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	11/27/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 51144 Complaint #: NJ00180094 Based on observation, interview, and record review, it was determined that the facility failed to appropriately respond to a resident family's request regarding resident food preferences and follow the facility policy related to resident self-determination. This deficient practice was identified for 1 of 1 resident reviewed for choices (Resident #3) and was evidenced by the following: A review of the Admission Record (AR) reflected that Resident #3 was admitted to the facility with diagnoses which included but were not limited to dysphagia, pharyngeal phase (difficulty swallowing); other lack of coordination; and need for assistance with personal care. According to the most recent Minimum Data Set (MDS), an assessment tool, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognition was severely impaired. During a unit tour on 11/26/2024 at 11:57 A.M., the surveyor observed a large sign with large writing that read please do not feed pudding or milk on the room door of Resident #3. No milk, no pudding was also observed written on the whiteboard in Resident #3's room. The same signage remained in place during a meal observation on 11/27/2024. During a lunchtime meal observation on the third floor on 11/27/2024 at 12:44 P.M., the surveyor observed Resident #3's meal tray arrive. The tray contained a clear plastic cup filled with a creamy appearing yellow substance. The Assistant Director of Nursing (ADON) confirmed that the creamy yellow substance was pudding. During an interview on 11/27/2024 at 1:01 P.M., the ADON stated that Resident #3's family placed the signs about pudding on the resident's door. The ADON stated that if pudding was against the family's preferences, then it should not have been on the resident's tray. The ADON further stated that Nurses or Dieticians were responsible to notify the kitchen of this type of preference. During an interview on 11/27/2024 at 1:15 P.M., Licensed Practical Nurse (LPN) #2 stated everyone should follow resident preferences. LPN #2 went on to state that the person who was notified of a resident's preference should have made other staff aware. LPN #2 stated that everyone could have passed Resident #3's preference for no pudding along to dietary. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The undated facility policy Resident Self Determination and Participation (Schedules) was reviewed. Under the section titled Policy Explanation and Compliance Guidelines the document revealed According to federal regulations the resident has the right to [.] c. Make choices about aspects of his or her life in the facility that are significant to the resident. Review of the Policy Explanation and Compliance Guidelines section of the Resident Self Determination and Participation (Schedules) policy document further revealed If the resident is unable to communicate preferences, the resident's family members should be asked for input. NJAC 8:39-17.4 (a)1

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NAME OF PROVIDER OR SUPPLIER The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 113 Route 73 Voorhees, NJ 08043	

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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 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 51144 Complaint #: NJ00180094 Based on interviews, medical record review, and review of other pertinent facility documentation on 11/26/2024 and 11/27/2024, it was determined that: the facility failed to provide the correct therapeutic diet to a cognitively impaired resident (Resident #3) with a known diagnosis of dysphagia, pharyngeal phase who had a physician's order and plan of care for ground diet and required feeding assistance. It was determined that on 11/12/2024 a Certified Nursing Assistant (CNA) delivered a meal tray containing a regular texture meal to Resident #3, who had orders for a ground diet. The regular texture meal was left with Resident #3. The CNA confirmed that Resident #3's meal tray included corn and tortillas that were not ground texture. The resident's family arrived shortly after the tray was left with Resident #3 and observed the resident with food in her/his mouth. The family reported to facility staff that Resident #3 was choking. The facility also failed to follow its policies titled Therapeutic Diet Orders and Comprehensive Care Plans. This deficient practice was identified for 1of 3 residents (Resident #3) reviewed for therapeutic diet orders and posed a hazard to residents with the need for mechanically altered diets. This deficient practice had the potential to result in serious injury or death. The past noncompliance and Immediate Jeopardy began on 11/12/24 and ended on 11/13/2024 after the facility implemented a systemic plan before this complaint survey began. The facility's plan included the following: On 11/12/2024 Resident #3 was assessed for aspiration precautions. On 11/12/2024 Resident #3's physician was notified of the incident. On 11/12/2024 the DON (Director of Nursing) was notified of the incident. On 11/12/2024 at 2:00 P.M., the CNA was in-serviced regarding verification of tray and ticket information. On 11/13/2024 resident care staff was in-serviced regarding meal tray accuracy. On 11/13/2024 kitchen staff were in-serviced regarding ensuring resident meals are of the correct texture. On 11/13/2024 the [NAME] on shift at the time of the incident was given an Employee Corrective Action related to failure to follow the meal tracker ticket as read. On 11/13/2024, 11/14/2024, 11/15/2024, 11/16/2024, and 11/17/2024 tray accuracy audits were performed for Resident #3's breakfast, lunch, and dinner trays. 100% accuracy was documented. On 11/13/2024 the facility initiated weekly meal tray audits for texture meals and tray accuracy for all residents. (continued on next page)

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F 0808

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

On 11/13/2024 a system compliance plan was developed to submit texture meals and tray accuracy results to Quality Assurance and Performance Improvement (QAPI) on an ongoing basis.

According to the Admission Record, Resident #3 was admitted to the facility with diagnoses which included but were not limited to dysphagia, pharyngeal phase (difficulty swallowing); other lack of coordination; and need for assistance with personal care.

According to the most recent Minimum Data Set (MDS), an assessment tool, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 5 out of 15, which indicated the Resident #3's cognition was severely impaired.

Review of the facility's untitled document dated 11/12/2024 and timed 21:55 (9:55 PM) under Incident Description revealed Aid identified that resident received the incorrect tray. Tray was removed and a new diet tray was provided to resident.

Review of Resident #3's Progress Notes (PNs) revealed an undated and untimed LATE ENTRY authored by the facility's Director of Nursing (DON) that revealed Patient was assessed and monitored for aspiration precautions.

Review of Resident #3's Care Plan (CP), undated, included a focus of, nutritional status (Resident #3) is at nutrition risk due to inadequate oral intakes, chewing difficulties, self feeding deficits and recent wt [weight] loss. Dysphagia pharyngeal phase [.] mechanically altered diet Ground. The CP included an undated intervention to Provide diet as ordered: 2 gm [gram] Na [sodium] ground, 1500cc [cubic centimeter] FR [fluid restriction].

Review of the facility document Order Summary Report (OSR), dated 11/26/2024, revealed an order, dated 11/05/2024 for a ground texture diet with sodium and fluid restrictions. The OSR also revealed an order dated 11/06/2024 which indicated that Resident #3 required assistance and extra time for feeding.

Review of Resident #3's dinner meal ticket, dated 11/12/2024, revealed 2 Gm Na- Ground at the top of the ticket in bold lettering. The items selected for Resident #3 included mashed potatoes, pureed stewed tomatoes, and pureed cinnamon brown sugar blondie.

During an interview on 11/26/2024 at 12:52 PM, Licensed Practical Nurse (LPN) #1 stated that there should be a diet order for each resident. LPN #1 stated that CNAs passed trays to each resident at mealtimes. LPN #1 stated that the expectation was that trays were checked at the residents' bedside and matched to the meal ticket. LPN #1 stated that the CNA should have notified a nurse if a tray seemed wrong for any reason. The nurse should then address the issue with the kitchen. LPN #1 further stated that CNAs did the feedings and should have notified nurse with any feeding concerns.

During a telephone interview on 11/26/2024 at 3:56 P.M., the CNA informed the surveyor that on 11/12/2024 she delivered a regular texture tray to Resident #3. The CNA stated that Resident #3 got tortillas, corn, and something else. The CNA stated that she set the tray up for Resident #3 and the resident started eating. The CNA further stated that she was not aware that Resident #3 was on a altered texture diet or that the resident required feeding assistance. The CNA further stated that 10 minutes later Resident #3's family reported that the resident was choking. The CNA stated, The resident had food in (their) mouth, I think (they) just couldn't chew it.

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 11/27/2024 at 11:00 AM, the Food Service Director (FSD) stated that tray accuracy was important because getting the wrong food could have caused harm and possibly death to a resident because of choking or allergies. The FSD stated that the current process was for nursing staff to complete diet slips for each resident. The diet slips included name, room number, allergies, diet, and preferences. The FSD further stated that the FSD then entered the diet slip information into MealTracker (a nutrition management software) and printed a ticket to ensure accuracy. The FSD stated that as a tray was prepared it moved down a tray line where a Dietary Aide (DA) placed liquids and condiments. The [NAME] would have then looked at the ticket to determine what went on the resident's plate. The last person working on the tray line was usually a DA who was supposed to verify that the meal matched the ticket. The FSD stated that the expectation was for the [NAME] to make sure the correct texture food went on the residents' meal tray. The FSD stated that the facility did not follow its policy related to resident diet because a resident received the wrong meal. The FSD went on to state that the [NAME] on the P.M. shift on 11/12/2024 was given a verbal warning due to the meal ticket not being followed. During an interview on 11/27/2024 at 1:15 PM, LPN #2 stated that it was important to follow doctors' orders to make sure that residents received the care that they needed. LPN #2 stated that it was the expectation that residents' care plans (CPs) were followed by all staff. LPN #2 stated that if care plans were not followed errors or neglect could have happened. During an interview on 11/27/2024 at 1:49 P.M., the DON stated that it was expected that meals received by residents were in accordance with physician orders. The DON further stated that the expectation was that staff verified the ordered diet to what came on the meal tray to ensure accuracy. The DON stated that if a resident received the wrong diet and consumed it the outcome would have to be evaluated on a case-by-case basis. The DON stated that resident CPs were individualized to every resident and tailored to their needs. The DON further stated that CPs should have been followed by all staff and that there could be a hindrance to the resident if their CPs were not followed. Review of the facility's Therapeutic Diets policy, revised 10/2022, revealed under the Policy Statement All residents have a diet order [.] that is prescribed by the attending physician, physician extender, or credentialed practitioner. Under Procedures the policy revealed Diets are prepared in accordance with guidelines in the approved Diet Manual and the individualized plan of care. Review of the facility policy titled Comprehensive Care plans revealed Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Review of the facility document titled Diet and Nutrition Care Manual IDDSI Level 5: Minced and Moist with ground handwritten at the top of the pages was conducted on 11/27/2024. This section of the Diet and Nutrition Care Manual revealed This diet may be appropriate for individuals with swallowing or dental problems and requires no chewing or biting. The list of food examples in this category included but were not limited to Vegetables cooked, finely mashed or use a blender to finely chop it into 4mm [millimeter] lump size pieces and Breads are gelled or pureed following a recipe. NJAC 8:39-17.4(a)(2)