

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

PRINTED: 11/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2024
NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT VINELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>Complaint #: NJ175765</p> <p>Census: 176</p> <p>Sample: 3</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/30/2024

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2024
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NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT VINELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360
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S 000	<p>Initial Comments</p> <p>Complaint #: NJ175765</p> <p>Census: 176</p> <p>Sample: 3</p> <p>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 deficiency 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.</p>	S 000		
S 560	<p>8:39-5.1(a) Mandatory Access to Care</p> <p>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ175765</p> <p>Based on interviews and review of facility documents on 09/09/2024, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents.</p> <p>Findings include:</p>	S 560	<p>1. There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements.</p> <p>2. All residents have the potential to be affected by the deficient practice of not meeting the NJ staffing requirement ratios.</p> <p>3. The following measures have been put into place to prevent the deficient practice</p>	10/4/24

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New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT VINELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360
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S 560	<p>Continued From page 1</p> <p>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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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.</p> <p>For the 2 weeks of staffing prior to complaint survey from 08/18/2024 to 08/31/2024, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts as follows:</p> <p>On 08/18/2024 had 13 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/19/2024 had 18 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/20/2024 had 18 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/21/2024 had 21 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p>	S 560	<p>from recurring: Advertisements/ job postings for CNAs have been posted on hiring platforms. Incentives are offered to CNAs to work extra shifts such as gift cards and bonuses. Many agencies are being utilized to fill in any open shifts. Bonuses are also being offered to agency staff to pick up shifts. Additional agencies have been contracted to attain the appropriate staff ratios for the facility census. Hiring and recruitment efforts now include referral bonuses, sign-on bonuses, weekend bonuses amongst other incentives to bring in good staff and quickly. NJ Ex Order 26,4b1 payout system implemented for staff to receive instant pay as incentive to employing more staff. Overtime is made available to all current employees.</p> <p>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.</p>	
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NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT VINELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360
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S 560	<p>Continued From page 2</p> <p>On 08/22/2024 had 21 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/23/2024 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/24/2024 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/25/2024 had 16 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/26/2024 had 17 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/27/2024 had 17 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/28/2024 had 15 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/29/24 had 17 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/30/2024 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p> <p>On 08/31/2024 had 15 CNAs for 174 residents on the day shift, required at least 22 CNAs.</p>	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060607	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/11/2024
NAME OF FACILITY AUTUMN LAKE HEALTHCARE AT VINELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/04/2024	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	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/6/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO 		