STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification and Complaint investigation was conducted by Healthcare Management Solutions, LLC on behalf of the State of New Jersey. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT SURVEY. Survey Dates: 09/26/23 to 09/29/23 Survey Census: 110 Sample size: 28 Deficiencies were issued related to Intakes: NJ164068 and NJ162927. No deficiencies were issued related to Intakes: NJ166209 and NJ160238.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		11/3/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/19/2023

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of the maintenance log, and interview, the facility failed to provide a clean, comfortable, homelike environment for two of three units (B and C units) of the facility. Findings include: 1. Observation on 09/26/23 at 12:20 PM of "C" unit revealed in room 50 on the "B" side of the room there were water marks going down the wall by the air conditioning window unit. The molding around the air conditioner appeared dark in color	F 584	F Tag 584 Corrective Action Room 50 the AC unit box was repositioned so that it slopes and drains to the outside of the building. The watermarks were removed, the damaged walls were cleaned repaired and then painted. The molding around the air unit was cleaned and repaired. The handrail was repaired on b hall and the handrail across from room 46 was	

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F 584	Continued From page 2 and not clean. There was no resident currently residing on the "B" side, however there was a resident in the room on the "A" side. 2. Observation on 09/26/23 at 12:50 PM of the "B" unit revealed the plastic handrail on the B hall across from the nurse's station had a crack in the rail which could fit a hand inside and could cause possible injury. There was also a handrail with a crack and hole in it across from room 46. Review of the "Maintenance Log" provided by the Maintenance Director (MD) dated August 2023 did not reveal the handrails or room 50 to be on the log to be fixed. Interview and observation on 09/29/23 at 11:28 AM with the MD confirmed the plastic handrail on the "B" unit hall across from the nurse's station had a crack in it which could fit a hand inside and could cause possible injury. Observation of Room 50 on "C" unit revealed the air conditioner unit was installed above B bed and there were water marks down the wall. The molding was dark in color. The MD stated the box was not installed properly to drain backwards outside. He confirmed that this could cause a problem for residents residing in the room. The MD confirmed he did not have room 50 and the handrails on the maintenance log to be repaired. NJAC 8:39-4.1(a)11 NJAC 8:39-31.2(e) NJAC 8:39-31.4(a)(f)	F 584	repaired. Identification of At-Risk Resident The facility has determined that all residents have the potential to be affected by this deficient practice. Systemic Change All staff will receive in-servicing on utilizing the maintenance log to indicate any identified areas in need of repair. The maintenance director will receive in-servicing to make daily rounds to identify any areas in the facility in need of repair, document his findings on his round sheet and indicate repair completion date. The maintenance director will review the maintenance log on each unit during his daily rounds and note his awareness of the repair by initial the maintenance log. The maintenance director will report his findings in the morning meeting. All staff will be in-serviced on the policy for home like environment. Quality Assurance The maintenance director will report his findings to the administrator weekly for 2 months and then monthly until substantial compliance has been met. The administrator/ maintenance director will review findings with the QA committee quarterly for 4 quarters or until substantial compliance has been met.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		11/3/23

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F 600	Continued From page 3 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ162927, NJ164068 Based on interview, record review, and facility policy review, the facility failed to ensure two (Resident (R) 20 and R57) of six sampled residents reviewed for EX Order 26 § were free from resident-to-resident EX Order 26 § 4b1 out of a total sample of 28 residents. Findings include: 1. Review of R20's "Admission Record," located in the "Profile" section of the electronic medical record (EMR), revealed R20 was admitted to the facility on EX Order 26 § 4b1. Review of R20's quarterly "Minimum Data Set (MDS)" assessment with an assessment reference date (ARD) of 04/12/20, located in the "MDS" tab of the EMR, revealed R20 scored seven of EX Ord on the Brief Interview Mental Status	F 600	F600 Corrective Action: Resident 20 care plan was updated to reflect Ex.Order 26.4(b)(1) interventions and diversional activities to attempt to EX Order 26 . Resident 57 care plan was updated to reflect Ex.Order 26.4(b)(1) interventions and diversional activities to attempt to EX Order 26 . Identification of At- Risk Resident: The facility has determined that all residents with Ex.Order 26.4(b)(1) inclinations have the potential to be affected by this deficient practice. Systemic Change: Staff in-serviced to monitor for any Ex.Order 26.4(b)(1) that may provoke a reaction by residents or others. Administration will be in-serviced on while investigating resident to resident incident	

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F 600	Continued From page 4 (BIMS) which indicated EX Order 26 § 4b1 [redacted] Review of R20's "Nursing Notes,' located in the "Progress Notes" section of the EMR, dated 05/05/23 at 4:48 PM, revealed, "Called to C wing by nurse on floor s/p [status post] resident to resident altercation. Observed [R20] seated in EX Order 26 § 4b1 at nurse's station with EX Order 26 § 4b1 [redacted] Assessed area and initiated treatment." Review of R77's "Admission Record," located in the "Profile" section of the EMR revealed R77 was admitted to the facility on EX Order 26 § 4b1. Review of R77's annual "MDS" assessment with an ARD of 02/17/23, located in the "MDS" tab of the EMR, revealed R77 scored EX Orde of 15 on the BIMS which indicated EX Order 26 § 4b1 [redacted] Review of R77's "Nursing Notes," located in the "Progress Notes" section of the EMR dated 05/05/23 at 5:16 PM, revealed, "Called to C wing by nurse on floor s/p resident to resident altercation in which [R77] was the EX Order 26 § 4b1. Resident was observed standing in the hallway. Assessed for EX Order 26, none noted. . . When asked about incident, the resident did not give verbal response & shrugged shoulder. Escorted resident back to room & placed on 1:1 [one on one] supervision." Review of the facility's "Investigation and Summary," dated 05/08/23, of the resident-to-resident altercation between R20 and R77 revealed, "On May 5th the following incident	F 600	to provide evidence that the facility completed resident assessments and provided care plan interventions to address a resident□s Ex.Order 26.4(b)(1) [redacted] Administration will be in-serviced on including evidence in investigation summary determining willful, deliberate, or inadvertent, accidental actions of resident□s Ex.Order 26.4(b)(1) All active residents who have had Ex.Order 26.4(b)(1 resident to resident altercations in the last 6 months care plans will be reviewed and updated with interventions specific to their Ex.Order 26.4(b)(1) and interventions to attempt to defer their Ex.Order 26.4(b)(1). All resident-to-resident incidents will be reviewed by DON/designee to assure that immediate intervention was implemented, resident reassessed, and care plan interventions related to incident was updated to ensure resident safety. Activities for Ex.Order 26.4(b)(1) l residents will be increased to provide diversional activities. All staff will continue to be in-serviced annually and as needed on abuse and neglect Quality Assurance: DON/ designee will report findings of all resident to resident incidents daily in morning meeting, resident to resident incidents will be reviewed immediately with administrator, findings reported quarterly to QA committee until substantial compliance has been met.	

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F 600	Continued From page 5	F 600		

occurred. At approximately 3:45 PM, the district nurse notified the supervisor that there was a resident-to-resident EX Order 26 § 4b1 occurred between resident [R20] and [R77]. The district nurse heard yelling coming from the room of [R20], when she entered, she found [R20] sitting in his EX Order 26 § 4b1 with a EX Order 26 § 4b1 and resident [R77] standing in front of the closet. The two residents were immediately separated. . . The supervisor interviewed [R20] who stated, Ex.Orde came into my room and was going through my closet. I took the sweatshirt away from Ex.Order 26.4(b)(tried to take it back and EX Order 26 § 4b1 my arm." Then the nurse walked in. Then [sic] supervisor then interviewed [R77], who was unable to provide information due to EX Order 26 § 4b1 status. [R20] denied any EX Order at the time of the incident. [R77] was placed on 1:1 close monitoring. . . IDC [Interdisciplinary Care Team] met to discuss the incident and believe that EX Order 26 did not occur. [R77] made contact with [R20's] arm while trying to obtain the sweatshirt back from Ex.Orde. [R77] intention was not to harm [R20] but to obtain the sweatshirt from Ex.Order 26

Interview with the Director of Nursing (DON) on 09/28/23 at 3:16 PM confirmed on 05/05/23 R77 entered R20's room and EX Order 26 § 4b1 R20's arm. The DON stated the facility investigated this resident-to-resident altercation between R77 and R20 and the IDC team did not believe EX Order 26 occurred.

2. Review of R57's "Admission Record," located in the "Profile" section of the EMR, revealed R57 was admitted to the facility on EX Order 26 § 4b1.

Review of R57's annual "MDS" assessment with an ARD of 05/15/23, located in the "MDS" tab of

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F 600	Continued From page 6	F 600		

the EMR, revealed R57 scored [redacted] of 15 on the BIMS which indicated [redacted].

Review of R57's "Nurses Notes" in the "Progress Notes" section of the EMR, dated 03/23/23 which specified R57 called a nurse to [redacted] room following a physical altercation between [redacted] and another resident (R79). Residents were immediately separated with no apparent injuries and no complaints of pain or discomfort.

Review of R79's "Admission Record," located in the "Profile" section of the EMR revealed R79 was admitted to the facility on [redacted].

Review of R79's annual "MDS" assessment with an ARD of 02/10/23 located in the "MDS" tab of the EMR, revealed R79 scored [redacted] of 15 on the BIMS which indicated [redacted].

Review of the facility's "Investigation and Summary," dated 03/24/23, of the resident-to-resident altercation between R57 and R79 revealed, on 03/23/23 "At approximately 5:45 PM, a nurse was called to [R57's] by resident [R57]. Resident [R57] stated that resident [R79] wandered into his/her room. [R57] stated that [redacted] attempted to coach [R79] out of [redacted] room by the arm when [R79] began hitting [R57] in the chest. The nurse immediately separated the two residents...No skin impairments or complaints of pain were noted upon assessment. [R79] was placed on 1:1 close monitoring. . . IDT [Interdisciplinary Team] met to discuss the incident and believe that [redacted] did not occur. Due to [R79's] cognitive impairment [redacted] did not understand what was occurring when [R57] attempted to redirect [R79] out of [redacted] room and

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F 600	Continued From page 7 became defensive due to the redirection." During an interview on 09/28/23 at 3:16 PM the DON confirmed that the 03/23/23 incident occurred and added that R79 is no longer EX Order 26 § 4b1 and has not been EX Order 26 § 4b1 since the incident of 03/23/23. Interview with the facility's Regional Nurse on 09/29/23 at 12:35 PM revealed the facility's expectation was residents would be free from EX Order 26 § 4 Review of the facility's undated policy titled, "Preventing Resident Abuse," indicated, "It is the policy of the facility that our facility will not condone any form of resident abuse and will continually monitor our facility's policies and procedures, training programs, systems, etc., to assist in preventing resident abuse."	F 600		
F 609 SS=D	NJAC 8:39-4.1(a)5 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		11/3/23

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F 609	Continued From page 8 EX Order 26 and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to send a final investigation report within 5-days to the Department of Health, as required for one (Resident (R)260) of one sampled resident reviewed for misappropriation of resident property in a total sample of 28. Findings include: Review of an undated facility policy titled, "Investigating Incidents of Theft and/or Misappropriation of Resident Property," revealed, " ...Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent ...It is the policy of Facility (sic) that all reports of theft or misappropriation of resident property be promptly and thoroughly investigated ..."	F 609	F Tag 609 Corrective Action Resident number 260 no longer resides at the facility. Identification of At-Risk Resident The facility has determined all residents have the potential to be affected by this deficient practice. Systemic Change An in-service education program was conducted with administration addressing completing and submitting reporting summary within appropriate timeframes (5 days from date of report to DOH). Facility policy on reporting was reviewed and updated to include the timeframe. An in-service on company policy	

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F 609	Continued From page 9 Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R260 was admitted to the facility on [redacted] and discharged on [redacted]. Review of the annual "Minimum Data Set (MDS)" assessment, located in the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of 06/14/23 revealed, R260 had a "Brief Interview of Mental Status (BIMS)" score of [redacted] out of 15 which indicated she was EX Order 26 § 4b1. Review of the 07/24/23 "Social Service Note" located in the "Progress Notes" tab of the EMR revealed, "Administrator, DON [Director of Nursing], Unit Coordinator, and myself met with R260 and [redacted] dgt (daughter) to discuss a number of issues. [redacted] dgt is requesting that she be called for changes/problems regarding her mother since she is POA (Power of Attorney.) R260 is agreeable to this ...R260 had reported money missing that [redacted] Kept (sic) in [redacted] pillow. R260 has two lock (sic) areas in [redacted] room. [redacted] e stated [redacted] prefers to keep [redacted] money on [redacted] because nursing has a key. Administrator suggested and dgt agreed they will buy a lock and only [R260] will have a key ..." The final "Investigation Report," summary, dated 08/02/23, provided by the Director of Nursing (DON), revealed, " ...On July 19th, 2023, the Administrator and Director of Nursing were made aware of the following incident. R260 reported to the social worker than (sic) [redacted] was missing $30 that she kept in a pillow case in her [redacted]. She stated she noticed the money missing Sunday morning, July 15th. The social worker immediately notified the Administrator for investigation.	F 609	regarding reportable events and appropriate timeframes will be conducted with administration. Quality Assurance The administration will maintain a log of all reportable events to ensure the appropriate timeframe was followed. Findings of this audit will be discussed weekly in morning meeting and will be reported to Corporate risk management weekly and quarterly to the QA committee meeting quarterly for 4 quarters or until consistent substantial compliance has been met.	

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F 609	Continued From page 10 During an interview on 09/27/23 at 3:37 PM, the DON confirmed the initial report was sent on 07/19/23 and the final report was sent to the Department of Health on 08/02/23 which was more than five days. The DON acknowledged the final "Investigation Report" was sent in late however, she wanted to have the meeting with the resident's daughter prior to sending in the report so everything was in order. NJAC 8:39-9.4(f)	F 609		
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 interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the accuracy of the "Minimum Data Set (MDS)" assessment for one resident in a total sample of 28 residents (Resident (R) 77) whose assessments were reviewed. The facility failed to accurately assess behaviors exhibited for R77. This failure placed the residents at risk of having unmet care needs and services. Findings include: Review of the RAI Manual 3.0, dated 10/19 revealed, " ...If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected ..."	F 641	F Tag 641 Corrective Action Resident 77 was reassessed and MDS dated 10-19-22 was reviewed and corrected to reflect resident 77 Ex.Order 26.4(b)(1) [redacted] Resident 77 care plan was updated to reflect Ex.Order 26.4(b)(1), entering other residents rooms and taking their belongings, pacing looking in other resident rooms, wandering into female rooms and attempting to Ex.Or staff members when confronted, stealing, etc& Identification of At-Risk Resident The facility has determined that all	11/3/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 Review of the "Admission Record" found on the "Profile" page of the electronic medical record (EMR) revealed R77 was admitted to the facility on Ex.Order 26 § 4b1 with diagnoses of Ex.Order 26 § 4b1 [redacted] Review of R77's behavior and medication administration notes found on the "Progress Notes" tab revealed the following entries: On 05/26/23 at 2:20 PM Behavior Note: "Resident noted entering other resident rooms and taking their belongings. During attempt at redirection, resident Ex.Order 26.4(b)(1) male aide." On 05/27/23 at 11:07 AM Medication Administration Note: "Resident was noted pacing corridors looking into other residents [sic] room. Resident was redirected back to Ex.Orde room multiple times where Ex.Or would remain for a short period then attempts to enter other residents [sic] room and steal there [sic] belongings." On 05/27/23 at 7:06 PM Medication Administration Note: "Resident wandering into female bedrooms and tried to Ex.Orde staff members when confronted." On 05/28/23 at 12:00 PM Medication Administration Note: "Resident noted entering other residents [sic] room and stealing there [sic] belongings." On 05/30/23 at 1:38 PM Behavior Note: "Resident noted pacing corridors looking into other residents [sic] room. Resident was redirected back to Ex.Order 26.4(b)(1) multiple times where Ex.Orde would	F 641	residents have the potential to be affected by this deficient practice. Systemic Change Any residents who initiated or received Ex.Order 26.4(b)(1) will be tracked daily and have updated care plans to reflect resident specific Ex.Order 26.4(b)(1). DON/designee will conduct an audit of 5 residents per week regarding assessment accuracy for 4 weeks, then 5 residents monthly for 3 months, then monthly with each quarterly review. All staff will be in-serviced regarding Ex.Order 26.4(b)(1). The MDS coordinator will be in-serviced regarding accuracy of assessments. Quality Assurance DON/designee will report findings of audit quarterly to the QA committee for 4 quarters or until substantial compliance has been met.	

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	315271	A. BUILDING _____ B. WING _____	C 09/29/2023

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F 641	Continued From page 12 remain for a short period then attempts to enter other residents [sic] rooms and steal there [sic] belongings." Review of R77's discharge- return anticipated "MDS" with an Assessment Reference Date (ARD) of [redacted], located in the "MDS" tab of the EMR, indicated, R77 exhibited [redacted] daily, but the assessment did not reflect that R77 was exhibiting [redacted]) or "other" [redacted] not directed toward others (including pacing and rummaging). During an interview on 09/29/23 at 8:30 AM, the MDS Coordinator (MDSC) reviewed R77's progress notes and [redacted] discharge "MDS" assessment. The MDSC stated, R77 had exhibited [redacted] and "other" behaviors including pacing, rummaging, and attempting to steal other resident's belongings that were not reflected on the resident's 05/30/23 "MDS." The MDSC stated she coded R77's [redacted] discharge "MDS" assessment inaccurately. NJAC 8:39-11.2(g)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		11/3/23

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F 656	Continued From page 13 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 656	F Tag 656	

