #124 can become upset if things are not done his/her way. On 5/30/25 at 12:32 PM, during an interview with the DON, in the presence of the LNHA and the RCDON, the DON confirmed that CNA #4 should not have continued to attempt to enter the room after Resident #124 refused to let her in, and this behavior resulted in the injury to Resident #124. The DON further acknowledged that staff received training on how to care for residents with cognitive impairments. The DON stated that all residents have the right to privacy and refuse care, and that the expectation was that CNA #4 was to stop what she was doing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's undated Certified Nursing Assistant Job Function identified the following: [.] Ensure that you treat all resident fairly, and with kindness, dignity, and respect; [.]Honor the resident's refusal of treatment request. Report such request to your supervisor. A review of the facility's undated Resident Rights Policy identified the following under Policy Explanation: Employees shall treat residents with kindness, respect, and dignity. The following was located under Policy Interpretation and Implementation: Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: A dignified existence; Be treated with respect, kindness, and dignity; [.] self-determination; Be supported by the facility in exercising his or her rights; [.] privacy and confidentiality; [.] orientation and in-servicing training programs are conducted quarterly to assist our employees in understanding our resident rights. A review of the facility's undated Fall Prevention Policy identified the following under Policy Explanation and Compliance Guidelines: 3. The nurse will indicate on the (specify location) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. A review of the facility's undated Abuse Neglect, and Exploitation Policy identified the following under Policy Interpretation and Implementation, and subheading Employee Training: A. New employees will be educated on abuse, neglect during initial orientation; B. Existing staff will receive annual education and as needed; and C. Training topics included that understanding behavioral symptoms, such as wandering, resistance to care and outbursts, of residents that may increase the risk of abuse and neglect. NJAC 8:39-33.1 (d)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide appropriate treatment and care for a resident with a indwelling, urinary catheter. The deficient practice was identified for 1 of 3 residents (Resident # 254) reviewed for Urinary Catheter or UTI (Urinary Tract Infection). The deficient practice was evidenced by the following: On 05/27/2025 at 10:37 AM during the initial tour, the surveyor observed Resident # 254 in bed in their room. At that time, the surveyor observed a urinary catheter drainage bag containing tinged, red urine. The drainage bag did not have a cover for privacy. At that time, the surveyor asked the resident if there was a device on his/her leg that secured the tube of the indwelling, urinary catheter. Resident # 254 denied having one and showed the surveyor his/her leg. There was no securement device observed on his/her leg. On 05/28/2025 at 11:23 AM, the surveyor observed Resident # 254 in bed in their room. At that time, the surveyor observed the urinary catheter drainage bag unsecured from the frame of the bed and instead left in a privacy cover. On 05/30/2025 at 12:35 PM during an interview with the surveyor, the Director of Nursing replied, We have them [indwelling catheter drainage bag] in a privacy bag, Sometimes the cover is on them and there is a hook on the bag as well. Below the bladder. Lastly, the DON replied, We have a stat lock that would be placed on them and attach the tubing to that. when the surveyor asked how should a urinary catheter tube be secured to a resident. The DON replied, So it's not tugging or causing discomfort or harm. when asked why it would be important to secure the tube. A review of Resident # 254's orders revealed an order to maintain the catheter for a diagnosis of Urinary Retention (inability to fully empty the bladder). A review of Resident # 254's Care Plans located in the Electronic Medical Record revealed a focus that [Resident 254] has indwelling catheter for Urinary Retention. A review of the undated policy titled, Foley Catheterization revealed, The purpose of urinary catheterization is to facility urinary draining when medical necessary. Urinary catheters should be evaluated every day for need and removed promptly when no longer necessary. N.J.A.C. § 8:39-27.1 (a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. NJ Complaint: #00173841 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to follow the prescriber's orders and acceptable professional standards and principles by administering medications past the required time frame. The deficient practice was identified for 1 of 1 resident reviewed for being free of significant med errors. The deficient practice was evidenced by the following: A review of Resident #77's annual Minimum Data Set (an assessment tool) dated 03/08/2025, revealed that Resident #77 had a brief interview of mental status score of 0 which indicated he/she was not cognitively intact. A review of Resident #77's physician's orders revealed the following orders but not limited to Jardiance 10mg (milligrams, a medication used to manage and treat diabetes) one time a day, metoprolol tartrate 25mg (milligrams, a medication used to treat high blood pressure) twice a day, and Depakote Sprinkles delayed release 125mg (milligrams, a seizure medication often used for mood disorders) 3 capsules in the morning. A review of Resident #77's Medication Administration Audit Report for May 2025 revealed the following medications were administered past the required time frame as follows: On 05/25/2025: Jardiance scheduled for 08:00 AM was given at 09:36 AM Metoprolol Tartrate