STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Subacute at Autumn Lake Healthcare	113 Route 73 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49509 Complaint # NJ00175045 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that meet each resident's physical, mental and psychosocial needs for a resident with a history of falls. This deficient practice was identified for 1 of 3 residents reviewed for quality of care, (Resident #3) and was evidenced by the following: Review of the Electronic Medical record revealed the following: According to the Admission Record, Resident #3 was admitted to the facility on [DATE] with diagnoses which included but not limited to: Difficulty Walking, Fall Risk and Muscle Weakness and Fall. A review of the Minimum Data Set (MDS), an assessment tool dated 02/09/2024, showed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident was cognitively impaired. The MDS also showed Resident #3 required extensive assistance with bed mobility, personal hygiene, transfer two persons assist, toileting total dependence, meal setup. A review of the Baseline Care Plan (BCP) indicated on 04/01/24 revealed, Resident #3 was on hourly checks by staff and Perimeter mattress in placed on bed. Resident #3 required extensive one person assistance with bed mobility and personal care. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Surveyor reviewed the Facility Reportable Event (FRE) dated 4/5/2024 for Resident #3, that was provided by the facility. The FRE revealed that on 04/05/24, the day shift staff noted Resident #3 on the floor mat next to the resident's bed. An attempt to interview Resident #3, who was not able to recall details of the event. The facility was notified by the family that the resident was on the floor for some time, per a video monitoring device that was recording at that time. This device was placed in the room with the resident by the family with the facility's permission. The family reported to the staff that the resident was "yelling" prior to the fall. The family member reported that the nurse assigned to the resident had closed the door instead of checking on the resident based on the facility's policy for making rounds on residents identified for the need for regular checking due to history of falls. The reportable also revealed that the family requested that the resident be sent out to the hospital. The resident was sent out to the hospital and did not return to the facility. The facility determined the staff that was on that night was a License Practical Nurse #2 (LPN), that worked for an outside agency that was used by the facility to supplement staffing for the assigned floor. The FRE indicated that LPN#2 had reported to the day shift staff nurse that Resident #3 was disturbing other residents prompting her to close the resident's door. On 07/30/24 at 10:31a.m., the Surveyor interviewed Certified Nurse Assistant #1 (CNA) who stated that fall risk resident should be monitor every fifteen to thirty minutes. On 07/30/24 at 1:44 p.m., the Surveyor interviewed LPN #5, he stated that he found the resident on the mat lying on the left side. He took the resident's vital signs and neurological check was done. LPN #5, also spoke to a family member from the monitoring device at that time. The Director of Nursing, (who is no longer at the facility) also came into the room and completed a physical and neurological assessment on Resident #3. There were no injuries noted and the resident was assisted back to bed. The resident had floor mats located on each side of the bed due to history of falls. The family requested to the facility staff to send Resident #3 to the hospital for an evaluation. On 07/30/24 at 2:24 p.m., the Surveyor interviewed Assistant Director of Nursing (ADON), who stated Resident #3 was a fall risk and was dependent on staff in all aspects of care. The ADON stated LPN #5 reported that Resident #3 was on the floor mat and in need of assistance and the night shift nurse LPN #2 had gone and closed the resident door. The ADON stated that LPN #2 was suspended immediately and was not permitted to work at the facility anymore. The ADON stated that when residents fall on mats the incident was considered a fall. A review of the facility's policy 'Purposeful Rounding. Policy statement. Purposeful rounding is an initiative approach to the care of an identified resident that involves regularly checking on the resident to address their anticipated needs, prevent problems, and enhance their overall well-being. Frequency of Rounding: The established process of an individual schedule for purposeful rounding is determined by the IDT team may varies depending on the needs of the residents and which can include but not limited to hourly every 30 minutes, and every 15 minutes. NJAC 8:39-27.1(a).