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F 656	Continued From page 14 and review of facility policy, the facility failed to develop a comprehensive plan of care directing measurable goals and person-centered interventions for two (Residents (R)100 and R59) in a total sample of 28. The facility failed to develop specific care plan and person-centered interventions related to an Ex.Order 26.4(b)(1) [redacted] for R100, and failed to develop a person-centered care plan with interventions related activities of daily living (ADLs) for R59. These failures placed the residents at risk for unmet care needs and a diminished quality of life. Findings included: Review of an undated facility policy titled, "Care Plan, Comprehensive Person-Center," revealed, " ...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ...Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: ~ Services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. ~ Any specialized services to be provided as a result of PASARR [Pre-Admission Screening and Resident Review] recommendations and ~ Which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes. ~ builds on the resident's strengths; and ~ Reflects currently recognized standards of	F 656	Corrective Action Resident 100 care plan was updated to reflect any black box warning medications and side effects monitoring. Resident 59 care plan was updated to reflect Ex.Order 26.4(b)(1) interventions regarding washing Ex.Orde hair and Ex.Orde Kardex information was included and updated. Shower caps with dry shampoo will be utilized for resident 59 when Ex.Order 2 refuses to wash Ex.Order hair, Identification of At-Risk Resident The facility has determined that all residents have the potential to be affected by this deficient practice. Systemic Change IDT team conducted facility wide audit and revisions of all care plans and Kardex. All interdisciplinary care plan team members responsible for care plans will be re-educated on the facility policy and procedure for developing comprehensive care plans. The DON/designee will review all care plan and Kardex updates weekly in accordance with the care plan review schedule for 6 consecutive weeks and then monthly thoroughly review each quarterly MDS or with each significant change review over the next year. The audits will be completed to ensure that comprehensive care plans are developed for each resident and that information is transferred to resident Kardex for CNA awareness. Quality Assurance	

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F 656	Continued From page 15 practice for problem areas and conditions. ~ Services provided for or arranged by the facility and outlined in the comprehensive care plan are: Provided by qualified persons; culturally competent; and trauma-informed ..." The "Care Plan, Comprehensive Person-Centered" facility policy further revealed, " ...Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms ..." 1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R100 admitted to the facility on EX Order 26 § 4b1 [redacted] Review of the "Order Summary" located in the "Orders" tab of the EMR revealed the follow physician orders: EX Order 26 § 4b1 [redacted] Review of the quarterly "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 06/07/23 revealed R100 had a "Brief Interview of Mental Status (BIMS)" score of [redacted] out of 15 which indicated he was EX Order 26 § 4b1 [redacted]	F 656	DON/designee will review all audit records with QA committee quarterly for 4 quarters or until substantial compliance has been met.	

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F 656	Continued From page 16 According to the "Food and Drug Administration" online resource at "accessdata.fda.gov, revealed that [redacted] are "black box warning" medications. "A black box warning is the strictest and most serious type of warning that the FDA gives a medication. A black box warning is meant to draw attention to a medication's serious or life-threatening side effects or risks." Review of the updated "Behavior's Care Plan" located in the "Care Plan" tab of the EMR, dated 07/17/23, did not reveal a focus, measurable goal, or specific interventions for the use of the [redacted]. During an interview on 09/27/23 at 2:30 PM, the Director of Nursing (DON) was asked who was responsible for care plan development. The DON stated, "It used to be me and the MDS Coordinator and now we have unit managers who are starting to do some of them." The DON was asked if a resident is on [redacted] medication would you expect a care plan for the medication as it's a high-risk medication. The DON stated, "Yes, but we just put it on the "Skin Care Plan" to monitor for [redacted]." During an interview on 09/28/23 at 9:33 AM, the MDS Coordinator (MDSC) stated that [redacted] did not come up in the "Care Area Assessment" as a triggered problem therefore a care plan was not developed for the medication. 2. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed, R59 was admitted to the facility on [redacted] with diagnoses that included induced [redacted],	F 656		

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F 656	Continued From page 17	F 656		

EX Order 26 § 4b1 [redacted]

Review of the quarterly "MDS" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 08/08/23 revealed R59 had a "BIMS" score of [redacted] out of 15 which indicated [redacted] was EX Order 26 § 4b1 [redacted]

Review of the updated "Care Plan" located in the "Care Plan" tab of the EMR, dated 08/23/23 revealed no focus, measurable goal, or specific person-centered interventions related to ADL's including hair washing.

Review of the "Kardex (a care plan for nursing assistants with direction on how to care for residents)" located in the "Tasks" tab of the EMR revealed Ex.Order 26.4(b)(1) ADLs, based on the "MDS" assessment on how to care for R59.

During an initial observation on 09/26/23 at 10:00 AM, R59 was in [redacted] room and [redacted] hair appeared greasy and matted. R59 stated, Ex Order 26 § 4b1 [redacted]

During an interview on 09/28/23 at 9:12 AM, R59 was asked if [redacted] was getting [redacted] showers routinely. R59 stated, "EX Order 26 § 4b1 [redacted]

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F 656	Continued From page 18 EX Order 26." R59 further stated, "EX Order 26 § 4b1 [redacted] During an interview on 09/28/23 at 9:13 AM, Certified Nurse Assistant (CNA) 2 was asked about R59's ADLs. CNA 2 stated, EX Order 26 § 4b1 [redacted] " CNA 2 further stated that the facility has shower caps with the dry shampoo in them and her normal aide is good with Ex.Order they aren't great but if Ex.Order will let us, they are better than nothing." During an interview on 09/28/23 at 9:45 AM, MDSC was asked if there was an "ADL Care Plan" developed with resident-specific interventions. The MDSC stated, "No, not by itself." The MDSC was asked on the "Kardex" there is no information for the aides to document how independent, assisted, or what support is needed or what her specific needs were related to ADLs. The MDSC stated, "Yes, I am aware that it's not in the computer. Our other sister facilities have that tab, but we don't, and I don't know who it works." NJAC 8:39-11.2(e)	F 656		
F 812 SS=F	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.	F 812		11/3/23

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F 812	Continued From page 19 (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, staff interview, and facility policy review, the facility failed to keep the kitchen's convection oven, stove spill pan, large manual can opener and base attachment, large electric mixer, and ice machine clean. Additionally, the date opened on bread products was not labeled with an use by date. This failure had the potential to affect 107 residents who consumed food prepared in the facility's kitchen. Findings include: Review of the facility's policy titled, "Sanitation," dated January 2023, indicated, "All kitchens, kitchen areas and dining areas shall be kept clean. . . All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions." Review of the facility's policy titled, "Dating and Labeling," dated January 2023, indicated, "It is the policy of this facility for the kitchen to assure	F 812	Corrective Action: On 9/26/2023 the DM immediately instructed staff to clean the heavy accumulation of blackened and dried food spills from the interior of the convection oven and the inside of doors and the stove tops. The large manual can opener was removed and cleaned removing all food substances from the blade and the large electric mixer underside was cleaned. The scoops with accumulated nesting water were taken out of service while staff washed, rinsed, and sanitized. All bread with no with no expiration date or use by date were discarded immediately. The interior of the ice machine was washed and sanitized immediately. Identification of Residents at Risk: All residents who eat food from the kitchen have the potential to be affected. These residents can be identified by	

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F 812	Continued From page 20 food safety by maintaining proper dates and labels to all food products. . . All food must have a receive date as well as a use by date." 1. Observation on 09/26/23 from 9:45 AM to 10:30 AM, during the initial kitchen inspection with the Dietary Manager (DM) present, revealed the following: a. The kitchen's convection oven was unclean with heavy accumulated blackened and dried food spills on their interior cooking compartment and on the inside of their doors. b. The stove top's spill pan was unclean with a heavy accumulation of burnt on food spills. c. One of the kitchen's large manual can openers, which was attached to a food preparation table, was unclean with accumulated food substances on its blade and metal table base attachment. d. Eight serving scoops, that were stored and ready for use, were stored wet with accumulated pooled water in them. e. The kitchen's large electric mixer was unclean with dried food substances on the mixer's underside of the mixer's head and the mixer's base that could be wiped away with a paper towel. f. The interior of the kitchen's ice machine contained a black colored substance, which appeared to be mold, which could be wiped away with a paper towel. g. Observation on 09/26/23 from 9:45 AM to 10:30 AM, during the initial kitchen inspection with	F 812	facility census. Systemic Change: Beginning 9/26/2023 Dietary Staff were all in-service on how to properly clean the ovens, stove tops, can openers and mixer. For one year the Food Service Director will document a weekly audit to ensure that all cooking equipment, mixer and can openers remain clean. Beginning on 9/26/2023, Dietary Staff were in-serviced regarding labeling and dating food items with a received and used by date. Signs have been posted in the kitchen as visual reminders. In addition, the dietary staff was in-serviced on procedure for properly air drying all equipment. For one year, Food Service For one year the Food Service Director will document a weekly audit to ensure all equipment is properly air-dried and all stored food is properly labeled and dated according to the facility policy. On 9/27/2023 the cleaning schedule was revised and changed to ensure cooking equipment, mixer, ice machine, and can opener remain clean. Dietary Staff were in-serviced on this change as well as the proper procedure for cleaning kitchen equipment. Quality Assurance: A quarterly review of dietary audits will be conducted and documented by the Food Service Director for one year. 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	

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F 812	Continued From page 21 the DM present, revealed four packages of opened sliced bread, two packages of opened hamburger buns, and two packages of opened hot dog buns, stored on bread racks and ready for use, which did not have a use by or expiration date on their package. Interview with the DM, during the initial kitchen inspection on 09/26/23 from 9:45 AM to 10:30 AM, the DM confirmed the kitchen's convection oven, stove top's spill pan, large manual can opener, electric mixer, ice machine and eight serving scoops were unclean and/or stored wet. The DM stated food preparation and service equipment should be kept clean and dry. The DM further confirmed the eight opened packages of bread products that were stored and ready for use in the kitchen did not have a use by or expiration dates on their package. The DM stated when bread products are delivered to the kitchen staff are expected to date the bread. NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812	Assurance committee at their quarterly meeting for one year.	
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in	F 836		11/3/23

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F 836	Continued From page 22 such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an 855 application for facility name change was done in a timely manner. This failure had the potential to create confusion for not knowing the current name of the facility. Findings include: On 09/26/23 at 9:20 AM, the survey team entered the facility. The front door of the facility and all signs leading to the facility indicted that the name of the facility was "Autumn Lake Healthcare at Memorial Bridge" despite documentation, provided by the State of New Jersey indicating the name of the facility was "Carney's Point Rehabilitation and Nursing Center."	F 836	F Tag 836 Corrective Action The 855 form was completed and submitted. Identification of At-Risk Resident The facility has determined that all residents have the potential to be affected by this deficient practice. Systemic Change Corporate compliance will ensure all appropriate licenses, permits and certifications required for operation under state and federal regulation will be	

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AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 23 Upon entrance, the survey team was met by the Human Resources Director (HR) who was asked about the difference in the name of the facility as compared to what the survey team had. The HR Director was then asked if there was an 855-application on file, indicating the State of New Jersey had acknowledged the name change. The HR Director stated she did not know what an 855-application was and to ask the Administrator. During the entrance conference on 09/26/23 at 9:44 AM, the Administrator was asked if he had an 855-application for facility name change which had been sent to the "Medicare Administrator Contractor (MAC)." The Administrator stated, "It is a DBA (doing business as), and we are under the same license number." The Administrator further stated that he did not know if an 855-application had been sent but would check with the corporate office. On 09/26/23 at 4:00 PM, the Administrator provided the survey team with the "New Jersey Department of Health Division of Certificate of Need and Licensing" which indicated that the facility "Carney's Point Rehabilitation and Nursing Center LLC is hereby licensed to operate as Autumn Lake Healthcare at Memorial Bridge." The "Certificate" was dated 09/26/23 at 3:56 PM During an interview on 09/26/23 at 4:30 PM, the Administrator stated, "We had paid an outside company to do this, and I guess they didn't do it." NJAC 8:39-2.4(e)2 NJAC 8:39-3.1(b)	F 836	obtained and maintained within the required timeframe and kept available for inspections as indicated. Quality Assurance When a name change is initiated, or licensure issue the administrator will confirm and verify license standing with appropriate authorities immediately. The findings will be reviewed by the QA committee as they arise over the next 4 quarters.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24	F 880		
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: §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;	F 880		11/3/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure staff followed enhanced barrier precautions (EBP) for one of one resident observed (Resident) (R) 72) during medication pass. Findings include: Observation during medication pass on 09/27/23	F 880	F Tag 880 Corrective Action LPN2 received immediate counseling on EBP and multi-use equipment. LPN 2 received immediate in-servicing regarding EBP and decontamination of multi-use equipment. The stethoscope and med cart were	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. BUILDING _____ B. WING _____	C 09/29/2023

