STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315500	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Voorhees	1086 Dumont Circle Voorhees, NJ 08043

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2613158 Based on interviews, medical record review, and review of pertinent facility documents on 09/18/2025, it was determined that the facility failed to implement their abuse policy and procedure to ensure all residents were protected from abuse when a severely cognitively impaired resident (Resident #1) alleged the Certified Nursing Aide (CNA #1) physically abused them, and CNA #1 was taken off the resident's assignment, but remained on that nursing unit assisting other residents as well as having access to Resident #1. This deficient practice was identified for 1 of 3 residents reviewed (Resident #1).On 09/07/2025 at 11:30 PM, Resident #1 put on their call light, and CNA #1 responded to the resident's room. The Licensed Practical Nurse (LPN #1) heard Resident #1 screaming and entered the resident's room. LPN #1 observed water on the resident's floor, and Resident #1 stated that CNA #1 pulled their hair and beat them up. LPN #1 immediately reported it to the Nursing Supervisor (NS), who removed CNA #1 from Resident #1's assignment, but kept them on the same nursing floor, which gave them access to Resident #1 as well as other residents. An interview with LPN #1 on 09/18/2025, revealed that Resident #1 was observed after the incident following CNA #1 around on the unit in their wheelchair saying, She beat me. During an interview with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), on 09/18/2025, the LNHA stated that they were informed of the incident on 09/08/2025, at approximately 5:00 AM or 6:00 AM, by the NS, and the LNHA stated he told the NS to send CNA #1 home. The DON stated that during their investigation, it was determined that the incident occurred on 09/07/2025 at 11:30 PM, and staff should have reported it at that time and CNA #1 should have been sent home then. A review of CNA #1's timecard for 09/07/2025, revealed that they clocked out for their shift on 09/08/2025 at 6:03 AM.The facility's failure to implement their abuse policy including protecting Resident #1 from abuse by not immediately removing CNA #1, who continued to work having access to Resident #1 and other residents until an investigation was completed, placed Resident #1 and all residents at risk for abuse. This posed the likelihood of serious physical and psychosocial harm, or impairment which resulted in an Immediate Jeopardy (IJ) situation.The IJ began on 09/07/2025 at approximately 11:30 PM, after LPN #1 heard Resident #1 allege that CNA #1 pulled their hair and beat them up, and CNA #1 continued to work with other residents as well as have access to Resident #1. The facility was notified of the IJ on 09/18/2025 at 4:50 PM. The facility submitted an acceptable Removal Plan (RP) on 09/22/2025 at 1:47 PM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 09/23/2025 at 12:15 PM.The evidence was as follows:A review of the facility's policy titled Abuse, Neglect, and Exploitation updated January 2025, included Policy: It is the policy of this facility to provide protections [.] that prohibit and prevent abuse, neglect [.] VI. Protection of resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation [.] VII. Reporting/Response. 1. Reporting of all alleged violations that the to the Administrator, state agency. within specified timeframes.A review of the Facility Reported Event (FRE) dated 09/08/2025, revealed the following: On the morning of 09/08/2025, the DON was informed that Resident #1 alleged that CNA #1 struck the resident while care was being provided. It further indicated that LPN #1 witnessed the incident and stated that CNA #1 was the one that was struck and had water thrown at her by Resident #1. The FRE also revealed that CNA #1, .was sent home and removed from the schedule while the investigation is ongoing. The FRE included a summary of the investigation created by the DON, which indicated that LPN #1 was in the room at the time of the incident and that CNA #1, .acted accordingly, and within the norms of the facility's policies and standards of practice.A further review of the FRE included a written statement from CNA #1, which indicated that upon responding to a call bell for Resident #1, the resident became upset after not hearing CNA #1 enter the room. CNA #1 then saw Resident #1 spill water on the floor and while attempting to get the resident to sit, Resident #1, .started yelling at me, told me to take my hands off [gender redacted], yelling at me saying that I beat [gender redacted] up . CNA #1 then indicated, I left the room to go get the nurse to assist me with the resident and make her aware of what happened.CNA #1's statement did not corroborate the FRE that indicated LPN #1 witnessed the incident since CNA #1 documented that she left the room to get [LPN #1] to assist her and make her aware of what just happened.According to the admission Record face sheet (an admission summary), Resident #1 was admitted to the facility with