STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING _____ B. WING _____	C 04/20/2023

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AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey with complaints was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00152230, NJ00152821 Survey Dates: 04/17/23 - 04/20/23 Survey Census: 136 Sample Size: 33 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		5/31/23

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

Electronically Signed | 05/09/2023

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.

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F 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility policy the facility failed to maintain a clean and safe environment on three of three resident care wings. Observations revealed residents' furniture in disrepair and loose commode seats in resident's bathrooms. Findings include: Observations during the facility's initial tour on 4/17/23 at 10:40 AM revealed the following: A1. A Wing *R59's overbed table with puncture marks on top of the table exposing wood splinters. The plastics	F 584	A1. A Wing R59□s Both overbed table removed and replaced. R117 Trash debris on floor in bathroom removed and floor cleaned, loose commode seat tightened, and clothing on floor removed. Blue padded Geri chair on A wing with dried red spillage□leg rest adjusted and now even, chair cleaned. 2 B wing R125□s debris and trash on floor removed and cleaned. Nightstand	

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F 584	Continued From page 2 edges of the table peeling away from the wood exposing wood splinters; also has beige colored dried splatter on the legs of the table. Second overbed table with exposed wood edges. *R117's bathroom with trash debris on floor; loose commode seat. Clothing on the floor. *Blue padded Ex Order 26. 4B1 on the A wing with uneven leg rests and dried red spillage. 2. B Wing *Resident (R)125's room had trash debris on floor (i.e., medication cup and bits of paper); night stand bottom cabinet drawer coming apart. *R56's room's nightstand door is off track and does not close completely. The closet door is coming off the hinges. The bathroom in this room had a loose commode seat. Both residents in this room utilized the commode. 3. C Wing *Chair at nurses' station with the arm of the chair covered with an abdominal pad and then wrapped with an ace wrap. The arm of the chair was missing the covering and metal frame exposed with sharp edges. *The nurses station cracked sharp edges around the top of the nurses' station. The wall of the nurses' station had several areas with missing tiles or brocade; these areas were covered with duct tape. During a secondary environmental observation conducted on 04/20/23 at 12:45 PM with the Maintenance Director revealed the following:	F 584	repaired. R 56□s room nightstand door repaired. Closet door hinge repaired. Loose commode seat tightened. 3. C wing The chair at nurse□s station was removed and replaced immediately. The nurses station repaired, and wall tiles replaced. B1. A wing R67□s Both Over bed tables were removed and replaced with new overbed tables. R97□s Trash debris on floor in bathroom removed and floor cleaned, and loose commode seat tightened. Dayroom desk discarded. 2 B wing R125□s debris and trash on floor removed and cleaned. Nightstand repaired. R 56□s room nightstand door repaired. Closet door hinge repaired. Loose commode seat tightened. R123's clothing closet door was repaired. 3. C wing The nurses station repaired, and wall tiles replaced. C1. R10□s walls repaired and painted.	

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F 584	Continued From page 3 B1. A Wing *R67's overbed table with puncture marks on top of the table exposing wood splinters. The plastics edges of the table peeling away from the wood exposing wood splinters. Second overbed table with exposed wood edges. *R97's bathroom with trash debris on floor; loose commode seat *Day Room desk drawer missing a handle. Desktop with peeling edges exposing wood splintered edges. 2. B Wing *R125's night stands bottom cabinet drawer coming apart exposing sharp edges. *R56's nightstand door is off track and does not close completely. The closet door is coming off the hinges. The bathroom in this room has a loose commode seat. *R123's clothing closet door coming off the hinges. 3. C Wing *The nurses station cracked sharp edges around the top of the nurses' station. The wall of the nurses' station had several areas with missing tiles or brocade; these areas were covered with duct tape. An interview with the Maintenance Director (MD) during the environmental tour on 04/20/23 at 12:45 PM revealed the staff are expected to record any maintenance problems in the designated maintenance notebook kept at the nurses 'station. The MD stated he reviewed the	F 584	2. All residents can be affected by this deficient practice. 3. All resident rooms will be inspected by the IDT team for any identified repair needs on a rotation basis during weekly room rounds. All staff will be in- serviced on the homelike environment policy and to utilize the maintenance log book for identified repair needs. 4. The Maintenance Director or designee will conduct weekly audits of 5 rooms for preventative maintenance and inspections of repairs needed or completed. The administrator will track and review maintenance director work order logs monthly for 6 months to ensure that work orders are getting completed timely. A list of all findings will be completed monthly and presented to the quarterly Qapi meeting for 1 year.	

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F 584	Continued From page 4	F 584		

maintenance repair log this morning and there were none of the concerns that were identified during this tour. The MD acknowledged there was an issue with some of the residents' furniture. Damage to the overbed tables is caused by water spillage that is left to sit. Some of the overbed tables will need to be replaced. The MD acknowledged that he does not have a maintenance or environmental schedule to ensure the equipment is operational and the environment is safe for residents.

C1. During observations conducted by a second surveyor, on 04/17/23 at 10:38 AM, 04/18/23 at 9:20 AM, and 04/19/23 at 9:17 AM, R10's walls were observed to having scuffing, peeling, and chipping of paint and plaster near the head of the bed, corner of the wall near the foot of the bed, and near the closet area. R10 stated [redacted] walls had been in disrepair for more than four years.

During an observation and concurrent interview on 04/19/23 at 9:20 AM, the Assistant Director of Nursing (ADON) confirmed R10's walls were in disrepair. The ADON stated, the walls were reported to the Director of Maintenance (DM) "at least a month ago." The ADON was unable to state who reported the disrepair of the walls to the DM.

During an observation and concurrent interview on 04/19/23 at 9:54 AM, the DM confirmed the disrepair of R10's walls. The DM stated, the staff put maintenance requests in the logbook and the logbook is checked daily. The DM stated the issue with R10's walls had not been reported by

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the staff. The DM stated the disrepair of the walls may have been noted by the other maintenance staff during rounding. The DM stated he would check the rounding logs.

During a follow-up interview on 04/19/23 at 10:05 AM, the DM stated the issue with R10's wall had been noted on a rounding audit on 03/29/23. The DM stated, "We have not gotten to it as of yet. We just hired a new guy. I don't know how long it has been like that, but the walls were painted before that resident moved into the room."

Review of untitled maintenance logs, dated 03/29/23, provided by the DM from a file in his office, revealed, R10's room "Needs paint and spackle behind bed."

Review of the facility undated policy titled "Preventative Maintenance Program" revealed the policy documented "A Preventative Maintenance Program shall be developed to and implemented to ensure the provision of a safe, functional, sanitary and comfortable environment for residents, staff and the public." The policy also documented " .... The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the building, grounds, and equipment are maintained in a safe and operable manner."

Review of undated facility policy titled, "Preventative Maintenance Program," indicated, "The Maintenance Director shall assess all aspects of the physical plant to determine if Preventative Maintenance (PM) is required. Required PM may be determined from

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F 584	Continued From page 6 manufacturer's recommendations, maintenance requests, grand rounds, life safety requirements, or experience." NJAC 8:39-4.1(a) NJAC 8:39-31.2(e) NJAC 8:39-31.8(e)	F 584		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that four of four residents (Resident (R) 48, R50, R83 and R124) reviewed for bed rail use had documented	F 700	1. Resident R48 - Ex Order 26. 4B1 evaluated for side rail use and side rails were discontinued. Resident R50— Ex Order 26. 4B1 evaluated for	5/31/23

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F 700	Continued From page 7 alternatives to the use of bed rails attempted prior to the use of the bed rails. This failure had the potential to increase the potential for accidental entrapment or injury when an alternate assistive device may have been effective. Findings include: 1. Review of R48's printed "Admission Record" from the facility electronic medical record (EMR), "Profile" tab, showed an admission date of Ex Order 26. 4B1, readmission date of Ex Order 26. 4B1, with medical diagnoses that included Ex Order 26. 4B1 [redacted]. During an interview with R48 on 04/18/23 at 12:36 PM, it was noted [redacted] had Ex Order 26. 4B1 bed rails. When asked if the facility had advised [redacted] of the risks and benefits of the rails, or if [redacted] signed an informed consent, R48 stated not that [redacted] remembered. Review of R48's admission "Minimum Data Set [MDS]," located in the EMR under the "MDS" tab, assessment reference date (ARD) 02/05/23 showed a "Brief Interview for Mental Status [BIMS]" score of [redacted] out of a possible 15, or indicative of being Ex Order 26. 4B1. Observations of R48's bed on 04/18/23 at 3:02 PM, 4/19/23 at 10:30 AM and 12:48 PM showed the Ex Order 26. 4B1 bed rails in place towards the head of the bed, in the up position. A review of the 01/30/23 and 03/16/23 "Assist Bar/Side Rail" from the EMR "Evaluations" tab	F 700	side rail use. Ex Order 26. 4B1 mattress was implemented as an alternative and side rails were discontinued. Resident R83—No longer resides at facility. Resident R124— Ex Order 26. 4B1 evaluated for side rail use. Ex Order 26. 4B1 mattress was implemented as an alternative and side rails were discontinued. 2. All residents are at risk for this deficient practice. 3. The facility policies and procedures regarding side rails were reviewed/ revised to include appropriate alternative measures prior to side rail placement. The DON/ designee will educate all staff on the revised side rail policy. 4. Audits will be conducted by the DON/ designee monthly on new admissions and reported to the QAPI Committee quarterly for a year.	

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showed R48 had been informed of the risks/benefits of rails and had consented. Both forms were completed on the date of admission/readmission and stated an alternative to bed rail attempted prior to the use of the rails was "resident education on bed mobility, transfers."

During a follow-up interview on 04/19/23 at 1:10 PM regarding if the facility had attempted any alternatives before the bed rails were put on the bed, R48 responded "No, they were on the bed when I got to the room. They didn't try anything else." When queried if they discussed using something other than the rails, R48 stated, "No ma'am, they didn't."

In an interview on 04/20/23 at 3:05 PM regarding the "Assist Bar/Side Rail" form completed by her on 03/16/23 for R48, Unit Manager (UM) 1 stated, "When they [resident] first comes in, if alert and oriented we go over the paper and ask them if they want them [rails] or not. If not alert and oriented, we go over the paper with the family and ask the family if they want them or not." When asked if she attempted or presented any alternatives to the bed rails to R48, UM1 responded "No." In a follow-up interview at 3:22 PM, UM1 was asked if the bed rails were on the bed when the residents are admitted and responded "Yes."

2. Review of R50's printed "Admission Record" from the EMR "Profile" tab showed an admission date of Ex Order 26. 4B1, readmission on Ex Order 26. 4B1 with medical diagnoses that included Ex Order 26. 4B1 [redacted]

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Observation of R50's bed showed:
04/17/23 at 4:08 PM [redacted] bed rails in upper position (by head of bed (HOB)
04/18/23 at 3:40 PM [redacted] rails in upper position
04/19/23 at 12:15 PM [redacted] rails in upper position
04/19/23 at 4:30 PM one rail was in the upper position, the other was lowered which was in the middle of the mattress (where one would sit up to get out of bed).
04/20/23 at 10:10 AM the bed has one rail in the upper position and one in the lower position in the middle of the mattress.

Review of R50's admission "MDS" ARD 03/08/23 showed a "BIMS" score of [redacted] out of a possible 15, or indicative of [redacted].

Review of the 09/24/22 "Assist Bar/Side Rail" form, printed from the EMR "Evaluations" tab, completed on admission showed attempted alternatives as "resident education on bed mobility, transfers."

A review of R50's hard [paper] chart showed a "Consent for Use of Side Rails" form that was blank for the recommendations with a check mark by the [redacted] signed by R50's daughter but not dated.

In an interview on 04/20/23 at 3:18 PM regarding the completion of the 09/24/22 "Assist Bar/Side Rail" form UM3 stated, "If [resident] alert and oriented, we ask if they would like rails to enable

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turning; if not alert and oriented, we ask the family if they would like in place. We give them the risk/benefits and have them sign a consent." When asked if alternatives to rails were attempted, UM3 responded "No because that is part of the admission packet. We offer the bed rails." When asked if bed rails were on the bed when the resident is admitted, UM3 stated, "Yes, they are already on the bed."

3. Review of R83's printed "Admission Record" from the EMR "Profile" tab showed an admission date of [redacted], readmission date of [redacted], with medical diagnoses that included [redacted]

Observation of R83 while in [redacted] bed on 04/17/23 at 1:23 PM showed [redacted] asleep in bed with [redacted] rails. On 04/18/23 at 11:05 AM, R83 was asleep in bed with [redacted] rails, in the up position.

Review of R83's hard chart showed a "Consent for Use of Side Rails" that was totally blank with the exception of a check mark by [redacted] signed by the resident on 02/27/23.

On 04/19/23 at 10:30 AM, R83 was asleep in bed with [redacted] rails; same at 12:48 PM and at 1:10 PM.

Review of the 02/27/23 and 03/26/23 "Assist

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Bar/Side Rail" forms printed from the EMR "Evaluations" tab showed attempted alternatives as "resident education on bed mobility, transfers."

During an attempted interview on 04/20/23 at 10:15 AM, R83 did not seem to understand questions about the bed rails as Ex Ord would wiggle them and say, "No it's not coming off." When asked if Ex Ord used the rails, Ex Ord again stated "No" and wiggled the rail again.

In an interview on 04/20/23 at 3:32 PM, regarding the completion of the 03/26/23 "Assist Bar/Side Rail" form, Registered Nurse Supervisor (RNS)1 stated, "When they [resident] come in we explain the uses, risks and benefits with the patient or family and ask them yes or no if they want them." When asked if any alternatives were attempted, RNS1 stated, "We don't have anything else, so no." RNS1 confirmed the bed rails are on the bed when the resident is admitted.

4. Review of R124's printed "Admission Record" from the EMR "Profile" tab, showed a facility admission date of Ex Order 26. 4B1, readmitted on Ex Order 26. 4B1, with medical diagnoses that included *Ex Order 26. 4B1* [redacted].

Review of R124's, 02/16/23 and 03/26/23 "Assist Bar/Side Rail" forms from the EMR "Evaluations" tab showed attempted alternatives as "resident education on bed mobility, transfers," and the latter form also showed "family education on bed mobility, transfers."

A review of R124's admission "MDS," ARD

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 12 03/29/23 showed a "BIMS" score of [Ex Order] out of a possible 15, indicative of being *Ex Order 26. 4B1*. During a brief interview on 04/17/23 at 2:30 PM, R124 was noted to have *Ex Order 26. 4B1* rails down in the middle position of the mattress (where one would sit to stand up out of bed). When asked if the rails kept the resident from getting out of bed due to the position, R124 stated [Ex Order] had bad knees and [Ex Order] had to learn to walk again and [Ex Order] couldn't get out of bed without assistance. Observation on 04/18/23 at 2:50 PM showed R124 in bed working with [Ex Order 26. 4B1], with [Ex Order 26. 4B1] rails in the middle mattress position. Review of R124's hard chart showed a "Side Rail Consent" in chart for *Ex Order 26. 4B1* rail and *Ex Order 26. 4B1* rail signed for by [Ex Order] durable power of attorney for healthcare. In a follow-up interview on 04/19/23 at 12:15 PM showed R124 seating in a *Ex Order 26. 4B1*, [Ex Order] bed has one rail in the upper (HOB) position, and one in the lowered (middle of mattress) position. When asked if R124 had had any alternatives to the bed rails attempted, [Ex Order] responded [Ex Order] had no clue what else would have worked, but no, no alternatives attempted, and the rails were on the bed when [Ex Order] arrived. Observation on 04/19/23 at 4:30 PM showed R124 asleep in bed with [Ex Order 26. 4B1] bed rails in the lowered (middle of mattress) position. An interview with the licensed nurse that completed the 03/26/23 "Assist Bar/Side Rail" form was unsuccessfully attempted. The 02/16/23 form was completed by UM1 who had stated she	F 700		

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F 700	Continued From page 13 does not attempt any alternatives. During an interview on 04/19/23 at 4:14 PM regarding alternatives attempted prior to bed rail usage and her expectations, the Director of Nursing (DON) stated they provided a Ex Order 26. 4B1 screening. When clarified if any alternatives to bed rails were attempted, the DON stated, "If using for enablers or mobility like in sub-acute, we don't; if using for fall risk we might try a Ex Order 26. 4B1 mattress, bed alarm, or floor mats. It's patient specific though." The DON stated her expectation of what should be done prior to bed rail use, she responded, "Ex Order 26. 4B1 should evaluate for risk of entrapment as well as use of the side rail." Review of the undated facility policy titled "Proper Use of Bed Rails" showed "It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Definitions: "Bed Rails" are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to side rails, bed side[sic] rails, safety rails, grab bars and assist bars. . . Policy Explanation and Compliance Guidelines: . . . 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the	F 700		

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F 700	Continued From page 14 resident's assessed needs unless siderail is utilized to promote residents[sic] highest level of physical functioning and contribute the individuals [sic]Ex Order 26. 4B1 well-being by enhancing independence and mobility. . . " NJAC 8:39-27.1(a)(b)	F 700		
F 745 SS=G	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and Ex Order 26. 4B1 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to provide medically related social services to meet the resident's needs, by specifically failing to help one (Resident (R) 72) of 29 sampled residents obtain a birth certificate and state-issued identification (ID). This caused the resident harm as Ex Orde has had extreme frustration for the past five years in Ex Orde attempt to move back to Ex Orde home in Ex Order 26. 4B1 . Findings include: Review of R72's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R72 was admitted on Ex Order 26. 4B1 with a diagnosis of Ex Order 26. 4B1 . Review of R72's quarterly "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 03/25/23, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of Ex Orde	F 745	1. The Social Worker sent out another application for a Ex Order 26. 4B1 and the facility continues to exhaust all efforts to obtain the needed credentials for R72. 2. All residents have the potential to be affected by this deficient practice. 3. Social worker will be in-serviced to document all attempts to obtain information, to reach out office of ombudsman and to other social workers for guidance when necessary. Social services met with all residents to identify residents needs. Social services will document in the resident's chart all continued updates on the status of R72 credentials. 4. Social Services will continue to monitor and review residents needs quarterly and will report to the QAPI	5/31/23

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F 745	Continued From page 15 out of 15, indicating R72 was *Ex Order 26. 4B1*. During an interview on 04/18/23 at 9:30 AM, R72 called this surveyor into Ex Orde room. At this time of interview and observation, R72 was notably frustrated and was pacing back and forth in Ex Orde room. R72 was attempting to communicate and wrote "Puerto Rico" on a piece of notebook paper. R72 began looking through paperwork in Ex Orde drawer and kept making shrugging gestures, grunting sounds, and patting Ex Orde back pocket. When asked if NJ Exec was looking for Ex Orde ID, R72 nodded yes. When asked how long Ex Orde ID had been missing, R72 held up five fingers. When asked if the ID had been missing for five weeks, R72 shook Ex Orde head no. When asked if the ID had been missing for five months, R72 shook Ex Orde head no. When asked if the ID had been missing for five years, R72 nodded yes. R72 began pacing again, making grunting sounds, raising both hands in the air, shaking Ex Orde head while looking at the floor. During this time, Certified Nursing Assistant (CNA) 44, was observed walking by R72's room. This surveyor asked CNA44 to assist in deciphering R72's gestures. CNA44 spoke in R72's native language. CNA44 was able to interpret that R72 wanted to return Puerto Rico or leave the facility but Ex Orde ID and birth certificate had expired. CNA44 stated R72 had been asking the social services staff for five years and they told him they would check on it, but nothing had happened. CNA44 stated R72 was frustrated that Ex Orde could not work, earn money, get an apartment, or leave the facility due to not having an ID or birth certificate. Review of R72's "Social Services Notes," located under the "Notes" tab of the EMR, revealed the following notes dated 09/19/19, 09/30/19, and	F 745	committee quarterly over the next year. Social services will update QAPI committee quarterly on R72 status over the next year or until credentials are obtained.	

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F 745	Continued From page 16 01/02/20, respectively: 1. SW [social worker], interrupter and resident met to complete quarterly ...assessments. Resident is [redacted] can only minimally verbalize [redacted] needs clearly. Resident is [redacted] speaking but understands English, can write at grammar school level, and will use hands to aid in expressing needs/feelings. Resident is[sic] seen attending activities, helping other residents at times and continue to be frustrated w lack of money and locating community housing. SW has been working w resident to complete housing applications but there are many barriers we are trying to overcome (ie [id est] [sic]: [redacted] resident is unable to obtain needed paperwork, resident history w [redacted] is barrier w [with] family to help resident... Resident lacks insight to barriers that need to be addressed and keeps reporting plans to just leave AMA [against medical advice] even if [redacted] is homeless w/o [without] any concerns to medical needs or housing. Family is involved minimally and have informed resident if [redacted] leaves AMA, they will not assist [redacted]." 2. "Resident and brother .... requested meeting to discuss resident housing and concerns. SW updated ...on continued discussion being had w [with] resident (w interrupter also) regarding barriers interfering w resident completing housing application (expired/no ID, [redacted] for resident to call SSA [Social Security Administration], lack of family support locally to help resident make needed connections to community resources ...)." 3. "Resident and interrupter requested SW to	F 745		

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F 745	Continued From page 17	F 745		

send copy of residents [sic] photocopy ID to [redacted] sister in Puerto Rico as she is trying to obtain *Ex Order 26. 4B1* for resident. SW sent out copies in mail today."

Further review of R72's EMR revealed no other notes regarding helping R72 to obtain a [redacted] or ID.

Review of R72's "Progress Notes," located under the "Notes" tab of the EMR, revealed seven documented instances from 08/20/19 through present with the following note: "frustrated w[with] lack of money and locating community housing."

During an interview on 04/20/23 at 8:56 AM, CNA44 stated, "I wanted to tell you that I followed up for you on [redacted] ID and *Ex Order 26. 4B1*. I can go to a place and get a *Ex Order 26. 4B1* application for [redacted], and I told the social worker about it, and she told me to bring it [the application] to her and I told her that I would do it when I got off from work today. I wanted you to know that I wanted to help you help [redacted] because I know you are leaving today, and I didn't want [redacted] to have to wait longer."

During an interview on 04/20/23 at 8:58 AM, Social Services Clerical (SSC) 2 stated, "I do help residents with getting an ID and a *Ex Order 26. 4B1*. I have exhausted all resources to help [redacted] [R72]. [redacted] comes to me daily and asks about an ID and *Ex Order 26. 4B1* and I have told [redacted] that I cannot do anything for [redacted]. I started working here in 2020 and I was told when I started that all previous social workers attempted to help [redacted] with no progress made." When asked what she had done for R72 regarding [redacted] ID and [redacted] in her three years of working in the

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social services department, SSC2 stated she had not done anything. SSC2 also stated she had not searched the internet for resources or reached out to other coworkers. SSC2 also stated, "I didn't know what resources I had available because I live in the US [United States} and our Ex Order 26 [redacted] don't expire." The SSC2 further confirmed CNA44 informed her of a local agency to obtain the *Ex Order 26. 4B1* application and that CNA44 was going to pick up the application on R72's behalf. When asked what she was going to do as R72's social worker, SSC2 stated, "I'm going to wait for the CNA. I do not know her name. She is an agency. She is new. I guess I'm going to wait until she brings the application or maybe I can go there on my lunch break."

During an interview 04/20/23 at 2:01 PM, the Administrator stated, "I expect the social worker to do what she knows how to do. If she does not know how to get an id or *Ex Order 26. 4B1*, then what can she do?"

Review of an undated facility policy titled "Social Services," indicated, "Policy Explanation and Compliance Guidelines: The social worker, or social service designee, will pursue the provision of any identified need for medically related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include Making arrangements for obtaining items, such as adaptive equipment, clothing, and personal items."

NJAC 8:39-27.1(a)
NJAC 8:39-39.1

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F 745	Continued From page 19 NJAC 8:39-39.4(f)	F 745		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain 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 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		5/31/23

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F 880	Continued From page 20 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and review of facility policy, the facility failed to handle clean linen in sanitary manner to prevent contamination before transporting to the resident care units. The facility failed to store nebulizer masks in a sanitary manner for three residents(R)10, R335, and R86) of five [redacted] residents sampled from a total 33	F 880	1. The soiled sheets were removed and placed in soiled bin to be rewashed. The heavily stained handwashing sink was replaced and the wall behind the sink was painted. The floor was cleaned, and the missing tiles was replaced by maintenance. The screen in the laundry room was	

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F 880	Continued From page 21 residents. Findings include: 1. Observation during a tour of the facility's laundry on 04/19/23 at 11:23 AM revealed housekeeper (HSK)12 preparing clean linen for transport to the resident care areas. HSK 12 was observed taking the clean bed sheet from the prep table, as he removed the clean sheet from the table the bottom edge of the sheet dragged on the floor. The staff member then started to fold the bed sheet while holding the sheet against his body. Once the sheet was folded, he placed the sheet on the prep table. HSK 12 repeated this manner of folding bed sheets seven times. The staff member folded bath towels and residents' gowns by holding the items against his body while folding. An interview with HSK12 on 04/19/23 at 11:30 revealed the staff had received training on how to fold laundry and transport to the resident care areas. The employee demonstrated folding the bed sheet. Again, the edge of the sheet touched the floor but this time the employee did not hold the sheet against his body. The employee was unaware of the concern. Continued tour of the laundry department on 04/19/23 at 11:40 AM revealed a heavy stained sink where employees performed handwashing. The sink had brown and beige stains; some stains had a hard gummy consistency. The wall behind the sink had brown splatter stains. The soap dispenser had beige color splatter marks. The floor of the laundry room had several tiles with missing pieces. The floor had a black residue built-up especially around the areas with	F 880	cleaned. R10's, R335's, R86's, *Ex Order 26. 4B1*/ mask were removed, replaced, and stored appropriately. 2. All residents have the potential to be affected by this deficient practice. 3. All staff will be in-serviced on handling clean linen and proper storage of respiratory equipment . 4. IP will monitor laundry personnel weekly x's 4, then monthly over the next year. Findings will be reported to the QAPI committee quarterly for the next year. IP will monitor nursing staff on proper storage of respiratory equipment weekly x's 4, then monthly over the next year. Findings will be reported to the QAPI committee quarterly for the next year.	

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missing or cracked tiles. Also, the laundry room had an open window with a screen that had a large amount of white lint collected.

During an interview with the housekeeping director (HSKD) on 04/19/23 at 12:10 PM the observation of the HSK12 handling the clean linen was described. The HSKD stated the employee handled the clean linen incorrectly. By letting the edge of the sheet touch the floor it was contaminated; and when folding the laundry, the items should not be held against the staff member's body, and again stated this was another form of contamination. The HSKD stated this was not the way the employees have been trained to handle clean linen. The HSKD also stated the sink in the laundry room had been a great concern for him. He and the Maintenance Director had tried several chemicals to remove the stains and had been unsuccessful. The HSKD stated a new sink would be necessary. The HSKD acknowledged there were several cracked and missing tiles in the laundry room floor. He stated not only was it an infection control issue but also a safety issue.

Review of the facility's undated policy titled "Handling Clean Linen" revealed it was the facility's policy "It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection."

1. Review of R10's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R10 was admitted on Ex Order 26. 4B1 with a diagnosis of Ex Order 26. 4B1 [redacted].

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F 880	Continued From page 23 Review of R10's quarterly "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 04/08/23, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, indicating R10 was [redacted]. Review of R10's "Order Summary Report," located in the EMR under the "Orders" tab, revealed the following order dated 12/12/22: [redacted] 1 vial inhale orally every 8 hours for [redacted]." This order was discontinued on 01/09/23. During observations on 04/17/23 at 10:38 AM, 04/18/23 at 9:20 AM, and 04/19/23 at 9:17 AM, R10's [redacted]r mask was observed on her bedside table, uncovered/unbagged. 2. Review of R335's "Admission Record," located under the "Profile" tab of the EMR, revealed R335 was admitted on [redacted] with a diagnosis of [redacted]. Review of R335's admission "MDS," located in the EMR under the "MDS" tab with an ARD of [redacted], revealed the resident had a "BIMS" score of [redacted] out of 15, indicating R335 was [redacted]. Review of R335's "Order Summary Report," located in the EMR under the "Orders" tab, revealed the following order dated 03/29/23: [redacted] 1 vial	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 inhale orally via [redacted] every 12 hours for [redacted]." During observations on 04/17/23 at 10:51 AM, 04/18/23 at 9:40 AM, and 04/19/23 at 9:25 AM, R335's [redacted] mask was observed on his bedside table, uncovered/unbagged. 3. Review of R86's "Admission Record," located under the "Profile" tab of the EMR, revealed R86 was admitted on [redacted] with diagnoses of [redacted] Review of R86's admission "MDS," located in the EMR under the "MDS" tab with an ARD of [redacted], revealed the resident had a "BIMS" score of [redacted] out of 15, indicating R86 was [redacted]. Review of R86's "Order Summary Report," located in the EMR under the "Orders" tab, revealed the following order dated 04/06/23: [redacted] 1 vial inhale orally four times a day for [redacted]." During observations on 04/17/23 at 11:02 AM, 04/18/23 at 9:24 AM, and 04/19/23 at 9:20 AM, R86's [redacted] mask was observed on [redacted] bedside table, uncovered/unbagged. During an interview on 04/19/23 at 9:20 AM, the Assistant Director of Nursing (ADON) confirmed R10, R335, and R86's [redacted] masks were uncovered and unbagged on the residents' bedside table. The ADON stated, "The [redacted] masks should be stored in bags. The process is	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 to take off the tubing and store tubing and masks in bags. The nurses are responsible for the bagging of the masks." During an interview on 04/20/23 at 2:01 PM, the Administrator stated, "If they[Ex Order 26. 4B1 masks] are supposed to be bagged and it is in our policy, that is what I expect." Review of an undated facility policy titled, [NJ Exec. Order 26 4.b.1] Treatments," indicated, "After treatment, [Ex Order 26. 4B1] equipment will be placed in plastic bag at bedside". This policy further indicated, "If the order is obtained from the physician to discontinue [Ex Order 26. 4B1] usage, the [Ex Order 26. 4B1] is to be returned to stock for [Ex Order 26. 4B1]." NJAC 8:39-19.4(k) NJAC 8:39-21.1(d)	F 880		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on interview, document review, and review of manufacturer's instructions, the facility failed to ensure bed frames and rails, if present, were inspected and serviced per the	F 909	1. The maintenance director/ designee completed the inspection of all bedframes, mattresses, and bed rails.	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 26 Manufacturer's Instructions for Use (MIFU) to minimize the risks of bed malfunction or resident injury. This failure had the potential to affect any of the current 136 residents that use a bed. Findings include: During the initial pool observations of the "Sub-Acute" and "Suites" halls, 20 residents were noted to have bed rails on their beds. On 04/19/23 at 4:15 PM a request for bed maintenance and inspection documentation was given to the Director of Nursing. On 04/20/23 at 7:45 AM, the maintenance's two, three-ring binders were on the table in the conference room upon arrival, the first contained the bed MIFUs. Review of the eight MIFUs of the bed types provided by the facility showed the "Zenith 7000" and "Liberty" beds have items listed to be inspected every three and every six months; the "Dynarex" showed casters were to be inspected every six months; the "Drive" and the "Patriot" beds are to be inspected between placements of users; the "Panacea" showed a periodic inspection for compliance with the "Warnings" listed in the manual; the "Invacare Carroll" and "American Spirit" did not have any inspection recommendations Four "Maintenance Bed Rail Entrapment Risk Assessments" for the four residents reviewed for bed rails (see F700) were on the table outside of a binder and showed they were completed by the Director of Maintenance (DM) on 04/19/23. Review of the second three-ring binder showed "Maintenance Bed Rail Entrapment Risk Assessment" showed ALL beds were checked on 04/19/23.	F 909	2. All residents have the potential to be affected by this deficient practice. 3. Maintenance director will be in-serviced on following manufacturer guidelines related to bed inspections and maintaining list of bed frames, mattresses, and bedrails in the facility. The facility Maintenance Director will conduct quarterly inspections of beds or per manufacturer guidelines. 4. Maintenance director will submit report of audit findings quarterly to QAPI Committee over the next year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 27 During an interview on 04/20/23 at 8:50 AM, the DM stated the four bed rail entrapment assessments for the four residents reviewed for bed rails (see F700) were "done about, probably like 6:00 [clarified PM], yeah late, it wasn't early. The [name of Regional Nurse Consultant (RNC)] had asked me to go down and do the assessments and get the model numbers off of each of the beds." When asked how often do you check the beds for broken welds, frayed cords, loose bolts, etcetera, DM stated, "We're [maintenance] regularly in and out of the rooms checking the beds but we don't have a regular audit for checking the beds." DM reviewed the Zenith MIFU and stated the recommendation was for "Looks like 6 months and 3-month inspections." DM continued that the Maintenance department was advised when a new resident was being admitted and "we check the bed, reprogram the remote, check the call light, the lights, all for the new resident, but we don't write it down." DM confirmed at that point in time, there were no records of bed inspections or maintenance. At 10:52 AM, DM provided a three-ring binder that showed the same bed rail inspection forms were complete before, in 2017. Review of the undated facility policy titled "Bed Maintenance and Inspection" showed ". . .It is the policy of this facility to conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program. . . Policy Explanation and Compliance Guidelines: 1. A list of bed frames, mattresses, and bed rails will be maintained, including the manufacturer for each. The Maintenance Director shall be notified of any new equipment brought into the facility. 2. The Maintenance Director shall review each	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360**

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F 909	Continued From page 28 manufacturer's recommendations and requirements for bed maintenance and bed inspections, and shall establish maintenance and inspection accordingly. . . 5. Bed frame, mattress, and bed rail inspections will be conducted upon each item entering the facility and then placed on a regularly [sic] inspection. . . " NJAC 8:39-31.4(c)	F 909		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060607	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in CNA staffing for 17 of 28-day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements during the 7:00am -3:00pm shift on the dates of 2-05-23 through 2-11-23, 2-19-23 through 2-21-23, 2-24-23, 2-25-23, and 4-02-23, 4-03-23, 4-08-23, 4-09-23, 4-12-23 2. All residents have the potential to be affected by this deficient practice. 3. The staffing coordinator was in serviced on the N.J. staffing requirements. Advertisements / Job postings for CNAs have been posted on hiring platforms. Incentives are offered to CNAs to work	5/31/23

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

Electronically Signed | 05/09/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060607	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 02/05/2023 through 02/11/2023, 2/19/2023 through 2/25/2023, and 04/02/2023 through 04/12/2023, revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 17 of 28 day shifts as follows: 1. For the 1st week, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -02/05/23 had 14 CNAs for 140 residents on the day shift, required 17 CNAs. -02/06/23 had 14 CNAs for 139 residents on the day shift, required 17 CNAs. -02/07/23 had 16 CNAs for 139 residents on the	S 560	extra shifts. Agencies are being utilized to fill in any open shifts. The staffing Coordinator will report to the Administrator of any discrepancy in staffing. 4. The Administrator or designee will review the staffing schedule weekly to monitor the staffing ratio on all shifts weekly x 90 days and review for the next 3 quarters. The Administrator will report findings to the QA committee on a quarterly basis x 4 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 day shift, required 17 CNAs. -02/08/23 had 16 CNAs for 139 residents on the day shift, required 17 CNAs. -02/09/23 had 16 CNAs for 139 residents on the day shift, required 17 CNAs. -02/10/23 had 15 CNAs for 145 residents on the day shift, required 18 CNAs. -02/11/23 had 16 CNAs for 145 residents on the day shift, required 18 CNAs. 2. For the 2nd week, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -02/19/23 had 15 CNAs for 149 residents on the day shift, required 19 CNAs. -02/20/23 had 18 CNAs for 149 residents on the day shift, required 19 CNAs. -02/21/23 had 16 CNAs for 146 residents on the day shift, required 18 CNAs. -02/24/23 had 17 CNAs for 145 residents on the day shift, required 18 CNAs. -02/25/23 had 15 CNAs for 145 residents on the day shift, required 18 CNAs. 3. For the 2 weeks of staffing 4/02/2023 through 4/12/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -04/02/23 had 14 CNAs for 145 residents on the day shift, required 18 CNAs. -04/03/23 had 16 CNAs for 144 residents on the day shift, required 18 CNAs. -04/08/23 had 17 CNAs for 143 residents on the day shift, required 18 CNAs. -04/09/23 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. -04/12/23 had 15 CNAs for 137 residents on the day shift, required 17 CNAs.	S 560		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060607	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315233 Y1	A. Building B. Wing Y2	6/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0700	Correction	ID Prefix F0745	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(n)(1)-(4)	Completed	Reg. # 483.40(d)	Completed
LSC	05/31/2023	LSC	05/31/2023	LSC	05/31/2023
ID Prefix F0880	Correction	ID Prefix F0909	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(d)(3)	Completed	Reg. #	Completed
LSC	05/31/2023	LSC	05/31/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060607		6/5/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/31/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING **01** B. WING _____	**04/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE** **VINELAND, NJ 08360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 04/19/2023. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/19/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Autumn Lake Healthcare is a 1-story building that was built in 1986, It is composed of Type II protected construction. The facility is divided into 12 - smoke zones. The generator does approximately 25 % of the building as per the Maintenance Director. The current occupied beds are 141 of 190.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in	K 291	1 – Emergency lighting was installed by the transfer switch in accordance to NFPA 110 Standard for Emergency and Standby	5/31/23

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

Electronically Signed | 05/09/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING **01** B. WING _____	**04/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE** **VINELAND, NJ 08360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 1 accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 141 residents. Findings include: An observation on 04/19/23 at 01:25 PM revealed emergency lighting was not present at the emergency generator transfer switch located in the electrical room. The Maintenance Director who was present at the time of the observation confirmed the emergency lighting was not present. NJAC 8:39-31.2(e)	K 291	Power Systems (2010 edition) Section 7.3 2- All residents are at potential risk by this deficient practice. 3 –The maintenance director was in serviced on the importance of the emergency lighting by the transfer switch. The Maintenance Director will do monthly checks for 6 months to ensure that the emergency lighting is functioning properly 4- The Maintenance Director will report any issues quarterly to the QAPI committee for the next year.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all	K 345	1- A smoke detector sensitivity test was conducted by an outside vendor. 2- All residents are at potential risk by this deficient practice. 3- The Maintenance Director was in serviced on the need of the sensitivity testing. The Maintenance Director will	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING **01** B. WING _____	**04/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 2 141 residents. Findings include: An observation of the facility smoke detectors on 04/19/23 from 11:22 AM to 01:30 PM revealed smoke detectors were in the corridors at the smoke barriers, 15 feet from the end of the corridors and 30 feet on center, and other concealed areas throughout the building. A review of the facility binder, provided by the Maintenance Director, contained inspection and testing reports for the fire alarm system for the calendar year 2021 and 2022. A review of the facility fire alarm "Inspection and Testing Reports" dated 01/26/23 revealed no reference to a smoke detection sensitivity test. During an interview on 04/19/23 at 12:15 PM, the Maintenance Director was present at the time of inspection and confirmed that the smoke sensitivity testing had not been completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	schedule all smoke detector testing and sensitivity testing with vendor in a timely manner. 4- The Maintenance Director will submit smoke detector reports to the QAPI committee quarterly for the next year.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K 761		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315233	A. BUILDING **01** B. WING _____	**04/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	**1640 SOUTH LINCOLN AVENUE** **VINELAND, NJ 08360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 3 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 141 residents. Findings include: An observation of the facility's fire doors on 04/19/23 from 11:22 AM to 01:30 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. The Maintenance Director was present at the time of the observation and confirmed the fire doors were not inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	1 - All fire doors were inspected. 2- All residents are at potential risk by this deficient practice. 3- The Maintenance Director was in serviced on proper door inspections. The Maintenance Director will log and keep documentation of inspection of the doors. 4-The Maintenance Director will submit door inspection reports to the QAPI committee quarterly for the next year.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315233 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VINELAND	1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0291	Correction Completed 05/31/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 05/31/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 05/31/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO