STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 000	INITIAL COMMENTS Complaint #'s: NJ00161440, NJ00152258, NJ00160158, NJ00161126, NJ00160281 Standard Survey: 5/18/23 Census: 101 Sample Size: 24 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		6/8/23

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

Electronically Signed | 05/31/2023

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
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 623	Continued From page 1 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 623	Continued From page 2 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide the resident representative with written	F 623	Resident # 106 is no longer in the facility to review for the corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 623	Continued From page 3 notification of the reason for emergency transfer for 1 Resident #106, of 2 residents reviewed for [redacted]. The deficient practice is evidenced by the following: A review of the electronic medical record revealed the following information. The "Census" tab indicated the resident was transferred to the [redacted] on [redacted]. On 5/12/23 at 9:15 AM, the surveyor interviewed the Regional Director of Nursing (RDON) who stated the facility is responsible for providing written documentation to the resident representative and the Long-Term Care Ombudsman (LTCO) with the reason for a resident's emergency transfer. She further stated the notification was sent to the LTCO, however, it was not sent to the resident representative. She stated, "It was missed." On 5/16/23 and 5/17/23 the surveyor requested the facility policy for notifications to resident representatives regarding the reason for emergency transfers. None was provided. The undated Policy for "Transfer and Discharge (including AMA)" is revealed under "Policy Explanation and Compliance Guidelines 4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge." NJAC 8:39-4.1(a)31	F 623	To ensure other residents were not affected by the deficient practice, An audit was completed by Director of Nursing (DON) and the Social Worker on 5/18/2023 of all residents that were discharged in the last 30 days for the appropriate Transfer/discharge including that written notice was sent to the resident representative, per the facility policy. No issues found. On 5/23/23, The Director of Nursing in-serviced all the staff nurses, Unit clerks and the Social Worker on the policy of discharge/transfer/bed hold to include that written notice of transfer is to be sent to the resident representative. All residents may be potentially at risk for this deficient practice. This can be identified by reviewing the residents medical records. To ensure the deficient does not occur, on 5/23/23, all Staff nurses, Unit clerks and social worker were in serviced by the Director of nursing/designee on the facility policy of transfer/discharges notice include that written notice of transfer is to be sent to the resident representative. The transfer/discharge notice policy reviewed and educated the staff nurses/ unit clerk on the importance documenting the reason for transfer upon the residents transfer to the hospital and sending the written notice to the resident representative.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 623	Continued From page 4	F 623	The DON/Designee will complete an audit of all hospital transfers weekly for 3 months, then bi weekly for 3 months to ensure that written notice is being sent to the resident representative. All findings will be addressed immediately and reported to the administrator, as well as the Quality Assurance committee/ QAPI quarterly for 6 months or until compliance is met.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		6/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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
F 625	Continued From page 5 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide written notification of the bed hold policy to the resident representative upon emergency transfer for 1 Resident, #14, of 2 residents reviewed for NJ Exec. Order 26:4.b.1 The deficient practice is evidenced by the following. Resident #14 was observed on 5/4/23 seated in a Ex Order 26. 4B1 in the unit day room. The resident pleasantly engaged in conversation with the surveyor. A review of the electronic medical record revealed the following information. The "Census" tab indicated the resident was transferred to the NJ Exec. Order 26:4.b on Ex Order 26. 4B1 and Ex Order 26. 4B1. On 5/12/23 at 9:15 AM, the surveyor interviewed the Regional Director of Nursing (RDON) regarding written notification of the bed hold party to Resident #14's resident representative for the emergency transfers on Ex Order 26. 4B1 and Ex Order 26. 4B1. The RDON was unable to provide the documentation of the notifications. On 5/17/23 at 9:00 AM, the RDON provided the facility policy titled Bed Hold Notice Upon Transfer, undated. The policy specified that prior to discharge, the facility will provide to the resident and/or the resident representative written information regarding the bed hold policy.	F 625	Resident # 14 medical records were reviewed for deficient practice and bed hold forms were sent to the resident representative for the Ex Order 26. 4B1 and Ex Order 26. 4B1 emergency transfers. To ensure other residents were not affected by the deficient practice, an audit was completed by the Director of Nursing (DON) and the Social Worker on 5/18/2023 of all residents that were discharged in the last 30 days for the appropriate Bed-hold notice upon transfer to the hospital per the facility policy and that written notice was sent to the resident representative. No issues found. The DON/designee 0n 5/10/23 Nurses, Unit clerks and the Social Worker were in serviced on the requirement to send all pertinent documentation to include the Bed-hold notice with the resident upon transfer/discharge to the hospital and that written notice is to be sent to the resident representative. All residents have the potential to be at risk for the deficient practice. This can be identified by reviewing the residents medical records. To ensure the deficient practice does not re-occur, on 5/23/23, all Nurses, Unit clerks and the social worker were in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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
F 625	Continued From page 6 NJAC 8:39-4.1(a)31	F 625	serviced by the Director of Nursing/designee on the importance to send all pertinent documentation to include the Bed-hold notice with the resident upon transfer/discharge to the hospital and that written notice is to be sent to the resident representative, to ensure compliance with the facility policy and regulations. The DON/designee will audit all residents transferred or discharged to the hospital weekly for 3 months then bi-weekly for 3 months to ensure that the Bed-hold notice sent with the resident at the time of the transfer and that written notice is to be sent to the resident representative, as evidenced by the documentation in the residents medical record. Findings of the audits will be addressed immediately and reported to the administrator, as well as the Quality Assurance committee/ QAPI quarterly for 6 months or until compliance is met.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately assess and properly code a resident's status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was	F 641	Resident # 26, # 55 and # 53 are current residents in the facility, MDSs (minimum Data set) were reviewed and corrected on 5/12/23. To ensure other residents were not	6/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 641	Continued From page 7 identified for three (3) of 27 residents (Residents #26, #53 and #66). This deficient practice was evidenced by the following: Reference: According to the CMS's (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual dated October 2019 indicates the completion of the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. 1. On 5/4/23 at 11:41 AM, the surveyor observed Resident #26 ambulating on his/her own down the hallway using a [redacted] walker. The resident	F 641	affected by the deficient practice 10 random MDS's were audited by the Regional MDS coordinator on 5/12/23. No further findings were found from the deficient practice. The MDS coordinator was in-serviced on 5/12/2023 by the Regional MDS coordinator on accurate documentation of assessment on the MDS. All residents may potentially be at risk for the deficient practice. This can be identified by reviewing the medical records. The MDS coordinator was in-serviced by the regional MDS coordinator on 5/12/2023 on the importance of ensuring that the residents assessment are correctly documented on the MDS. The Regional MDS coordinator will complete a random monthly audit of 10 residents MDSs to ensure that all assessments are accurately documented in the MDS. All findings will be addressed immediately and reported to the administrator, as well as the quality assurance committee/ QAPI quarterly for six months or until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 641	Continued From page 8	F 641		

