STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 PO BOX 746, OLD BRIDGE, New Jersey, 08857**

(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
F0000	INITIAL COMMENTS Survey: Complaint Intake ID#: 431692 and 431695 Survey Dates:10/27/25 to 10/27/25 Census: 110 Sample size: 5 A Complaint Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility was in compliance, and no deficiencies were cited for this survey.	F0000		11/22/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061210	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 PO BOX 746, OLD BRIDGE, New Jersey, 08857**

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 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	S0000		11/22/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 13 out of 35 day shifts reviewed and was evidenced by the following: 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 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	S0560	CORRECTIVE ACTION: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents have the potential to be at risk for the deficient practice. SYSTEMIC CHANGE: The staffing coordinator was educated on the required minimum direct care staffing ratios of 1 to 8 on day shift 1 to 10 on evening shift and 1 to 14 on night shift. The Facility Administrator has Contracted with additional staffing agencies to secure supplemental facility staffing. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, sign on bonuses and, referral bonuses are being utilized to ensure marketplace competitiveness. Bonuses are offered to staff members and agency staff if there are shifts needing to be filled. In addition, the director of nursing will meet daily with the staffing coordinator to ensure appropriate staffing QUALITY ASSURANCE: The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly	11/27/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061210	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 PO BOX 746, OLD BRIDGE, New Jersey, 08857**

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S0560	Continued from page 1 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. 1. For the 3 weeks of Complaint staffing from 01/12/2025 to 02/01/2025, the facility was deficient in CNA staffing for residents on 7 of 21 day shifts as follows: -01/14/25 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -01/18/25 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/19/25 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/26/25 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -01/27/25 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -01/28/25 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/31/25 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of Complaint staffing from 10/12/2025 to 10/25/2025, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -10/12/25 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/13/25 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -10/15/25 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -10/19/25 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -10/20/25 had 14 CNAs for 117 residents on the day	S0560	Continued from page 1 until compliance is met.	11/27/2025

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S0560	Continued from page 2 shift, required at least 15 CNAs. -10/21/25 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. A review of the facility's "Staffing" policy dated reviewed 6/20/24, included, "Our facility will provide sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents.....Staffing numbers and the skills requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care."	S0560		11/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 PO BOX 746, OLD BRIDGE, New Jersey, 08857**

(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
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/2/2025 in relation to the 10/27/25 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061210	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/2/2025 in relation to the 10/27/2025 State of New Jersey complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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