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	03/24/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of facility policy, it was determined that the facility failed to ensure that 1 of 4 residents (Resident #122) observed during the medication administration observation were given their medication. Specifically, Resident #122 did not have their medication Sevelamer HCl (phosphate binding medication) available for administration in the medication cart and was given another unidentified resident's home medication of Sevelamer HCl.This deficient practice was identified by the following: On 3/18/2026 at 9:04 AM, during medication pass observation on the third floor nursing unit, the surveyor observed a Licensed Practical Nurse (LPN #2) administer medications for Resident #122. The LPN was unable to locate Resident #122's medication, Sevelamer HCl (phosphate binding medication) Oral Tablet 800 MG (Sevelamer HCl) give 2 tablets by mouth three times a day and take with meals. The LPN stated that the medication should have been available in the medication cart, however she could not locate it. She explained that she could not obtain the medication from the back up medication dispensing machine because that medication was not stocked there. The LPN referred the issue to the Licensed Practical Nurse Unit Manager (LPN/UM).A review of the admission Record (an admission summary) indicated that Resident #122 was admitted to the facility with the diagnoses which included but were not limited to; polyneuropathy (a general degeneration of the peripheral nerves) and end stage renal (kidney) failure.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated 3/6/26, indicated that Resident #122 scored a 14 out of 15 on the Basic Interview for Mental Status (BIMS), which indicated that the resident was cognitively intact. Further review of the MDS also indicated that the resident required supervision with activities of daily living and was on hemodialysis (a life-saving treatment for kidney failure to filter wastes and excess fluid from the blood).A review of Resident #122's Medication Administration Record (MAR) indicated that the resident was admitted to the facility on [DATE]. The surveyor observed nursing signatures on the MAR which indicated that some nurses documented that they administered the medication, some were documenting that the resident refused the medication, and some nurses were documenting that the medication was not available. A Review of Resident #122's physician orders (PO) reflected the following orders:-PO dated 3/6/26 for the medication Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) give two tablets by mouth three times a day for take with meals.-PO dated 3/6/26 for Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) give 2 tablets by mouth three times a day for take with meals and discontinued 3/14/2026. -PO dated 3/14/26 for Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) give 2 tablets by mouth three times a day every Monday, Wednesday, Friday. Take with meals. Discontinued on 3/18/2026.-PO dated 3/14/26 for Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) Give 2 tablet by mouth three times a day every Tuesday, Thursday, Saturday, and Sunday. Take with meals. Discontinued on 3/18/2026. -PO dated 3/18/26 for Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) give 2 tablets by mouth three times a day every Tuesday, Thursday, Saturday, Sunday for supplement take with meals. On 3/18/2026 at 9:37 AM, the surveyor interviewed the third floor LPN/UM who stated that Resident #122 was a dialysis patient who was admitted to the facility a couple of weeks ago. The LPN/UM explained the process the facility (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	followed when medications were ordered. She explained that when medications were ordered on admission the physicians confirmed the medications orders, the medications were then entered into electronic medical records (EMR) and once confirmed, the medication orders were considered active and then the pharmacy delivered the medications. She stated that the medication Sevelamer was ordered for Resident #122 on the 3/6/26, and that the resident should still have a supply of the medication Sevelamer in the medication cart. The LPN/UM reviewed the MAR with the surveyor and she stated that she was not sure how some nurses were documenting that they administered the medication, some nurses documented that the medication was not available, and some nurses documented that the resident refused the medication. She stated that the medication Sevelamer was not available in the electronic back up medication machine and was not a stock medication. She revealed that the nurses who documented on the MAR that the medication was not available should have documented in the progress notes (PN) what they did about the unavailable medication or should have notified a supervisor. She added that if a resident was not receiving scheduled medication as ordered, they could have adverse effects. She stated that sometimes the dialysis center would supply the Sevelamer and sometimes the facility provided it. She then added that if the resident's medication was to be provided by the dialysis center, then someone should have called them to let them know that the medication was not there and then someone should have notified the supervisor so that they could have investigated where the medication was.The surveyor reviewed the PN with the LPN/UM who confirmed that there were no PN documented when the resident refused their scheduled dose of Sevelamer and that there was no documentation to indicate what the nurses did when they identified that the medication was not available.On 3/19/2026 at 9:39 AM, the surveyor interviewed Resident #122 who was alert and oriented. The resident stated that they only took the medication, Sevelamer, about three times since admission to the facility. The resident stated that they refused the medication the rest of the time because the nephrologist told him/her that they did not need to take the medication as their phosphorus levels were within normal range. The resident stated that the facility continued to offer him/her the medication because they told him/her they had not received any orders to stop the medication. The resident stated that the nurse was in this morning with the medication and offered it to him/her, however he/she refused it. The resident further added that during their stay, some nurses would sometimes bring in one pill and sometimes they would bring in three pills of the Sevelamer. The resident stated, When I questioned the nurse, they would tell me this is what was ordered. Considering I have all my faculties I knew it was not the right dosage, so I would refuse to take the medications.On 3/19/2026 at 11:14 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she investigated the reason Resident #122 did not have the medication Sevelamer in the medication cart to be administered on 3/18/26 during the medication pass observation. The DON stated that the delivery did not occur when the resident was first ordered the medication and based on her investigation staff were administering Resident #122's, another resident's home supply of medication that was discharged from the facility. She stated that the medication was from a bottle that the other resident had brought from home. She stated that she was not sure whose medication it was because the name was blacked out on the bottle with marker. The DON confirmed delivery of the Sevelamer on 3/18/26 from the pharmacy. She also confirmed that the medication was not delivered from the pharmacy or dialysis when ordered on admission. She stated that the facility performed laboratory work to ensure that there were no concerns with Resident #122s phosphorous levels. She stated that labs were done immediately and were within normal range. The surveyor reviewed those labs, and they were in fact within normal range. She stated that there was no harm to Resident #122. The DON provided the surveyor with the bottle of medication and stated that the facility pharmacy consultant (PC) identified the medication that was in the bottle to be Sevelamer 800 mg tablets.On 3/19/2026 at 12:04 PM, the surveyor telephoned the facility pharmacy consultant (PC) who confirmed that she came to the facility on 3/18/26 and inspected the medication cart of the third floor and found a bottle of Sevelamer 800mg with the resident's name blacked out on (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the bottle. The PC further explained to the surveyor that she talked to the nurse who was assigned to the medication cart who stated that she had not used the medication. The PC could not provide the surveyor with the nurse's name because she could not remember it. She stated that when she conducted medication review for the residents, she reviewed the orders and the MAR. The PC stated that she reviewed Resident #122's medications on 3/8/26, because the resident was a new admission and she had seen that there was a 3 coded on the MAR. She stated that the code indicated that the resident was out of the facility. The PC stated at that time, my recommendation included changing the time of the medications to accommodate for dialysis days and times. The PC further stated that if the nurses were administering another resident's medication to Resident #122, there was a federal law that indicated that you cannot share medications that were not prescribed to you. She stated that the law protected people from taking other people's medications that were not prescribed to them. She continued to add that even though the nurse should not have been giving Resident #122 another resident's medication, at least it was the right medication and the right dose.On 3/19/2026 at 1:24 PM, the surveyor interviewed LPN #15 who admitted resident #122 to the facility. The LPN stated that she put medication orders in the system (EMR) and then the medications would be delivered. She stated that she was not sure why the medication was not delivered from the pharmacy and was not sure if dialysis provided the medication or the pharmacy provided the medication.On 3/19/2026 at 1:46 PM, the surveyor telephone interviewed the Pharmacist from the facility pharmacy who stated that for residents who were on dialysis and had insurance, insurance would not pay for the medication through the facility pharmacy. She further explained that the dialysis center provided the medication and that insurance would cover the medications when it was obtained through the dialysis center. She stated that the only reason why the facility pharmacy sent the medication Sevelamer on 3/18/26 was because the facility agreed to pay for the medication. On 3/23/2026 at 8:53 AM, the surveyor interviewed a Registered Nurse (RN) from the resident's dialysis center, and she explained that the residents' medications were bundled in Medicare part B and then the medication would be mailed to the facility. She stated that the nephrologist and the dietician were responsible for ordering the Sevelamer for the resident. She stated that she was not sure why the medication was not delivered to the resident and stated that the surveyor would need to speak to the clinical director of the dialysis center. On 3/23/2026 at 9:07 AM, the surveyor telephone interviewed LPN #8 who documented on the MAR on 3/7/26 at 2000 hours (8:00 PM) that she had administered Sevelamer 800 mg two tablets to Resident #122. The LPN stated that if the medication was not available, she would have borrowed it from another resident. She stated that this medication usually came in from the family, however, she did not notify the family that the resident did not have the medication. She also confirmed that she did not notify the pharmacy or the nursing supervisor that the medication was not available. She stated that when she realized that the medication was not available in the medication cart, she went to another unit to borrow another resident's medication. She stated that she was not educated regarding borrowing medications from other residents. On 3/23/2026 at 10:24 AM, the DON provided the surveyor with the following nurse statements: A review of an untimed written statement from LPN # 4 dated 3/18/26, indicated that she administered Resident #122 the medication off the medication cart but she did not remember if it was given from a home supply or a bingo card (a card with medications sealed beneath blister packaging). A review of the untimed written statement from LPN #5 dated 3/18/26, indicated that she administered Resident #122 the medication off the medication cart but did not remember if it was given from a home supply or a bingo card. A review of the untimed written statement from LPN #6 dated 3/18/26, indicated that she administered Resident #122 Sevelamer 800mg out of a bottle that was in the medication cart. She indicated that the PC was in and removed all expired medications, discharged medications and a bottle of Sevelamer out of the cart because the name on the medication was blacked out. She stated that she was assigned to that medication cart on 3/17/26 on the 7:00 AM to 3:00 PM shift. A review of the untimed written statement from LPN #8 dated 3/18/26, indicated that she administered (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #122 Sevelamer from a home supply that was in the medication cart.A review of the untimed written statement from LPN #9 dated 3/18/26, indicated that Resident #122 refused the medication and the refusal was documented. A review of the untimed written statement from LPN #10 dated 3/18/26, indicated that she administered Resident #122 Sevelamer from a home supply that was in the medication cart. A review of the untimed written statement from LPN #11 dated 3/18/26, indicated that she administered Resident #122 Sevelamer from a home supply that was in the medication cart. A review of the untimed written statement from LPN #12 dated 3/18/26, indicated that on 3/10/26 and 3/12/26 she administered Resident #122 Sevelamer 800mg the morning and noon doses out of a home supply of Sevelamer 800 mg.A review of the untimed written statement from LPN #13 dated 3/18/26, indicated that she administered Resident #122 Sevelamer from a home supply that was in the medication cart.On 3/23/2026 at 10:57 AM, the surveyor conducted a telephone interview with the dialysis Clinical Coordinator (CC) who stated that the resident's medication was ordered by the dialysis center from a pharmacy in Florida. The CC stated that it took a couple weeks for the medication to be mailed. The CC could not provide any additional information as to who was responsible for ensuring that the resident had the medication while a resident in the facility.On 3/23/2026 at 11:01 AM, the surveyor conducted a telephone interview with the dialysis center's Dietician who could not provide information regarding who was responsible to ensure that the resident received a medication that was ordered though the dialysis center.On 3/23/2026 at 11:10 AM, the surveyor conducted a telephone interview with the facility's Medical Director who stated he would have to call the dialysis center to find out where the medication was or how to get the medication. He stated that there should have been better communication between the facility and the dialysis center to assure that the medication was available for the resident.On 3/23/2026 at 11:25 AM, the surveyor interviewed the resident's primary care physician who stated that the Medical Director and the DON should have policies regarding medications that came from the dialysis center. She stated that she could not recall being notified by the facility staff that the resident did not have the medication Sevelamer in the facility. She stated that it should have been communicated to the DON and administration by the nurses so that the issue could have been resolved. On 3/24/2026 at 9:50 AM, the surveyor interviewed the DON who explained that during her investigation into why Resident #122's medication was not available, the dialysis center did not order the resident's medication, however the nursing staff upon recognizing that the medication was not available, should have followed the medication procurement policy and notified the physician, contacted the pharmacy, supervisor, DON and/or Medical Director. A review of the facility undated policy titled, Abuse, Neglect and Exploitation indicated that misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings, money without the resident's consent.NJAC 8:39-4.1(a)5

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2699716, #398990 Based on observation, interview, and review of medical records it was determined that the facility failed to establish a system to ensure that residents on dialysis received their medications according to physician orders. This deficient practice was identified during the medication pass administration observation for 1 or 4 residents (Resident #122), observed and was evidenced by the following:On 3/18/2026 at 9:04 AM, during medication pass observation on the third floor, the surveyor observed a Licensed Practical Nurse (LPN) administer medications for Resident #122. The LPN was unable to locate Resident #122's medication, Sevelamer HCl (phosphate binding medication) Oral Tablet 800 MG (Sevelamer HCl) give 2 tablets by mouth three times a day for take with meal. The LPN stated that the medication should be available in the medication cart, however she could not locate it. She explained that she could not obtain the medication in the back up medication dispensing machine because that medication was not stocked there. The LPN referred the issue to the Licensed Practical Nurse Unit Manager (LPN/UM).A review of the admission Record (admission summary) indicated that Resident #122 was admitted to the facility with the diagnoses which included but were not limited to polyneuropathy (a disease that affects the peripheral nerves) and end stage renal (kidney) failure.A review of the comprehensive Minimum Data Set (MDS), (an assessment that facilitates a resident's care) dated 3/6/26, indicated that Resident #122 scored 14 out of 15 on the Basic Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. Further review of the MDS indicated that the resident required supervision with activities of daily living and was on hemodialysis (life-sustaining treatment for kidney failure). A review of Resident #122's Medication Administration Record (MAR) indicated that the resident was admitted to the facility on [DATE]. The surveyor observed nursing signatures on the MAR that indicated some nurses documented that they administered the medication, some were documenting that the resident refused the medication, and some nurses were documenting that the medication was not available. A review of Resident #122's physician orders (PO) reflected the following orders:-PO dated 3/6/26 for the medication Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) give two tablets by mouth three times a day for take with meals.-PO dated 3/6/26 for Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) give 2 tablets by mouth three times a day for take with meals and discontinued 3/14/2026. -PO dated 3/14/26 for Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) give 2 tablets by mouth three times a day every Monday, Wednesday, Friday. Take with meals. Discontinued on 3/18/2026.-PO dated 3/14/26 for Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) Give 2 tablet by mouth three times a day every Tuesday, Thursday, Saturday, and Sunday. Take with meals. Discontinued on 3/18/2026. -PO dated 3/18/26 for Sevelamer HCl Oral Tablet 800 MG (Sevelamer HCl) give 2 tablets by mouth three times a day every Tuesday, Thursday, Saturday, Sunday for supplement take with meals.On 3/18/2026 at 9:37 AM, the surveyor interviewed the LPN/UM for the third floor who stated that Resident #122 was a dialysis patient who was admitted to the facility a couple of weeks ago. The LPN/UM explained the process the facility followed when medications were ordered. She explained that when medications were ordered on admission the physicians confirmed the medications orders, medications were then entered into electronic medical records (EMR) and once confirmed, the medications were considered active and then the pharmacy delivered the medications. She stated that the medication Sevelamer was ordered for Resident #122 on the 3/6/26, and the resident should still have a supply of the medication Sevelamer in the medication cart. The LPN/UM reviewed the MAR with the surveyor the LPN/UM stated that she was not sure how some nurses were documenting that they administered the medication, some nurses documented that the medication was not available, and some nurses documented that the resident refused the medication. She stated that the medication Sevelamer was not available in the electronic back up (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication machine and was not a stock medication. She revealed that the nurses who documented on the MAR that the medication was not available should have documented in the progress notes what they did about the unavailable medication or should have notified a supervisor. She added that if a resident was not receiving the scheduled medication as ordered, they could have an adverse effect. She stated that sometimes the dialysis center would supply the Sevelamer and sometimes the facility provided it. She then added that if the resident's medication was to be provided by the dialysis center, then someone should have called them to let them know that the medication was not there and then someone should have notified the supervisor so that they could have investigated where the medication was.The surveyor reviewed the progress notes (PN) with the LPN/UM who confirmed that there were no PN documented when the resident refused and that there was no documentation to indicate what the nurses did when they identified that the medication was not available.On 3/19/2026 at 9:39 AM, the surveyor interviewed Resident #122 who was alert and oriented. The resident stated that they only took the medication Sevelamer about three times since admission to the facility. Resident #122 stated that they refused the medication the rest of the time. He explained that the nephrologist (kidney doctor) told him/her that he/she did not need to take the medication as their phosphorus levels were within normal range. The resident stated that the facility continued to offer him/her the medication because they told him/her they had not received any orders to stop the medication. The resident stated that the nurse was in this morning with the medication and offered it to him/her, however they refused it. The resident further added that during the resident's stay, some nurses would sometimes bring in one pill and sometimes they would bring in three pills of the Sevelamer. The resident further stated, When I questioned the nurse, they would tell me this is what was ordered. Considering I have all my faculties, I knew it was not the right dosage so I would refuse to take the medications. On 3/19/2026 at 11:14 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she investigated the reason Resident #122 did not have the medication Sevelamer in the medication cart to be administered on 3/18/26 during the medication pass observation. The DON stated that the delivery did not occur when the resident was first ordered the medication. She confirmed delivery of the Sevelamer on 3/18/26 from the pharmacy after surveyor inquiry. The DON also confirmed that the medication was not delivered from the pharmacy or dialysis when ordered on admission. She stated that the facility performed laboratory work to ensure that there were no concerns with Resident #122s phosphorous laboratory levels. She stated that labs were done immediately and were within normal range. The surveyor reviewed those labs, and they were in fact within normal range. She stated that there was no harm to Resident #122. On 3/19/2026 at 12:04 PM, the surveyor telephoned the facility pharmacy consultant (PC) who confirmed that she came to the facility on 3/18/26 and inspected the medication cart on the third floor and found a bottle of Sevelamer 800mg with the name blacked out on the bottle. The PC interviewed explained to the surveyor that she talked to the nurse on the cart who stated that she hadn't used the medication. The PC could not provide the surveyor with the nurse's name because she could not remember it. She stated that when she conducted medication reviews for the residents, she reviewed the orders and the MAR. The PC stated that she reviewed Resident #122's medications on 3/8/26 because the resident was a new admission and she had seen that there was a 3 coded on the MAR. She stated that the code indicated that the resident was out of the facility. The PC stated at that time, my recommendation included changing the time of the medications to accommodate for dialysis days and times. The PC further stated that if the nurses were administering another resident's medication to Resident #122, it was a federal law that indicated that you cannot share medications that were not prescribed to you. She stated that the law protected people from taking other people's medications that were not prescribed to them. She continued to add that even though the nurse should not have been giving Resident #122 another resident's medication, at least it was the right medication and the right dose.On 3/19/2026 at 1:24 PM, the surveyor interviewed the LPN that admitted resident #122 to the facility. The LPN stated that she put medication orders in the system (EMR) and then the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications would be delivered. She stated that she was not sure why the medication was not delivered from the pharmacy and was not sure that dialysis provided the medication or the pharmacy provided the medication. On 3/19/2026 at 1:46 PM, the surveyor conducted a telephone interview with the Pharmacist from the facility pharmacy who stated that residents who were on dialysis and had insurance, insurance would not pay for the medication through the facility pharmacy. She further explained that the dialysis center provided the medication and that insurance would cover the medications when they were obtained through the dialysis center. She stated that the only reason why the facility pharmacy sent the medication Sevelamer on 3/18/26 was because the facility agreed to pay for the medication. On 3/23/2026 at 8:53 AM, the surveyor interviewed a Registered Nurse (RN) from the resident's dialysis center, and she explained that the residents' medications were bundled in Medicare part B and then the medication would be mailed to the facility. She stated that the nephrologist and the dietician would be responsible for ordering the Sevelamer for the resident. She stated that she was not sure why the medication was not delivered to the resident and further stated that the surveyor would need to speak to the clinical director of the dialysis center.On 3/23/2026 at 10:57 AM, the surveyor conducted a telephone interview with the dialysis Clinical Coordinator (CC) who stated that the resident's medication was ordered by the dialysis center from a pharmacy in Florida. The CC stated that it took a couple weeks for the medication to be mailed. The CC could not provide any additional information as to who was responsible for ensuring that the resident had the medication while a resident in the facility.On 3/23/2026 at 11:01 AM, the surveyor conducted a telephone interview with the dialysis center's Dietician who could not provide information regarding who was responsible to ensure that the resident received a medication that was ordered though the dialysis center.On 3/23/2026 at 11:10 AM, the surveyor conducted a telephone interview with the facility Medical Director (MD) who stated he would have to call the dialysis center to find out where the medication was or how to get the medication. He stated that there should have been better communication between the facility and the dialysis center to assure that the medication was available for the resident. On 3/23/2026 at 11:25 AM, the surveyor interviewed the resident's primary care physician who stated that the Medical Director and the DON should have policies regarding medications coming from the dialysis center. She stated that she could not recall being notified by the facility staff that the resident did not have the medication Sevelamer in the facility. She stated that it should have been communicated to the DON and administration by the nurses so that the issue could have been resolved. On 3/24/2026 at 9:50 AM, the surveyor interviewed the DON who explained that during her investigation into why Resident #122's medication was not available, the dialysis center did not order the resident's medication, however, the nursing staff upon recognizing that the medication was not available, should have followed the medication procurement policy and notified the physician, contacted the pharmacy, supervisor, DON and/or Medical Director. A review of the facility policy dated 1/2025 and titled, Medication Procurement Policy indicated that the facility was committed to ensuring that all residents receive their prescribed medications as ordered by their physician. Medications must be available in the facility when needed and alternate physician-approved medications must be provided if the medication ordered was unavailable. To ensure that all physician-ordered medications are received, available, and administered to residents in a timely, safe and accurate manner and to prevent delays that could result in unmanaged pain or other adverse outcomes. This policy applies to all licensed nursing staff, nursing supervisors, pharmacy personnel, and any other staff involved in ordering, receipt, and administration of medications.NJAC 8:39-29.2

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interviews, record review and review of facility provided documents, it was determined that the facility failed to obtain a physician's order (PO) for a left leg immobilization device for 1 of 1 resident (Resident #9) reviewed for supportive devices. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 3/17/26 at 11:21 AM, during the initial tour of the facility, the surveyor observed Resident #9 sitting in a wheelchair with a hinged brace (a supportive medical device using rigid bars on the sides of the leg connected by a mechanical hinge mechanism to control the knee's range of motion and prevent side-to-side instability) on their left leg, that was visible over top of their pants. On 3/18/26 at 10:02 AM, the surveyor observed Resident #9 sitting in their room with a hinged brace on their left leg, over top of their pants. Resident #9 stated they fell a few months ago and fractured their bone just below the knee, but did not have surgery to repair the broken bone. The resident stated a black knee immobilizer (a padded wrap made of foam or cloth with vertical supports extending from the mid-thigh to mid-calf) was put on their left leg which they wore all day and night. Resident #9 stated they had to pull their pants up over top of the immobilizer because the immobilizer could not be removed. The resident stated in mid-January (2026) they went to a follow up doctor's appointment where the immobilizer was removed and a hinged brace was placed, with the hinges locked straight for almost 60 days. Resident #9 stated the hinged brace was taken off when they went to bed and put back on every morning, to be worn when they stood or walked. Resident #9 added the hinged brace was put on overtop of their pants, which was much easier than pulling their pants up over the old immobilizer. Resident #9 stated in early March (2026) they went to another follow up doctor's appointment. At that appointment, the hinges were opened. The resident stated they were allowed to gradually bend their knee, and now I can bend it all I want, straightening and bending their left leg to demonstrate to the surveyor. At this point, the surveyor observed Resident #9 pull on the hinged brace by the 2nd strap from the top, on their thigh. Resident #9 stated they were lifting the strap off of their leg for comfort and added they were adjusting the position because it's important the hinges align with the top of my knee. Depending on what I'm wearing it slides down sometimes. On 3/18/26 at 11:09 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who was assigned to Resident #9. LPN #1 stated Resident #9 wore a left knee immobilizer with settings on it. LPN #1 stated there should be a PO for when to put it on, and where to put it. LPN #1, together with the surveyor, reviewed Resident #9's PO's in the electronic medical record (EMR). LPN #1 acknowledged she was not able to locate a PO for the resident to wear the knee immobilization device.On 3/18/25 at 11:25 AM, the surveyor interviewed LPN/UM #1 who stated Resident #9 was at the facility after a fall with fracture and wore a knee immobilizer. LPN/UM #1 stated her expectation was that the nurses followed the residents' care plans and orders. She stated Resident #9 should have an order for their device to make sure it was placed in the right location, and at the right settings. LPN/UM #1, together with the surveyor, reviewed the EMR for Resident #9. LPN/UM #1 acknowledged there was not a PO for the placement of the knee immobilization device. On 3/18/26 at (continued on next page)

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The Subacute at Autumn Lake Healthcare	113 Route 73 Voorhees, NJ 08043

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:03 PM, the surveyor interviewed the Registered Nurse/Assistant Director of Nursing (RN/ADON) who stated residents with immobilization devices should have physician orders including proper placement and fit. The RN/ADON stated it's the default that a brace stays on at all times unless the PO says otherwise. The RN/ADON, together with the surveyor, reviewed the EMR for Resident #9. The RN/ADON acknowledged there was not a PO for the resident to wear the knee immobilization device. The surveyor reviewed the EMR for Resident #9. A review of the admission Record (an admission summary) reflected diagnoses which included but were not limited to; unspecified fracture of upper end of left tibia, initial encounter for closed fracture.A review of the most recent comprehensive Minimum Data Set (MDS, a standardized assessment tool) dated 1/4/26, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the individualized comprehensive care plan (ICCP) with last reviewed date of 1/14/26 reflected focus areas including but not limited to; a risk for falls related to limited mobility, NWB (non-weigh bearing) LLE (left lower extremity), history of falls; and a self-care performance deficit in activities of daily living related to limited mobility, deconditioning, and ambulatory dysfunction. A review of the downloaded documents in the resident's EMR included a letter from [doctor's office name redacted] dated 3/4/26 which reflected Resident #9 was seen in their office on 3/4/26.WBAT (weight bearing as tolerated) LLE with hinged brace unlocked, only needs brace for walking.A review of the progress notes included a general nurses note dated 3/4/26 which reflected the resident had returned from [doctor's office name redacted].orders received WBAT LLE with brace unlocked, only needs brace when walking.A review of the Order Summary Report (OSR) which included order status: active, completed, and discontinued reflected a PO for WBAT LLE dated 3/9/26, but did not reflect a PO for the placement or use of the knee immobilization device. A review of the facility provided policy Physician Orders updated April 2024, reflected. Medications, diets, therapy, or any other treatment may not be administered to the residents without the written approval from the attending physician. A review of the undated facility provided policy Consulting Physician/Practitioner Orders reflected, policy explanation and compliance guidelines including but not limited to:Consulting physician/practitioner orders are those provided to the facility by a physician/practitioner other than their resident's attending physician.For consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will:Call the attending physician to verify the order.Document the verification order by entering the order and the time, date, and signature on the physician order sheet. NJAC 8:39-11.2(b)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, review of the medical record (MR) and review of other pertinent facility documents, it was determined that the facility failed to consistently ensure communication with a contracted dialysis facility according to facility policy and procedure. This deficient practice was evidenced for 1 of 1 resident (Resident #13) reviewed for dialysis. This deficient practice was evidenced by the following: On 03/18/2026 at 9:04 AM, the surveyor observed Resident #13 seated in the wheelchair eating breakfast. Resident #13 offered no complaints and told the surveyor that they attended dialysis for approximately two and a half years on Monday, Wednesday and Friday. On 3/18/2026 at 11:03 AM, the surveyor reviewed the medical record (MR) for Resident #13 which revealed the following:A review of the admission Record, an admission summary, revealed that Resident #13 had the following but not limited to diagnoses; Morbid obesity, end stage renal disease, malignant neoplasm (cancerous tumor) of liver and intrahepatic bile duct.A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/1/2026, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident received dialysis services.A review of Resident #13's Individual Comprehensive Care Plan (ICP) included a focus area, dated 3/9/2026, that the resident required hemodialysis. Interventions included: Monitor for dry skin and apply lotion as needed, monitor/report to MD (medical doctor) s/sx (signs/symptoms) of infection to access site: redness, swelling, warmth or drainage and monitor/report to MD s/sx of the following: bleeding, hemorrhage.A review of the Order Summary Report (OSR), dated as of 2/24/2026, included the following physician order dated 2/2/3/2026 for Send communication book with resident on dialysis days and check book upon return every day shift every Mon, Wed, Fri for dialysis protocol.A review of Resident #13's hemodialysis communication binder on 03/19/2026 at 11:36 AM revealed the following:On 2/25/2026 the facility failed to document post-dialysis information for Resident #13.On 3/3/2026 the facility failed to document Pre-Dialysis Information for Resident #13, which included vital signs, physician name, medications administered prior to dialysis, meal/snack sent, any additional information (changes in condition, physician order changes, new labs since last visit) and the nurse signature. In addition, no post-dialysis information was documented. (shunt/catheter location/status, catheter dressing intact, Bleeding, general condition of the resident, date/time and vital signs.On 3/4/2026, the facility failed to document post-dialysis information upon return to facility. On 3/6/2026, the facility failed to receive documentation from the dialysis center and failed to document post-dialysis information. On 3/9/2026, the facility failed to document post-dialysis information and failed to document pre-dialysis information for Resident #13.On 3/11/2026, the facility failed to receive documentation from the dialysis facility post-treatment and failed to document post-dialysis information.On 3/13/2026, the facility failed to document post-dialysis information. On 3/16/2026 the facility failed to document post-dialysis information.On 3/18/2026, the facility failed to document post-dialysis information for Resident #13.On 03/19/2026 at 11:54 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) for the 2nd Floor. The surveyor asked LPN/UM #1 to explain the purpose of the Dialysis Communication Form. LPN/UM #1 explained the communication sheet was to be filled out by the nurse assigned to the resident prior to leaving facility. The facility sends the communication book with the resident to dialysis. Dialysis staff was responsible for documenting pre and post weights and anything pertinent during treatment. LPN/UM #1 further explained that the communication form/book comes back with the resident, and the receiving nurse looks at the sheet and notes any new orders. Then, they assessed the catheter site upon return and write a progress note. The surveyor then asked LPN/UM #1 if the receiving nurse was to fill out the Post-Dialysis Information on the Dialysis Communication Form upon return to the facility. LPN/UM #1 could not confirm that the facility receiving nurse was responsible for documenting the post-dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information. She stated, I guess it could go either way (Dialysis staff to fill out or facility staff.) She then stated that it was the facilities' responsibility to fill out the post-dialysis information. The surveyor then asked LPN/UM #1 what the process was if the dialysis facility failed to document on the Dialysis Communication Form. LPN/UM #1 responded that If dialysis failed to document any information under dialysis center information the nurse was to call the dialysis facility and get any pertinent information. LPN/UM #1 further stated that on 3/11/2026, the receiving nurse should have called the dialysis facility to get the dialysis center information that was left blank.On 03/23/2026 at 2:11 PM, the survey team conducted an interview with facility administration which included the Licensed Nursing Home Administrator (LNHA), the facility Director of Nursing (DON) and the Regional Nurse (RN). The surveyor asked the staff to explain the dialysis communication form process. The DON told the surveyor that the facility filled out the communication form and took vitals prior to dialysis. The binder goes with the resident to dialysis and pre and post weights, vital signs, any medications delivered, or medications ordered were to be documented by the dialysis staff. The surveyor then asked what the facility should do if the dialysis staff failed to document on the dialysis communication form. The DON stated that the staff should contact the dialysis center if the form comes back blank and gets the necessary information from dialysis. The surveyor then asked the DON if facility staff were required to document post-dialysis information upon return to the facility. The DON responded, the receiving nurse should check the MAR (Medication Administration Record) and TAR (Treatment Administration Record) upon return to the facility. They could also write a skilled documentation note. These items were located on the MAR and TAR and are documented upon return (referring to the items to be assessed under post-dialysis information on the Dialysis Communication Form.)On 03/24/2026 at 9:56 AM, during a meeting with facility administration the DON told the surveyor the following: The sending staff would be responsible for filling out the top portion of the communication (dialysis) sheet. The dialysis facility will be responsible for filling out the middle section of the dialysis sheet (post-dialysis/part 2). She then told the surveyor that the receiving facility nurse would be responsible for documenting part 3 (post-dialysis information) upon return to the facility as well as, documenting in the electronic medical record status post return to facility. The surveyor then asked if all three (3) sections of the Dialysis Communication Form were required to be completed and the DON replied, Yes, all 3 sections are to be completed on the communication sheet.A review of the facility provided and undated policy titled Dialysis Care. revealed under Policy Statement: It is the policy of this facility to provide care to the resident with end stage renal disease who is receiving hemodialysis offsite. The purpose of this care is to provide comfort and quality of life for these residents. In addition, the following was observed under Policy Interpretation and Implementation: Initiate communication sheets which will be sent and received from the dialysis unit. The communication sheets will contain routine communication between the facility and dialysis unit. The dialysis unit will notify the facility by phone if there is any further information. This will be documented on the communication sheet. The communication sheets will be maintained on the unit.The surveyor reviewed the facility provided policy titled, End Stage Renal Disease, Care of a Resident with, updated and reviewed June 2024. The following was revealed under Policy Interpretation and Implementation: Staff caring for residents with ESRD (end stage renal disease), including residents receiving dialysis care outside of the facility, shall be trained in the care and special needs of these residents. The policy also revealed the following: Initiate communication sheets which will be sent and received from the dialysis unit to have routine communication. The communication sheet will be kept on the unit and/or in resident medical record.NJAC 8:39-27.1(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, and review of the Electronic Medical Record (EMR) and other facility documentation, the facility failed to follow through on recommendations made by the Consultant Pharmacist (CP) during their medication review regimen (MRR) in a timely manner. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #8) and was evidenced by the following: During the initial tour of the facility on 3/17/26 at 12:10 PM, Resident #8 was receiving care and was unavailable for an interview.A review of the electronic medical record (EMR) on 3/18/26 at 1:50 PM revealed the following:According to the admission Record, Resident #8 was admitted to the facility with diagnoses that included but was not limited to type II diabetes mellitus (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) and severe sepsis (a life-threatening, emergency condition where an infection triggers a severe, systemic immune response, causing organ dysfunction, such as kidney damage or low blood pressure).A review of the comprehensive Minimum Data Set (MDS), an assessment tool that facilitates a resident's care dated 2/23/26, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, reflecting intact cognition.A review of the Order Summary Report revealed the following physician orders (PO):A PO for Lispro insulin 100 units/mL (milliliter) subcutaneously. Inject as per sliding scale: if 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units for diabetes mellitus.A PO for ropinirole 5 mg (milligram) tablet two times per day for restless leg syndrome.A PO for Flomax capsule 0.4 mg one time a day for urinary incontinence.A PO for Protonix 40 mg by mouth one time a day for gastrointestinal reflux disease.A review of the consultant pharmacist's report dated 2/14/26 noted the following: Insulin Lispro.is a rapid-acting insulin and should be administered within fifteen minutes before a meal or immediately after a meal.A further review revealed, ropinirole is recommended 2-3 hours before bedtime when given for restless leg syndrome. Please review current time of administration. Flomax should be administered 30 minutes after a meal. Do not crush, chew, or open Flomax capsules. If the resident is unable to swallow the capsules whole, consider changing to Rapaflo, which can be opened if needed for administration. Alternatively, the physician can update the order to include ?may open for administration.' Do not crush Protonix. If the resident is unable to swallow whole, contact the physician to change to Protonix Granules or to another medication.There was no evidence in the medical record that the facility followed up with the CP's recommendations.On 3/23/26 at 10:51 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the desk nurse and unit managers have access to the CP reports daily. She added that the CP completed a medication regimen review upon admission and monthly. She continued to explain that the nurses were expected to address pharmacist concerns with the provider/physician to assure that corrections or updated were completed. She stated that the unit manager was responsible for ensuring recommendations were addressed, including making necessary updates and maintaining documentation to reflect that concerns were resolved. The unit managers should attach a copy of updated report with corrections which would indicate that the concerns were addressed. A review of the facility's Addressing Medication Regimen Review Irregularities policy, updated April 2023, included: It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event . 4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon . d. The nurses will forward the information to the attending physician, who must document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.NJAC 8:39-29.3(a)1

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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, record review, and review of facility documentation, it was determined that the facility failed to properly store and secure medication left at resident's bedside (Resident #15 and #43). This deficient practice was identified for 2 of 2 residents (Resident #15, and #43). This deficient practice was evidenced by the following: 1. On 3/17/2026 at 12:25 PM, the surveyor observed Resident #15 in their room, sitting on the side of their bed. At that time, the surveyor observed a Trelegy Ellipta inhaler (a prescription inhaler designed for adults to help manage breathing difficulties over the long term.) on top of their bedside table. The surveyor reviewed the medical record for Resident #15. 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 progressive lung disease that makes it hard to breathe due to long-term damage and airway inflammation, usually caused by smoking or irritants.), and acute respiratory failure with hypoxia (A sudden, life-threatening emergency where the lungs cannot bring enough oxygen into the blood). A review of Resident #15's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/20/2026, included that the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated that the resident's cognition was moderately impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 3/3/2026, that the resident had an altered respiratory status related to chronic obstructive pulmonary disease (COPD) exacerbation related to respiratory syncytial virus (RSV) (is a common respiratory virus that usually causes mild, cold-like symptoms), with acute respiratory failure (when your lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning). Interventions included: Monitor changes in orientation, increased restlessness, anxiety, and air hunger. Monitor for signs and symptoms of respiratory distress and report to the medical doctor as needed. Monitor and report abnormal breathing patterns to medical doctor. Review of the Order Summary report (OSR), dated 2/16/2026, included the following physician order (PO): A PO dated 2/16/2026, for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT (Fluticasone-Umeclidinium-Vilantero) prescription inhaler used by adults to improve breathing and reduce flare-ups for COPD. One Puff inhale orally one time a day for COPD. A review of the Medication Administration Record (MAR) revealed that Resident #15 was administered the Trelegy inhaler on 3/17/2026 at 9 AM. On 3/17/2026 at 1:36 PM, the surveyor interviewed the Registered Nurse (RN) #1, who stated that she administered Resident #15's 9 AM medications. She further stated that all medications should be stored in the medication cart and should never be left at the bedside. She added that it should not be left because the resident can take their own medication and can overdose. She added that if the nurse saw the medication at the bedside, the nurse should remove the medication, then put it in a bag and notify the provider and care manager. She further stated that the family would then be notified to pick up the medication. She further stated that the care manager would be notified if the resident wanted to self-administer any medications. On 3/17/2026 at 1:40 PM, the surveyor, accompanied by the Licensed Practical Nurse / Unit Manager (LPN/UM) #2, went to Resident #15's room, and she confirmed the findings. LPN/UM #2 removed the Trelegy inhaler from the bedside table and removed the packaging for the inhaler that was next to the sink. LPN/UM #2 exited Resident #15's room and stated that medication should not have been at the bedside unless the resident had an order to self-administer medication. She further explained that if the resident wanted to self-administer their own medication, they would have to be assessed by the nurse, then the physician must be notified, and an order for self-administration was obtained. On 3/18/2026 at 10:01 AM, the surveyor conducted a follow-up visit with Resident #15, when asked about the trelegy inhaler that was left on top of their bedside table the day before, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15 stated that the nurse gave them the inhaler. 2. On 3/17/2026 at 12:43 PM, the surveyor observed Resident #43 lying awake in their bed. At that time, the surveyor observed multiple medications on top of bedside table as follows: Breztri Aerosphere Inhalation Aerosol 160-9-4.8 MCG/ACT (Budesonide-Glycopyrrolate-Formoterol fumarate) used for COPD; Mylanta (used for fast relief of heartburn, acid indigestion, sour stomach, and gas.); TUMS (used to treat heartburn, indigestion and upset stomach caused by too much stomach acid.); and Asper Creme (a topical medication used for temporary relief of minor pain in muscles and joints). On 3/17/2026 at 1:41 PM, the surveyor, accompanied by LPN/UM #2, and another surveyor, went to Resident #43's room. LPN/UM #2 confirmed the findings. LPN/UM # 2 removed the following medications: Breztri inhaler, tums, mylanta and asper creme. LPN/UM#2 asked the resident where they got the medications from, and the resident stated that they brought the medications in from home. LPN/UM #2 explained to Resident #43 that they cannot have medication at their bedside unless they have an order to self-administer the medication. The resident allowed the nurse to remove the medications from their bedside. LPN/UM #2 verified that Resident #43 did not have an order to self-administer their medication. LPN/UM #2 stated that Resident #43 should not have had the medications at their bedside because they did not have an order to self-administer medications. On 3/17/2026 at 2:30 PM, the surveyor reviewed the medical record for Resident #43. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia (A sudden, life-threatening emergency where the lungs cannot bring enough oxygen into the blood.), Displaced fracture of greater trochanter of right femur, (Broken right hip bone where the bone fragments have moved out of place (displaced) Subsequent encounter for closed fracture with routine healing. (the skin was not broken, and the bone is healing normally.) Essential (Primary) Hypertension (A chronic long-term condition where blood pressure is consistently too high.) A review of resident #43's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/22/2026, included the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident's cognition was intact. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 3/6/2026, that Resident #43 had an altered respiratory status/difficulty breathing related to COPD and chronic respiratory failure. Interventions included: administer medication/ nebulizer/ puffers as ordered. Monitor for effectiveness and side effects. Elevate the head of the bed to help facilitate effective breathing. Maintain a clear airway by encouraging the resident to clear their own secretions with effective coughing. If secretions cannot be cleared, suction as ordered/required to clear secretions. Monitor /document changes in orientation, increased restlessness, anxiety, and air hunger. Provide oxygen as ordered. A review of the Order Summary Report (OSR), dated as of 3/13/2026, included a PO dated 03/13/2026, for Breztri Aerosphere 160-9-4.8 MCG/ACT Aerosol 1 Puff inhale orally two times a day for COPD, and the resident should rinse their mouth with water without swallowing after each use to decrease the risk of an oral fungus infections. On 3/19/2026 at 10:33 AM, the surveyor interviewed the Director of Nursing (DON), who stated medications should be stored on the medication cart, unless they have an order to self-administer medication, then the medication would be stored in a lock cabinet in the resident's room. She further stated that if medication was left at the bedside, it could result in adverse effects. The DON added that she would have to look up the policy for self-administering medications because she did not know it off top of her head. On 3/19/2026 at 10:42 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that medications should be stored in the medication cart unless the resident had an order for self-administration. A review of the facility's policy undated, titled, Storage of Medications, revealed Policy Statement: the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage. A review of the facility's policy titled, Self-Administration of medication, revealed residents in our facility who wish to (continued on next page)

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	315513	A. Building B. Wing	03/24/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administer medications may do so, if it is determined that they can do so. Self-administration medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for bedside storage, for return to the family or responsible party. NJAC 8:39-29.4(h)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on record review, interviews, and review of pertinent facility documents, it was determined that the facility failed to honor the food preference for one (1) of two (2) residents (Resident #141) reviewed for nutrition. This deficient practice was evidenced by the following: On 3/19/26 at 12:59 PM, the surveyor reviewed the medical record for Resident #141 which revealed the following:A review of the admission Record, an admission summary, revealed that Resident #141 had diagnoses which included but were not limited to dysphagia (difficulty swallowing), mild protein-calorie malnutrition (a nutritional deficiency characterized by inadequate intake of protein and calories), hyperlipidemia (elevated cholesterol), and type II diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) .A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/9/26, included the resident 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 10/25/25, which indicated that the resident had diabetes mellitus. Interventions included a dietary consult for nutritional regimen and ongoing monitoring.A subsequent focus area that was on Resident #141's ICCP indicated that the resident had an increased nutrient need for wound healing and that the resident followed a Halal diet (food allowed under Islamic law). The interventions included: Honor food preferences-Lacto-ovo vegetarian (a person who eats vegetables, eggs, and dairy products but who does not eat meat) preference, seafood allowed. No other meat unless Halal.A review of the physician Order Summary Report (OSR) included a physician's orders (PO) dated 10/3/25 for regular diet, regular consistency.A review of the Nutrition Evaluation Note dated 9/24/25 at 3:46 PM, indicated that Resident #141 ate Halal at home. The nutrition intervention included honor food pref [preference] as able -No meat.A review of the Nutrition Evaluation Note dated 10/4/25 included continue current diet food preference on meal tracker, will honor as able.A review of Resident #141's dietary slip, dated 10/6/25, included no chicken, beef, pork, or turkey.A review of the progress notes included a nurse's note (NN), dated 10/6/25 at 9:10 AM, which included that the resident rec'd (received) the wrong dinner meal from the kitchen, not respecting dietary restrictions (no meat). The resident care nurse went to the kitchen three different times to accommodate residents' food wishes and the resident was given a salad and ate dinner without complications. Resident [relation redacted] unhappy with dietary mistakes. The 3-11 supervisor made aware that a kitchen error was corrected and made family aware that he would escalate issues with his superiors.On 3/19/26 at 11:28 AM, the surveyor interviewed the Certified Nurse Aide (CNA), who stated that the meal trays should be accurate for the most part. She added that she would check the meal ticket to ensure that the tray was correct. On 3/23/26 at 12:08 PM, the surveyor interviewed the Food Service Director (FSD) who stated that the dietary aide would check to verify the diet was correct before placing the tray on the cart for transport to the unit. She further stated that the Certified Nursing Aide (CNA) would then distribute the meal tray to each resident when it arrived on the unit.On 3/19/26 at 1:39 PM, the surveyor interviewed the Registered Dietician (RD), who stated that she would meet with every resident upon admission to the facility to get their food preferences, allergies, and likes/dislikes. She stated she would educate them if they were on an altered diet, and she would offer the resident written education about their diet, if they wanted it. The RD stated that she would then go into the food service portal and update the preference or send it to the FSD so she could update it. She added that each resident was provided with a food preference questionnaire to complete. She further stated that if the resident did not complete the food preference form, the FSD would go to the resident and obtain the resident's food preference, so their likes and dislikes, and food preference would be documented on the dietary slip.The RD further stated that Resident #141 required a kosher diet (a term used to describe food (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that complies with the strict dietary standards of traditional Jewish law). Upon admission to the facility the resident and the family were notified that this was not a kosher facility, and they did not have Halal meat. She further stated that Resident #141 did not want to be served any meat from the facility. She noted that when Resident #141 first arrived at the facility, the resident's diet was modified to a puree diet. She stated that considering the facility would not have been able to give them a pureed kosher meal or Halal diet, they accommodated the resident with a vegan diet. The RD explained that she had received complaints regarding meal accuracy, and based upon an internal investigation, the person who made the meal trays did not look at the ticket. She added that they had new team members and there has been a 100% turnover.On 3/23/26 at 11:22 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that resident meals should be accurate and added that the dietician would obtain the resident's food preference upon admission to the facility. The LNHA further stated that the facility could not accommodate a resident with a Halal diet and different textured meats so they would offer a vegan diet. He added that the meals trays should be accurate. On 3/24/2026 at 11:22 AM, the surveyor conducted a follow-up interview with the RD who stated that upon admission to the facility Resident #141 had a preference for a halal diet and always maintained a halal diet throughout their admission to the facility. She added that a halal diet did not require a physician's order since it was a preference and the resident's preferences would be printed on the meal ticket. She further stated that the kitchen must verify the diet that was on the meal ticket. The RD added that once the meal was delivered to the unit, the CNAs would again verify the meal ticket when distributing the trays. The RD stated that half the staff probably doesn't know what a halal diet is. She further stated that she was aware of the incident when the grievance was filed. She noted that Resident #141 received meat that was not Halal /Kosher, and the family informed the facility, and it was taken care of. The 10/4/25 dietary evaluation that was completed by the dietician should have reflected that the resident preferred a halal diet. She then stated, That is why she doesn't work here anymore.A review of the facility's Resident Food Preferences, policy, updated January 2026, included Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications for diet will only be ordered with the resident's or representative's consent.A review of the facility's Resident Rights updated January 2026, included Residents are entitled to exercise their rights and privileges to the fullest extent possible.NJAC 8:39-17.4(a)1, e

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) prepare food in a manner to prevent food-borne illness, b.) maintain the kitchen equipment in a sanitary manner, and c.)maintain food-contact equipment in a sanitary condition for 2 of 2 bistros (second and third floor bistros). This deficient practice was evidenced by the following:On 3/17/26 at 10:17 AM, the surveyor began the initial tour of the kitchen and observed the following:Immediately at the start of the tour, the surveyor observed the Food Service Director (FSD) with hair extending near her shoulder blades, uncovered and not within the hairnet that she was wearing. At that time, the surveyor interviewed the FSD, who stated that hairnets must be worn while in the kitchen. She added that if the hair cannot be tucked under the hairnet, the hair would be tucked behind them, in their shirts. She further stated that for food safety, hair should never be exposed.At 10:41 AM, the Regional Director of Operations (RDO) was observed making peanut butter and jelly sandwiches. At that time, he was wearing a baseball cap with hair exposed along both sides and the back of his head. The RDO removed his hat. The hairnet was noted to be flat on top of his head and was not expanded to cover the hair on the sides and nape of his neck.At 10:45 AM, the surveyor requested that the FSD open the ice machine door. The white hard plastic area inside was noted with black and brown residue, and some buildup in various areas. At that time, the surveyor interviewed the FSD, who stated that she did not know when the ice machine was last cleaned. She further stated that the ice machine should be deep-cleaned weekly and as needed, and it should be maintained in a clean and sanitary manner.On 3/18/26 at 12:31 PM, the surveyor toured the third-floor bistro, and the following was observed:The ice machine was noted with slime-like residue in the drip tray.The ice machine contained white corrosion on the interior and exterior parts of the spout.The ice scooper was resting in a metal container and was unable to drain freely.On 3/18/26 at 1:25 PM, the surveyor toured the second-floor bistro, and the following was observed:The ice machine contained a buildup of residue and corrosion around the interior and exterior parts of the spout.An ice scooper and a tong were noted resting on a yellow-tinged paper towel inside a metal pan.At that time, the Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated that should not be like that, referring to the ice scooper, tong, and the yellow-tinged paper towel.On 3/23/26 at 8:32 AM, the surveyor returned to the kitchen for a follow-up visit.The surveyor requested the dishwasher temperature log. There was no entry on the log for 3/23/26.At that time, the surveyor interviewed the FSD, who stated that two wash cycles were completed that morning. She stated that the dishwasher temperature and chemical levels should have been checked and documented before running a cycle to ensure that the dishes were properly cleaned. On 3/23/26 at 8:36 AM, the surveyor interviewed the dietary aide, who stated that he was responsible for washing the dishes. He stated that he did not check the temperatures and chemical levels because he had to scrape four big racks of plates from last night's dinner.On 3/23/26 at 9:55 AM, the surveyor interviewed the Director of Maintenance, who stated that housekeepers were responsible for cleaning the ice machines. He further stated that the ice machines were deep-cleaned every three months or as needed. He also stated he agreed that the drip trays on the ice machines needed to be cleaned and or replaced. He added that he would attempt to clean them, and if they were uncleanable, he would replace them. The DM also stated that he would try to clean the ice machine spouts, and if they are uncleanable, he would replace them.On 3/23/26 at 10:16 AM, the surveyor interviewed the Infection Preventionist (IP), who stated that the ice machines should be maintained in a clean and sanitary manner at all times. She added that the ice scoopers should be washed daily and drain freely, and not where water could be collected and lead to bacteria buildup.On 3/23/26 at 10:37 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the ice machine was cleaned quarterly and as needed. He added that the ice machines should be maintained in a clean and sanitary manner. He also stated that the ice scoopers should (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drain freely for infection control purposes.The LNHA further stated that dishwasher temperatures should be checked every morning and documented. He added that it was important to check the temperature so they knew it was running properly. A review of the facility's Infection Prevention and Control Program policy, undated, included, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines.A review of the facility's Hair Restraint (Net) Policy updated January 2025, included, It is the policy of this facility that hair restraints prevent hair from contacting food, food service equipment, and utensils, thus avoiding cross-contamination. This policy applies to all food service staff within the facility, including those preparing, cooking, or serving food and/or any visitor or staff entering the kitchen area.Hair restraints must cover all head hair completely. This includes securing bangs and other loose strands that might escape from primary restraints.A review of the facility's Ice Machines and Ice Storage Chests Updated January 2025, included, Ice Machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. Our facility has established procedures for cleaning and disinfecting ice machines and storage chests, which adhere to the manufacturer's instructions. The Infection Preventionist maintains a copy of these procedures.A review of the facility's Ice policy, revised 10/2022, included Ice will be prepared and distributed in a safe and sanitary manner.Ice scoops will be cleaned and stored in a separate container that limits exposure to dust and moisture retention.NJAC 8:39-17.2(g)