then stopped at the nursing station and spoke with the Unit Secretary (US) in a different language other than English. The resident then independently went and sat in a chair across from the nursing station.

At that time, the US stated that she was getting another employee to interpret because she could not understand everything the resident was saying. The surveyor attempted to interview the resident, but the resident had not responded to the surveyor.

On 5/8/23 at 11:05 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that she was familiar with Resident #26 and had been assigned to care for the resident. The CNA stated that the resident needed help with dressing but was able to get in and out of bed and eat independently. The CNA added that the resident spoke another language but was able to understand some English and understand gestures. The CNA was unable to speak to any restraints or alarms that the resident had.

On 5/8/23 at 11:16 AM, the surveyor observed Resident #26 sitting on his/her bed folding clothes. The surveyor attempted to interview the resident who was able to shake his/her head yes and no. The surveyor pointed to the half length bed rails on the resident's bed that were in the down position. The surveyor asked the resident if the resident wanted the bed rails, and the resident shook his/her head yes and through gesturing showed the surveyor how he/she used the rails to help themselves when they were in bed. The surveyor observed the resident using the [redacted] walker and was able to move around the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 641	Continued From page 9	F 641		

The surveyor reviewed the medical records of Resident #26.

The Admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not [redacted].

The quarterly Minimum Data Set (QMDS) with an Assessment Review Date (ARD) of 3/21/23, reflected a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident had a [redacted]. In addition, in Section P: Restraints and Alarms indicated that "Bed Rail" was coded "used daily" as a restraint.

On 5/11/23 at 12:36 PM, the surveyor interviewed the Charge Nurse/Registered Nurse (CN/RN) who stated that Resident #26 had no restraints. The surveyor, with the CN/RN, reviewed the resident's interdisciplinary care plan which revealed that the resident had no focus area for a restraint. The CN/RN was unable to speak to the QMDS coding of a restraint and stated that the MDS Coordinator completed the MDS.

On 5/12/23 at 10:59 AM, the surveyor, in the presence of another surveyor, interviewed the MDS Coordinator via speaker phone who stated that she had worked for the facility a little over a year. The MDS Coordinator stated that she had completed the QMDS with the ARD of 3/21/23 for Resident #26. The MDS Coordinator verified that she had entered the coding in the MDS that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 641	Continued From page 10 indicated that the resident had a restraint of bed rails in Section P. The MDS Coordinator stated that she had mistakenly coded the QMDS incorrectly for Section P because the resident had never had a restraint. The MDS Coordinator added that she was unaware of any restraint that the resident had and would have to modify the QMDS. On 5/16/23 at 12:18 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Regional Director of Nursing (RDON). The RDON acknowledged that Resident #26 had no restraints. On 5/17/22 at 11:13 AM, the survey team met with the LNHA, the Director of Nursing (DON) and RDON. The LNHA stated that the QMDS with the ARD of 3/21/23 for Resident #26 was modified. The LNHA also stated that the facility policy for "Resident Assessment" was the current policy. A review of the undated facility policy "Resident Assessment" provided by the LNHA revealed that "All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information." NJAC 8:39-11.1, 11.2(e)(1) 2. During the initial facility tour on 5/4/23 at 12:39 PM, the surveyor observed Resident #55 out of bed to a Ex Order 26. 4B1 inside the main dining room.	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 641	Continued From page 11 The surveyor reviewed the medical records of Resident #55 which revealed the following: The QMDS with an ARD of 4/10/23 reflected that the resident had a BIMS score of [redacted] out of 15 which indicated that the resident's [redacted] was [redacted]. The QMDS Section J Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) of Resident #55 Fall on 2/5/23 was coded 0 (zero) or No, which did not reflect the resident's [redacted]. The Care Plan initiated on 11/24/21 reflected "Focus: [redacted] is at risk for [redacted] of a [redacted] of the [redacted], [redacted], [redacted], Use of [redacted] medication, Use of [redacted] medication, [redacted], [redacted], Independent transfers from [redacted] level, and Noncompliance with calling for help 2/05/23 Actual [redacted], unwitnessed with [redacted]." The Progress Notes dated 2/05/23 under General Nurses Notes stated that "At about 7:49 pm writer was called into the resident room to observed [redacted] sitting on [redacted] bathroom floor [redacted] entire body was assess, no apparen[redacted] noted." On 05/12/23 at 11:05 AM, the surveyor, in the presence of another surveyor, interviewed the MDS Coordinator via speaker phone who stated she is not aware that the resident had a [redacted] incident and that it should be coded in the quarterly assessment. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, dated October 2019 reflected	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 641	Continued From page 12 under "Section J: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent" under "Steps for Assessment 2. If this is not the first assessment/entry or reentry, the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment" the "Coding instructions, Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls, Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item, whichever is more recent."	F 641		

3. On 05/04/23 at 11:30 AM, during the initial facility tour, the surveyor observed Resident #53 lying in bed with an *Ex Order 26. 4B1* in a *Ex Order 26. 4B1* draining yellowish *Ex Order 26.*.

The surveyor reviewed the medical records of Resident #53 which revealed the following:

The Admission Record showed that Resident #53 was admitted to the facility with a diagnosis that included but was not limited to *Ex Order 26. 4B1* .

The Admission MDS (AMDS) dated 03/29/23 showed that the resident had a BIMS score of *Ex* out of 15 which reflected that the resident's had *Ex Order 26. 4B1* in cognition. The AMDS Section H Appliances did not reflect that Resident #53 had an *Ex Order 26. 4B1* .

The Treatment Administration Record (TAR) for March 2023 reflected an order of "*Ex Order 26. 4B1* shift every shift."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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
F 641	Continued From page 13 The "Order Summary Report (OSR)" which reflected the active physician order date of 3/24/23 revealed, "Maintain Ex Order 26. 4B1 [redacted] for diagnosis of Ex Order 26. 4B1 [redacted]." On 05/09/23 at 10:01 AM, the surveyor interviewed CN/RN regarding resident used of Ex Order 26. 4B1 [redacted]. CN/RN stated that the resident was using Ex Order 26. 4B1 [redacted] since admission in Ex Order 26. 4B1 [redacted]. On 05/12/23 at 11:09 AM, the surveyor interviewed MDS Coordinator who stated that she is not aware that the resident has an Ex Order 26. 4B1 [redacted] and that it should be coded.	F 641		
F 805 SS=D	NJAC 8:39 - 11.2 (e) Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure that the resident was provided with the consistency of liquid in accordance with the physician's order. This was found with Resident # 57, 1 of 1 residents reviewed for Ex Order 26. 4B1 [redacted].	F 805	Resident # 57 medical records reviewed for deficient practice. On 5/9/23, The Director of Nursing (DON)/designee completed an audit of all residents on Ex Order 26. 4B1. The physician order and the diet slip matched, and the Ex Order 26. 4B1 [redacted] packets provided on	6/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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
F 805	Continued From page 14 The deficient practice was evidenced by the following: On 5/9/23 at 1:15 PM, the surveyor observed Resident # 57 being fed by a Certified Nursing Assistant (CNA). The CNA poured a packet of *Ex Order 26. 4B1* that read *Ex Order 26. 4B1* into 4 ounces of apple juice that the CNA had poured into a cup. The CNA held the cup and the resident drank the *Ex Order 26. 4B1* apple juice after feeding the resident half of a portion of chocolate pudding. The surveyor checked the meal ticket. The meal ticket read *Ex Order 26. 4B1* On 5/9/23 at 1:38 PM, the surveyor asked the CNA if she noticed the *Ex Order 26. 4B1* packet was *Ex Order 26. 4B1* but the meal ticket said *Ex Order 26. 4B1*. She said she usually checked the packet to make sure it was the right consistency but today she forgot to check the meal ticket before she mixed it with the apple juice. On 5/9/23 at 1:59 PM ,the surveyor spoke with the Director of Nursing (DON) the Regional Nurse, and the Administrator, and made them aware of the concern with the CNA providing apple juice in a consistency that was contrary to what the physician ordered. On 5/10/23 at 9:30 AM, the surveyor reviewed the resident's record which revealed the following: An admission record with diagnoses which included, *Ex Order 26. 4B1* [redacted]. A Physician's Order Sheet with an order that read	F 805	the meal tray was correct. There were no further issues found. On 5/9/2023 Dietary staff were in-serviced to ensure that residents on a *Ex Order 26. 4B1* [redacted] diet receive the correct *Ex Order 26. 4B1* powder. On 5/10/23, the *Ex Order 26. 4B1* policy was reviewed and revised, only *Ex Order 26. 4B1* [redacted] and licensed nurses are allowed to *Ex Order 26. 4B1*. All nursing staff were in-serviced by the Regional Director of Nursing on the revised policy. On 5/23/23, Licensed nurses and certified nurses Aides in-serviced by the DON that all fluids will be *Ex Order 26. 4B1* by the Speech Therapist and Licensed Nurses. All residents on *Ex Order 26. 4B1* liquids may be potentially at risk for the deficient practice. This can be identified by reviewing the physician orders and the electronic medication administration record (EMAR). On 5/10/2023, NJ Exec. Order 26:4.b.1 policy was reviewed and revised by the Administrator, Regional Director of Nursing and DON. To ensure the deficient practice does not re-occur, on 5/23/2023, All nursing staff were re-in-serviced on the revised policy, that only the speech therapist and licensed will *Ex Order 26. 4B1* fluids. On 5/23/2023, the kitchen staff were in-serviced by the food service Director to ensure the correct *Ex Order 26. 4B1* powder packets are sent on the meal trays per the residents die slip. The Dietary Manager/Designee will audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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
F 805	Continued From page 15 'Ex Order 26. 4B1 [redacted]. Small portions Ex Order 26. 4B1 [redacted]. 4 oz. moist puree and 4 oz. Ex Order 26. 4B1 liquid via straw or teaspoon sips. Ex Order 26. 4B1 precautions. Feed only when alert and willing to accept po. Provide Ex Order 26. 4B1 for lunch and supper only. No breakfast tray." A Minimum Data Set Quarterly Assessment dated 3/20/23. The assessment included a Brief Interview for Mental Status Assessment (BIMS). The BIMS was not able to be completed. The assessment indicated that the resident was NJ Exec. Order 26:4.b.1 and that their cognitive skills for daily decision making was Ex Order 26. 4B1 [redacted]. A quarterly screening by the Ex Order 26. 4B1 [redacted] dated 4/6/23. The quarterly screen indicated that the resident had Ex Order 26. 4B1. The screen also indicated that the resident was receiving Ex Order 26. 4B1 liquid and that there was no difficulty with the current diet. On 5/11/23 at 12:15 PM, the surveyor reviewed the facility's policy and procedure titled "Thickened Liquids" and updated October 2022. Number 6. read; "Considerations for safety and to ensure appropriate consistencies: a. Do not add ice to thickened liquids. b. Refrain from heating the liquid, which may inadvertantly thin the liquid, unless product specifications indicate it is safe to do so. Follow any product recommendations. c. C.N.A. may thicken 4 oz of fluid." Number 8. read "Per this facility policy, other than the speech therapist, nurses will thicken resident fluids." NJAC 8:39-27.1 (a)	F 805	meal trays on all residents on NJ Exec. Order 26:4.b.1 [redacted] 3 times a week for 1 month to include breakfast lunch and dinner. Then 2 times weekly for 2 months, then once a week for 3 months. All findings from the audit will be addressed immediately and reported to the administrator as well as the Quality Assurance Committee/QAPI quarterly for 6 months or until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 812	Continued From page 16	F 812		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) failed to sanitize and air-dry steam table pans in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 5/8/23 at 11:06 AM, in the presence of Director of Dietary (DD) the surveyor observed the following: In the dishwashing area, the surveyor observed a dishware drying rack with four shallow one quarter steam table pans stacked with water between them, three deep quarter steam table	F 812	On 5/8/2023 the Dietary Director immediately removed all the pans with water nesting between them. The four shallow quarter steam table pans, three deep quarter steam table pans, and two sheet pans were all rewashed and allowed to air dry. All residents on a by mouth diet have the potential to be affected by this deficient practice. Beginning on 5/8/2023 all dietary staff	6/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 812	Continued From page 17 pans stacked with water between them, and two sheet pans stacked with water between them as well. The DD stated that the dishware should not be stacked on top of each other when wet. On 5/8/23 at 1:13 PM, the surveyor discussed the above concerns with the Administrator, Director of Nursing (DON), and Regional DON. The surveyor reviewed the facility's policy titled, Sanitization" dated December 2022 which revealed that food preparation equipment and utensils that area manually washed will be allowed to air dry. NJAC 8:39-17.2(g)	F 812	were in-service on facility policy for air drying all equipment. The Dietary Director worked with each staff to complete a competency on air drying all equipment. More shelve space has been made available to ensure proper air drying. For 6 months Dietary Director/Designee will perform a weekly audit to ensure that wet nesting is not occurring. A quarterly review of weekly dietary audits will be conducted and documented by the Dietary Director for 6 months. Any concerns/recommendations will be made at that time and addressed as needed. Results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for 6 months.	
F 880 SS=D	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:	F 880		6/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 880	Continued From page 18 §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 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 880	Continued From page 19 §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 observation, interview, and record review, it was determined that the facility failed to store four of four linen carts in a sanitary manner. This deficient practice was as evidenced by the following: On 5/8/23 at 11:20 AM, the surveyor observed four blue linen carts outside of the facility on the sidewalk located underneath a tree, which were not covered. The surveyor observed that the items inside the first blue linen bin, nearest the building outside, which were washable incontinence under pads, bed sheets and blankets, was soiled with a small tree branch on top of the items and brown and tan colored debris from the tree above the bin. The surveyor observed that the items inside the second blue linen bin, which were resident gowns, was soiled with brown and tan colored debris from the tree above the bin. The surveyor observed that the items inside the third blue linen bin, which were more bedsheets, was soiled with brown and tan colored debris from the tree above the bin. The surveyor observed that the items inside the fourth blue linen bin, which were towels and washcloths,	F 880	All residents who receive care at the facility have the potential to be affected by this deficient practice. Beginning on 5/8/2023 all housekeeping staff were in-serviced on facility policy for handling, storing, and transporting linens to prevent the spread of infection. The Housekeeping Director worked with each member of the housekeeping staff to complete competency on handling linens. More shelve space has been added to ensure all linen is stored properly upon arrival at the facility. The contracted vendor that supplies the linen was educated to immediately notify the Facility when linen is delivered to ensure prompt storage of the linen. For 6 months the Housekeeping Director will document a weekly audit to assure linens are handled, stored, and transported in a manner that prevents the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 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
F 880	Continued From page 20 was soiled with brown and tan colored debris from the tree above the bin. At 11:33 AM, the surveyor showed the House Keeping Director (HKD), Director of Nursing (DON) and Regional DON the carts outside. The HKD stated that these carts contained newly laundered items and were delivered on Saturday 5/6/2023 and they should have been covered. The HKD stated that these items should have been brought inside and kept in a clean environment. At 12:17 PM, the HKD provided the surveyor a delivery receipt from the laundering service that the facility uses which revealed that these carts were delivered on 5/6/23 and included 300 large sheets, 50 knit contours, 40 draw sheets, 50 thermal blankets, 90 pillowcases, 200 washcloths, 600 bath towels, 150 patient gowns and 90 under pads. The HKD stated that the two porters who worked on 5/6/23 should have brought these carts inside once the laundered items were delivered. At 5/8/23 at 1:00 PM, the surveyor discussed the above concerns with the Administrator, DON and, Regional DON. On 5/9/23 at 930 AM, the surveyor received the Receiving and Storing Clean Linen policy, dated December 2022, which revealed that all linens shall be stored in a clean and dry area, free from any potential sources of contamination. N.J.A.C. 8:39-19.4(a)	F 880	spread of infection. A quarterly review of weekly housekeeping audits will be conducted and documented by the Housekeeping Director for 6 months. Any concerns/recommendations will be made at that time and addressed as needed. Results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for 6 months.	

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
	061210	A. BUILDING: _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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) 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 observation, interview, and review of pertinent facility documentation, it was determined 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 evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.	S 560	Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, facility will utilize staffing agencies to fill any open spots in the schedule. All residents have the potential to be at risk for the deficient practice. The Facility Administrator has Contracted with additional staffing agencies to secured supplemental facility staffing. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings and referral bonuses are being utilized to ensure marketplace competitiveness. In addition,	6/8/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061210	A. BUILDING: _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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) COMPLETE DATE
S 560	Continued From page 1 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of	S 560	the director of nursing will meet daily with the staffing coordinator to ensure appropriate staffing 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 until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061210	A. BUILDING: _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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) COMPLETE DATE
S 560	Continued From page 2	S 560		

required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.

(3) All computations shall be based on the midnight census for the day in which the shift begins.

d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...

A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 01/30/2022 to 02/05/2022 and 04/16/2023 to 4/29/2023 were reviewed. The week of 01/30/2022 through 02/05/2022 was reviewed for a Complaint investigation. The weeks of 04/16/2023 through 04/29/2023 was reviewed for the 05/18/2023 standard survey. The results were as follows:

1. For the Complaint week of 01/30/2022 to 02/05/2022, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows:

-01/30/22 had 9 CNAs for 79 residents on the day shift, required 10 CNAs.
-01/31/22 had 9 CNAs for 78 residents on the day shift, required 10 CNAs.
-02/02/22 had 8 CNAs for 76 residents on the day shift, required 9 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061210	A. BUILDING: _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 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) COMPLETE DATE
S 560	Continued From page 3 2. For the 2 weeks prior to the Standard survey from 04/16/2023 to 04/29/2023, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -04/17/23 had 7 CNAs for 92 residents on the day shift, required 11 CNAs. -04/23/23 had 10 CNAs for 94 residents on the day shift, required 12 CNAs. -04/25/23 had 11 CNAs for 93 residents on the day shift, required 12 CNAs. On 05/18/2023 at 12:15 p.m., the surveyor informed the Director of Nursing and the Licensed Nursing Home Administrator of the shifts when the minimum direct care staff to resident ratio was not met.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315381		7/6/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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 F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 06/08/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 06/08/2023	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	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

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	
5/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315381 Y1	A. Building B. Wing Y2	7/6/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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 F0623	Correction	ID Prefix F0625	Correction	ID Prefix F0641	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.20(g)	Completed
LSC	06/08/2023	LSC	06/08/2023	LSC	06/08/2023
ID Prefix F0805	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.60(d)(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	06/08/2023	LSC	06/08/2023	LSC	06/08/2023
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	
5/18/2023	☐ 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 (Y2)	DATE OF REVISIT (Y3)
061210	A. Building B. Wing	7/6/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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 06/08/2023	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
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

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	
5/18/2023	☐ 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
	315381	A. BUILDING **01** B. WING _____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 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
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 05/04/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/04/23 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. Summer Hill Nursing Home is a one-story building w/partial basement that was built in the 1970's, it is composed of Type II 000 protected construction. The facility is divided into five - smoke zones. The generator does 100 % of the building as per the Maintenance Director. The current occupied beds are 119 of 138.	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced	K 281		6/12/23

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

Electronically Signed | 05/31/2023

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
	315381	A. BUILDING **01** B. WING _____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 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
K 281	Continued From page 1 by: Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switches in 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 119 residents. Findings include: Observations on 05/04/23 at 01:13 PM revealed emergency lighting was not present at the emergency generator transfer switch located in the electrical rooms on the lower level in each building. The Maintenance Director who was present at the time of the observations confirmed the emergency lighting was not present. NJAC 8:39-31.2(e) NFPA 99, 110	K 281	Emergency lighting was installed at the emergency generator transfers switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on ensuring that there is emergency lighting in place where necessary. The Maintenance Director will perform a monthly audit for 6 months to ensure that the emergency lighting is in place and functioning properly. Finding of said audit will be reported to the Administrator and QAPI committee at the quarterly meeting.	
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	K 345	A smoke detector sensitivity test was	6/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING **01** B. WING _____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 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
K 345	Continued From page 2 review, the facility failed to conduct smoke detection sensitivity testing of the smoke detectors every alternate year 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 119 residents. Findings include: An observation of the facility smoke detectors on 05/04/23 from 12:10 PM to 2:05 PM revealed smoke detectors were in the corridors at the smoke barriers, in all sleeping rooms, 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. Review of the facility fire alarm "Inspection and Testing Reports," dated 05/03/23, revealed no reference to a smoke detection sensitivity test. During an interview on 05/04/23 at 12:40 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	performed by an outside vendor. All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on ensuring that all necessary fire alarm inspections are performed in a timely manner. The Maintenance Director will perform an audit monthly to ensure that all necessary Fire Alarm inspection are scheduled and performed in a timely manner. Finding of said audit will be reported to the Administrator and QAPI committee at the quarterly meeting.	
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	K 761		6/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING **01** B. WING _____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 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
K 761	Continued From page 3 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. 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 119 residents. Findings include: Observations of the facility's fire doors on 05/04/23 from 12:10 PM to 2:05 PM revealed the doors lacked the required inspection tags 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 8:39-31.2(e) NFPA 80	K 761	All fire doors were inspected in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on proper fire door inspections and performing/documenting them in a timely manner. The Maintenance Director will perform/document fire door inspections yearly. The inspection reports will be presented to the Administrator and QAPI committee for 1 year at the quarterly meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		6/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING **01** B. WING _____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 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
K 914	Continued From page 4 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 (2012 edition) Health Care Facilities Code section 6.3.4.1.3. This deficient practice had the potential to affect all 119 residents. Findings include: Documentation review of the Fire Safety Folder for 2022, provided by the Maintenance Director, revealed the electrical outlet testing was not completed on the electrical outlets.	K 914	An electric receptacle inspection was performed by an outside vendor. All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on ensuring that an electric receptacle inspection is performed on a yearly basis. The Maintenance Director will schedule and ensure that the electrical inspection is performed annualy The inspection reports will be presented to the Administrator and QAPI committee for 1 year at the quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING **01** B. WING _____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 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
K 914	Continued From page 5 During an interview at 11:45 AM on 05/04/23, the Maintenance Director confirmed that the annual electrical outlet testing was not completed on the electrical system. NJAC 8:39-31.2(e) NFPA 99	K 914		

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
315381 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/6/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	06/12/2023	LSC K0345	06/08/2023	LSC K0761	06/08/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0914	06/08/2023	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/18/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO