STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. BUILDING _____ B. WING _____	C 12/20/2024

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint: NJ181445 Census: 161 Sample:4 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		

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

Electronically Signed | 01/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061702	A. BUILDING: _____ B. WING _____	C 12/20/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint: NJ181445 Census: 161 Sample:4 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documents on 12/20/2024, it was determined that the facility failed to ensure staffing ratios were met for 4 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	1) 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. 2) All residents in the Facility have the potential to be affected by the deficient practice.	1/21/25

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061702	A. BUILDING: _____ B. WING _____	C 12/20/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to complaint survey from 12/01/2024 to 12/14/2024, the facility was deficient in CNA staffing for residents on 4 of 14-day shifts as follows: On 12/02/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. On 12/03/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. On 12/05/24 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 12/13/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs.	S 560	3) The Administrator and Director of Nursing shall continue to review the daily Certified Nursing Assistant (CNA) staffing schedules to ensure compliance with the state's minimum CNA staffing requirement. Furthermore, the facility will review its recruitment program and hiring efforts to attract and hire CNAs, as evidenced by placing advertisements on Indeed, contacting recruitment agencies, and offering referral bonuses to current staff for securing additional staff. The center shall offer overtime, incentive pay, and bonuses to current staff when a staffing shortage is identified or occurs throughout the day and/or week. The facility staffing coordinator will work with sister facilities staffing coordinator for CNAs/License Nurses for daily backup when call outs occur. CNAs will receive free meals and incentives on top of their regular pay. Facility will offer overtime, bonuses or incentives to Licensed Nurses to work as Nursing Assistant when warranted. The facility also maintains an agreement with nursing staffing agencies in the event of any staffing shortage. Meeting conducted on Tuesday with Staffing Company, HR, and DON to discuss current needs. 4) The Administrator and Director of Nursing or designee shall review/audit the	

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	061702	A. BUILDING: _____ B. WING _____	C 12/20/2024

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

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S 560	Continued From page 2	S 560	Certified Nursing Assistant (CNA) staffing schedule daily for 4 weeks, then monthly x 2 months and then quarterly for 3 quarters to determine compliance with the state's minimum CNA staffing requirement. The Administrator shall continue to monitor the facility's recruitment and retention practices to identify potential areas of improvement. The results of these audits will be submitted monthly to the Quality Assurance and Performance Improvement (QAPI) committee monthly for the next 6 months. This will be a part of the Quarterly Quality Assurance Program ongoing. Staffing Coordinator and DON will check staffing sheets the next day and initiate progressive discipline for those who are calling out. Weekend call outs will mandatorily be made up the following weekend. This will be ongoing.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061702 (Y1)	A. Building B. Wing (Y2)	1/23/2025 (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 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 01/21/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: D41Y12

STATE FORM: REVISIT REPORT (11/06)