STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	**438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079**

(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 #: NJ177309 Census: 97 Sample Size: 3 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 | 10/18/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061703	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

(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 #: NJ177309 Census: 97 Sample Size: 3 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ177309 Based on interviews and review of facility documents on 09/26/2024, it was determined that the facility failed to ensure staffing ratios were met for 12 of 14-day shifts and deficient in total staff for residents on 2 of 14 overnight shifts reviewed. This deficient practice had the potential to affect all residents.	S 560	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.	10/26/24

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

Electronically Signed | 10/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061703	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

(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 Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: 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 09/8/2024 to 09/21/2024, the facility was deficient in CNA staffing for residents on 12 of 14-day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: On 09/08/24 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs. On 09/09/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. On 09/10/24 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. On 09/11/24 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. On 9/12/24 had 10 CNAs for 92 residents on the	S 560	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 into place to prevent the deficient practice from recurring: Additional agencies have been contracted to attain the appropriate staff rations for the facility census. Advertisement/Job postings for staff have been posted on hiring platforms and social media websites. Incentives are offered to Nurses to work extra shifts such as gift cards and bonuses. Many agencies are being utilized to fill in any open shifts. Bonuses are also being offered to agency staff to pick up shifts. Hiring and recruitment efforts now include referral bonuses, sign-on bonuses, weekend bonuses amongst other incentives to bring in good staff and quickly. Tap check payout system implemented to staff to receive instant pay as incentive to employing more staff. Overtime is made available to all current employees. Quality Assurance: The DON or designee will review staffing levels daily to ensure that we have adequate staffing. Findings will be reported to the administrator daily and reviewed with the QA committee quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061703	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 day shift, required at least 11 CNAs. On 09/13/24 had 6 total staff for 92 residents on the overnight shift, required at least 7 total staff. On 09/14/24 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. On 09/15/24 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs. On 09/16/24 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs. On 09/17/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 09/18/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 09/19/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 09/20/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. On 09/21/24 had 6 total staff for 100 residents on the overnight shift, required at least 7 total staff.	S 560	until substantial compliance is obtained. The administrator or designee will review staffing schedule weekly to monitor the staffing ration on all shifts weekly x 90 days. The administrator will report findings to the QA committee on a quarterly basis x 4 quarters.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061703 Y1	A. Building B. Wing Y2	10/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SALEM COUNTY	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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 10/26/2024	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	
9/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO