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	03/17/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. COMPLAINT #2716078 Based on interviews, review of medical records and other pertinent facility documentation on 3/16/26 and 3/17/26, it was determined that the facility failed to maintain an accurate and complete medical record in accordance with acceptable professional standards of practice. This deficient practice was identified for 1 of 4 residents reviewed (Resident #1) and was evidenced by the following:Resident #1 was not at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: fracture of first cervical vertebra, heart failure, and type II diabetes. The comprehensive Minimum Data Set (MDS), an assessment tool, dated 1/12/26, revealed a Brief Interview of Mental Status (BIMS) of 12 out of 15, which indicated that the resident was moderately cognitively impaired. Further review of the MDS indicated that Resident #1 required substantial assistance with toileting hygiene and toilet transfer. A review of Resident #1's care plan (CP), revealed foci related to the resident being at risk for skin breakdown. Interventions for this focus included: checking for incontinence routinely, offering toileting every 2-3 hours, and keeping the skin as clean and dry as possible. Further review revealed an additional focus related to the resident having incontinent episodes. The resident also had a focus related to having a self care performance deficit. Interventions for this focus included the resident requiring one-person assistance for toileting and all transfers. A review of Resident #1's Documentation Survey Report v2 (DSR) for January 2026 included that the following should be documented during each shift. There was no evidence of documentation on the following dates and shifts:-Bladder Continence:1/2 Night1/4 Day1/6 Day1/9 Evening & Night1/11 Evening -Bowel Continence:1/2 Night1/4 Day1/6 Day1/9 Night1/11 Evening -Bowel Movements:1/2 Night1/4 Day1/6 Day1/9 Night -Toilet Use:1/2 Night1/4 Day1/6 Day1/9 Evening & Night1/11 Evening A review of Resident #1's Progress Notes (PN) for the corresponding dates did not reveal any documentation related to the above tasks on the corresponding dates. During an interview on 3/17/26 at 6:14 PM with Licensed Practical Nurse Unit Manager (LPN/UM), LPN/UM stated that certified nursing assistants (CNA) were primarily responsible for assisting residents with toileting and incontinent care. LPN/UM further stated that they were to document all care provided in each resident's electronic medical record (EMR). LPN/UM further stated that documentation was important because it confirmed that care was completed. She stated that there should be no blanks and that it was the responsibility of each supervisor to verify that CNAs were documenting. During an interview on 3/17/26 at 6:33 PM with CNA #1, she stated that CNAs were primarily responsible for assisting residents with toileting and incontinent care. CNA #1 stated that they were to document all care provided in each resident's electronic medical record (EMR). She stated that documentation was important because it communicated to everyone the type of care that the resident required and was provided. CNA #1 recalled providing care to Resident #1 and stated that sometime they are so busy providing the care that she forgets to document what was actually done. During a joint interview with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) on 3/17/26 at 7:25 PM, they both stated that CNAs were responsible for providing incontinent care and that they (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were expected to enter all care provided into each EMR. They further stated that documentation was important because it could signify that care was not provided. They further stated that nursing supervisors should be verifying that all care was documented. A review of the facility's undated Charting and Documentation policy revealed that all services provided to residents should be documented and that documentation should be complete and accurate. The policy listed what information was to be documented and included, .Treatment or services performed. N.J.A.C. 8:39-27.1(a)