scheduled for 08:00 AM was given at 09:36 AM Depakote Sprinkles scheduled for 08:00 AM was given at 09:36 AM On 05/29/2025: Jardiance scheduled for 08:00 AM was given at 10:08 AM Metoprolol Tartrate scheduled for 08:00 AM was given at 10:08 AM Depakote Sprinkles scheduled for 08:00 AM was given at 10:08 AM On 05/29/2025 at 12:08 PM, during an interview with the surveyor, the Registered Nurse (RN) stated that medications should be administered one hour before or one hour after the scheduled medication administration time. The RN acknowledged that he administered medication to Resident # 77 late. The RN said he should have administered medication to Resident #77 first. A review of the facility policy titled, Administering Medications with a revision date of November 2017, reflected under number 11., Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	N.J.A.C.: 8.39-29.2 (d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to properly store medications and failed to maintain a sanitary environment in a medication room. The deficient practice was identified for 1 of 3 medication rooms and 2 of 7 medications carts reviewed under the Medication Storage Task. The deficient practice was evidenced by the following: On 05/28/2025 at 9:17 AM during an inspection of the B Unit Medication Room, the surveyor observed six beverages in opened containers left on the counter inside the Medication Room. Two personal bags were also in the room. At the time of observation the Licensed Practical Nurse/Unit Manager (LPN/UM) replied, No when the surveyor asked if it is reasonable staff should be keeping their beverages and bags in the medication room. The LPN/UM confirmed that there is a staff breakroom where beverages can be kept. On the same date at 9:35 AM, the surveyor inspected the B wing medication cart 2. At that time, the surveyor observed two, loose tablets inside the drawer of the medication cart. On the same date at 11:10 AM, the surveyor inspected the A wing medication cart 2. At that time, the surveyor observed eleven, loose tablets inside the drawer of the medication cart. On 05/30/2025 at 12:35 PM during an interview with the surveyor, the Director of Nursing (DON) replied, I have them check monthly to do an audit. when the surveyor asked how often are medication carts cleaned of loose tablets. Lastly, the DON replied, There is a closet on B-Wing with lockers. when the surveyor asked if a variety of beverages and person bags in a medication room contribute to a clean environment for medication preparation. A review of the undated facility policy titled, Storage of Medications revealed that, Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. and The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean safe, and sanitary manner. Lastly, the policy revealed, Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer or or other holding area to prevent the possibility of mixing medications of several residents. N.J.A.C. § 8:39-29.4 (h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Memorial Bridge	201 Fifth Avenue Penns Grove, NJ 08069

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to use appropriate infection control practices, specifically when facility staff failed to wear the appropriate personal protective equipment while in a room under Contact Precautions. The deficient practiced was identified for 1 of 7 Residents (Resident # 258) reviewed under the Infection Control task. The deficient practice was evidenced by the following: On 05/27/2025 at 1:32 PM during the initial tour of the facility, the surveyor observed housekeeper (HK) # 1 inside Resident # 258's room. HK # 1 was mopping the floor. Outside of the room was a sign that revealed, Stop: Everyone Must: Clean their hands, including before entering and when leaving the room. The sign further revealed that, Providers and Staff Must Also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry, Discard grown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. At the time of observation, HK # 1 had no gown or gloves on. Attached to the door of the room was an over-door organizer containing disposable gowns and gloves. On the same date and approximate time, HK # 1 replied, It's only for aides when they change [him/her]. after the surveyor asked if HK # 1 should be wearing personal protective equipment in that room. A review of Resident # 258's orders located in the Electronic Medical Record (EMR) that he/she has an order to Maintain special contact isolation precautions every shift for VRE [Vancomycin Resistant Enterococcus) UTI (Urinary Tract Infection) for 7 days all nursing, therapy, dietary & activities services to be provided in resident's room. The order was started on 5/21/2025. A review of Resident # 258's Care Plan located in the EMR revealed a Care Plan intervention to Maintain contact isolation precautions for the duration of ABT [antibiotic] for VRE UTI On 5/30/2025 at 10:19 AM during an interview with the Infection Preventionist, the surveyor asked Should housekeeping be wearing a gown and gloves in rooms when there is a Contact Isolation sign at the doorway and PPE hanging on the door? The Infection Preventionist replied, Yes. The Infection Preventionist added further that, The housekeeper should have absolutely had PPE [Personal Protective Equipment] for sure. On 5/30/2025 at 12:35 PM, during an interview with the surveyor, the Director of Nursing replied, Yes, they should be. when the surveyor asked if a resident is on contact precautions, should house keeping be wearing a gown and gloves while inside that room. The DON further replied, They [housekeeping] could be in contact with furniture or devices. A review of the facility policy titled, Contact Isolation updated on 8-24 revealed, Staff and visitors will wear a disposable gown upon entering the room and remove them before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed . N.J.A.C. § 8:39-19.4 (a)