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AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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F 880	Continued From page 26 at 1:32 PM revealed Licensed Practical Nurse (LPN) 2 placed the medication cart by the door to R72's room. Posted on the wall by the entrance to R72's room was a sign that indicated R72 was on Ex.Order 2[redacted]. The signage revealed, "Staff must wear gloves and gown for the following high contact resident care activities; Ex.Order 26.4(b)(1)[redacted] LPN2 removed a stethoscope from a drawer in the medication cart, placed two-barrel syringes on top of the cart and removed a 10 milligram (mg) tablet of Ex.Order 26.4(b)(1) R72's bubble pack. LPN2 entered R72's room without donning (putting on) a gown and placed all the gathered supplies on the top of R72's over the bed table without cleaning the table or using a barrier. After doffing gloves and performing hand hygiene, LPN 2 picked up the potentially contaminated stethoscope and placed it back in the drawer of the medication care. During an interview with LPN2 at 1:45 p.m. on 09/27/23 when questioned about a gown not donned prior to entering R 72's room and potentially contaminating the stethoscope, LPN 2 replied, "I was going to check it [placement of the Ex.Order 26.4(b)[redacted] with the stethoscope but decided to Ex.Order 26.4(b)[redacted] instead. Yes I forgot to clean it off. I should have worn a gown. I didn't think of that." During an interview with the Director of Nursing (DON) at 12:30 PM on 09/29/23, the above observations of LPN2's breaks in infection control were reviewed. The DON indicated that he/she was aware and stated, "I've already done some education with that LPN." Review of the facility policy titled "Enhanced Barrier Precautions" updated June 2023	F 880	cleaned immediately. Identification of At-Risk Resident The facility has determined that all residents have the potential to be affected by this deficient practice. Systemic Change All nursing personnel will receive in-servicing on Enhanced barrier precautions and decontamination of multi-use equipment. All nursing personnel will policy for enhanced barrier precautions and decontamination of multi-use equipment. Quality Assurance The IP will complete competencies regarding enhanced barrier precautions and decontamination of multi-use equipment with 5 nursing personnel weekly x□s 4 then 5 random nursing staff monthly over the next year. Findings will be reported quarterly to the QA committee for 4 quarters or until substantial compliance has been met.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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F 880	Continued From page 27 revealed, "Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. . . a. Gloves and gowns are applied prior to performing the high contact resident care activity." g. The use of gown and gloves, "device care or use (central line, urinary catheter, feeding tube)." NJAC 8:39-19.4(a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061702	A. BUILDING: _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGI	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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S 000	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.	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 facility document review it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. 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:	S 560	F Tag S560 Corrective Action The following corrective actions have been accomplished for the identified deficiency: Efforts to hire more facility staff to allow us to have adequate or more than adequate staff to serve our residents have been ramped up. In meantime the facility will utilize agencies to fill open slots in the schedule. Identification of At-Risk Resident All residents have the potential to be affected by the deficient practice of not meeting the NJ staffing requirement ratios. Systemic Change The following measures have been put	11/3/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061702	A. BUILDING: _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGI	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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S 560	Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA staffing for residents on day shifts as follows: 1.For the week of Complaint staffing from 12/11/2022 to12/17/2022, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -12/17/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. 2. For the week of Complaint staffing from 03/19/2023 to 03/25/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -03/19/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. 3. For the 2 weeks of staffing prior to survey from 09/10/2023 to 09/23/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -09/10/23 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs -09/17/23 had 10 CNAs for 107 residents on the	S 560	into place to prevent the deficient practice from recurring: Advertisements/ job postings for CNAs have been posted on hiring platforms, social media websites as well as flyers posted. Incentives are offered to CNAs to work extra shifts such as gift cards, bonuses, and raffles. Many agencies are being utilized to fill in any open shifts. Bonuses are also being offered to agency staff to pick up shifts. Hiring and recruitment efforts now include referral bonuses, sign-on bonuses, weekend bonuses amongst other incentives to bring in good staff and quickly. Quality Assurance The DON or designee will review staffing levels daily to ensure that we have adequate staffing x□s 1 year. The administrator or designee will review the staffing schedule weekly to monitor the staffing ratio on all shifts weekly x 90 days. The administrator will report findings of the audits to the QA committee on a quarterly basis x 4 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061702	A. BUILDING: _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGI	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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S 560	Continued From page 2 day shift, required at least 13 CNAs.	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 Y2	DATE OF REVISIT Y3
315271	A. Building B. Wing	11/14/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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 F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 11/03/2023	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 9/29/2023	☐ 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
315271 Y1	A. Building B. Wing Y2	11/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0600	Correction	ID Prefix F0609	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	11/03/2023	LSC	11/03/2023	LSC	11/03/2023
ID Prefix F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0812	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	11/03/2023	LSC	11/03/2023	LSC	11/03/2023
ID Prefix F0836	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.70(a)-(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	11/03/2023	LSC	11/03/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/29/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061702		11/14/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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 11/03/2023	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
9/29/2023

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

EVENT ID: 209O12

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. BUILDING **01** B. WING _____	C **09/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	**201 FIFTH AVENUE** **PENNS GROVE, NJ 08069**

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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 09/28/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/28/23 and the facility and 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. Carneys Point Rehabilitation and Nursing Center is a one-story, Type V protected building that was built in 1989. The facility is divided into seven smoke compartments. The diesel generator powers 50% of the building per the Maintenance Director. The number of occupied beds were 111 out of 161 at the time of the survey. .	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in	K 271		11/10/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/19/2023

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. BUILDING **01** B. WING _____	C **09/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	**201 FIFTH AVENUE** **PENNS GROVE, NJ 08069**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 271	Continued From page 1 elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain means of egress free of all obstructions as required by NFPA 101 Life Safety Code (2012 Edition), Section 7.1. This deficient practice had the potential to affect 48 residents. Findings Include: An observation on 09/28/23 at 1:26 PM of the exit discharge, located by Room 57, revealed multiple weeds several feet in length were blocking the exit ramp. During an interview at the time of the observation, the Maintenance Director confirmed the weeds were blocking the exit ramp. He stated the facility was unaware of the weeds, and that landscaping personnel had missed them. NJAC 8:39-31.2(e) .	K 271	K 271 Corrective Action The weeds were removed from the exit ramp. Identification of At-Risk Resident The facility determined that all C wing residents have the potential to be affected by this deficient practice. Systemic Change All exit ramps facility wide were inspected for any obstructions. The maintenance director will ensure that all exit ramps are maintained free of obstructions weekly for one year. Quality Assurance The maintenance will report the findings to quarterly QA committee for 4 quarters or until substantial compliance has been met.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321		11/10/23

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	315271	A. BUILDING **01** B. WING _____	C **09/29/2023**

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AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	**201 FIFTH AVENUE** **PENNS GROVE, NJ 08069**

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K 321	Continued From page 2 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to separate hazardous areas from other parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. This deficient practice had the potential to affect 56 residents. Findings Include: An observation on 09/28/23 at 12:31 PM revealed the door to the Soiled Linen Room, located in the	K 321	K 321 Corrective Action The soiled linen room door was repaired and now latches. The maintenance storage room now has door closures on both doors. The fire rated wall in the laundry room was sealed. Identification of At-Risk Resident The facility determined that all A wing	

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AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	**201 FIFTH AVENUE** **PENNS GROVE, NJ 08069**

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K 321	Continued From page 3 corridor by Room 7, failed to close in the door frame and latch. The self-closing device was functioning, but the door was prevented from closing and latching by the door frame. An observation on 09/28/23 at 12:35 PM of the Maintenance Storage Room, located in the Corridor by Room 2, revealed door closers were not installed on the doors. Combustible materials (boxes, paper products, combustible construction materials) were observed in the room, which exceeded 50 square feet in size. An observation on 09/28/23 at 12:55 PM revealed the fire-rated wall, located in the Laundry Room, had an unsealed six-inch pipe penetration at the corridor wall near the vending machines. The Laundry Room exceeded over 100 square feet in size. During an interview at the time of the observation, the Maintenance Director confirmed the door failed to latch and close. He stated the facility was unaware of the door was not closing and latching in the door frame. During an interview at the time of the observation, the Maintenance confirmed door closers were not installed on the Maintenance Storage Room doors. He stated the facility was unaware the door closers were not on the doors to the hazardous area. During an interview at the time of the observation, the Maintenance Director confirmed the unsealed pipe penetration in the Laundry Room. He stated the facility was not aware of the unsealed penetration in the rated wall.	K 321	residents have the potential to be affected by this deficient practice. Systemic Change The following doors will be inspected monthly by maintenance for proper closure: A. Boiler and fuel-fired heater rooms B. Laundries (larger than 100 square feet) C. Repair, maintenance, and paint shops D. Soiled linen rooms (exceeding 64 gallons) E. Trash collection rooms F. Combustible storage rooms/spaces (over 50 square feet) The maintenance director will ensure that all smoke resistant partitions are fully sealed quarterly. Quality Assurance The maintenance director will submit finding of the monthly door inspections and quarterly smoke resistant partitions quarterly to the QA committee for 4 quarters or until substantial compliance has been met.	

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K 321	Continued From page 4 NJAC 8:39-31.1(c). 31/2(e) .	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to maintain the range hood fire protection system in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of	K 324	K 324 Corrective Action The hood system in the kitchen loose caulk hanging above the cooking	11/10/23

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K 324	Continued From page 5 Commercial Cooking Operations (2011 Edition). The deficient practice had the potential to affect all residents. An observation on 09/28/23 at 1:00 PM of the hood system, located in the Kitchen above the cooking equipment, revealed loose caulk hanging above the cooking equipment and unsealed gaps that were not grease tight. During an interview at the time of the observation, the Maintenance Director confirmed the peeling caulk and the gaps in the hood system. He stated the facility was unaware of the peeling caulk and gaps in the hood system. NJAC 8:39-31.1(c), 31.2(e) NFPA 96 .	K 324	equipment and unsealed gaps□the loose caulk was removed and replaced, and gaps were filled and made grease tight. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The maintenance director will inspect the hood quarterly for loose or missing caulk and gaps that are not grease tight in the hood system. Quality Assurance The maintenance director will report the findings quarterly to the QA committee quarterly x□s 4 quarters or until substantial compliance has been met.	
K 331 SS=E	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: .	K 331	K 331	11/10/23

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K 331	Continued From page 6 Based on observations and interviews, the facility failed to ensure interior wall finishes had a flame spread rating in accordance with NFPA 101 Life Safety Code (Life Safety Code) 2012 Edition, Section 19.3.3. This deficient practice had the potential to affect 22 residents. Findings include: An observation on 09/28/23 at 12:32 PM revealed the interior wall, located in the exit hallway near the Laundry Room, was covered with peeling wallpaper with an unknown flame spread rating. An observation on 09/28/23 at 4:00 PM revealed the interior wall, located in the Admissions Office near the Lobby, was covered with wood paneling with an unknown flame spread rating. During an interview at the time of the observations, the Maintenance Director and Administrator stated they did not know the flame spread rating of the wall finishes and were unable to provide documentation to indicate the rating. NJAC 8:39-31.2(e) .	K 331	Corrective Action The peeling wallpaper located in the exit hallway near the laundry room was removed. The wood paneling located in the admissions office was removed and walls repaired and painted. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The maintenance will monitor during daily rounds for any loose peeling wallpaper. The maintenance director will ensure that any materials utilized in the facility are fire rate appropriately. Quality Assurance The maintenance director will report the findings to the QA committee quarterly x□s 4 quarters or until substantial compliance has been met.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353		11/10/23

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K 353	Continued From page 7 maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) Section 5.2. This deficient practice had the potential to affect all 111 residents. Findings include: An observation on 09/28/23 at 1:45 PM revealed the sprinkler head, located in the closet of Room 70, had excessive corrosion buildup. An observation on 09/28/23 at 12:36 PM revealed the sprinkler head, located behind the dryers in the Laundry Room, had excessive lint build up. An observation on 09/28/23 at 1:40 PM revealed the electric fire pump had excessive corrosion on all components of the piping and valves. There was a hole in the base of the main pipe at least four inches in diameter.	K 353	K 353 Corrective Action The sprinkler head with corrosion was replaced. The sprinkler head in laundry was cleaned of excessive lint build up. The electric fire pump cleared of the corrosion and refinished. The pipe was replaced. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The maintenance director will accompany the sprinkler inspector and will review and follow up recommendations for timely repairs. Quality Assurance The maintenance director will report the findings to the QA committee quarterly	

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K 353	Continued From page 8 During an interview at the time of the observations, the Maintenance Director confirmed the sprinkler head in Room 70 had excessive corrosion buildup, the sprinkler head in the Laundry Room had excessive lint build up and the corrosion and hole on the fire pump. He stated the facility was aware of the deficient practice which was brought up at the quarterly sprinkler inspection conducted earlier in the week. The most recent Quarterly Sprinkler Report was not available for review during the survey. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	x□s 4 quarters or until substantial compliance has been met.	
K 372 SS=F	. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers	K 372	K 372 Corrective Action	11/10/23

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K 372	Continued From page 9 were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 111 residents. Findings include: An observation on 09/28/23 at 11:52 AM revealed the smoke barrier, located in the corridor by the Director of Nursing's Office, had a three-inch unsealed gap along at the top of the wall above the ceiling tile. Exposed wood framing was also observed. An observation on 09/28/23 at 11:55 AM revealed the smoke barrier, located in the Director of Nursing's Office, had a four-inch unsealed gap at the top of the wall and a six-inch unsealed over-cut around a conduit penetration above the ceiling tile. An observation on 09/28/23 at 12:00 PM revealed the smoke barrier, located in the corridor by Rooms 24 and 27, had a six-inch unsealed gap in the wall above the ceiling tile. An observation on 09/28/23 at 12:05 PM revealed the smoke barrier, located in the corridor by the Activities Room, had ten-inch unsealed gaps in the wall above the ceiling tile. The AC unit mounted on the wall had a 12-inch over-cut around the black hose penetrations. An observation on 09/28/23 at 1:09 PM revealed the smoke barrier, located in the corridor by Room 54, had an eight-inch unsealed gap in the	K 372	The DON office unsealed gaps, room 24 and 27 unsealed gaps, activities room unsealed gaps, The AC unit mounted on the wall with black hose penetration, corridor by room 54 unsealed gaps, corridor by room 64 unsealed gaps, Dining room unsealed gaps, room 70 unsealed gaps were repaired. Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change The maintenance director will ensure quarterly if any facility work has been performed that no penetration were made and if identified will correct immediately. Quality Assurance The maintenance director will report the findings to the QA committee quarterly x□s 4 quarters or until substantial compliance has been met.	

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K 372	Continued From page 10 wall above the ceiling tile. An observation on 09/28/23 at 1:22 PM revealed the smoke barrier, located in the corridor by Room 64, had a three-inch unsealed gap in the wall above the ceiling tile. In the Dining Room, a three-inch diameter hole was unsealed above the ceiling tile near the corner of the room at the shared corridor wall. An observation on 09/28/23 at 1:43 PM revealed the smoke barrier, located in Room 70, had a four-inch unsealed gap in the wall above the ceiling tile along the top of the wall. During an interview at the time of the observations, the Maintenance Director confirmed the unsealed openings and penetrations in the smoke barriers. He stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e) .	K 372		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		11/10/23

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K 918	Continued From page 11 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the Emergency Power Supply (EPS) was equipped with a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the EPS where so installed, or elsewhere on the premises where the prime mover is located outside the building in accordance with NFPA 110 Emergency and Standby Systems (2010 Edition) 5.6.5.6. This deficient practice had the potential to affect all 111 residents. Findings include:	K 918	K 918 Corrective Action The maintenance director had certified electricians come out to install a remote manual stop station. Identification of At-Risk Resident None of the residents were affected by this deficient practice, however it does have the ability to affect all the residents of the facility.	

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K 918	Continued From page 12 An observation on 09/28/23 at 1:31 PM revealed there was not a remote manual stop station installed for the EPS on the premises where the prime mover was located outside of the building. During an interview at the time of the observation, the Maintenance Director confirmed the EPS did not have a remote manual stop station. NJAC 8:39-31.2(e) NFPA 99, 110 .	K 918	Systemic Change The maintenance director and his staff have been in-serviced on the new remote manual stop station for the generator. Quality Assurance The Maintenance director will report quarterly if any new issues arise with the new manual stop station at the quarterly QAPI meeting.	

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
315271 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT MEMORIAL BRIDGE	201 FIFTH AVENUE PENNS GROVE, NJ 08069

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 K0271	11/10/2023	LSC K0321	11/10/2023	LSC K0324	11/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0331	11/10/2023	LSC K0353	11/10/2023	LSC K0372	11/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	11/10/2023	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	

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	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO