STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	**113 ROUTE 73 , VOORHEES, New Jersey, 08043**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint #: NJ00183386/398980, NJ00183423/398981, 2670006 Survey Dates: 12/9/25 Census: 115 Sample Size: 5 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 COMPLAINT VISIT.	F0000		01/16/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F0842	Corrective Action Resident #4 and Resident #5 records were immediately reviewed by the Director of Nursing and Unit manager Missing documentation related to [NJ Exec Order 2] and [NJ Exec Order 26.4b1] care was addressed through staff re-education by staff development on 1/20/2026 Resident #5 [NJ Exec Order 2] documentation was reviewed, and nursing staff were re-educated by staff development on required documentation elements, including time of departure, destination, reason for transfer, and return time. On 1/20/2026 Identification of At-Risk Resident The facility determined that all residents have the potential to be affected by this deficient practice, this can be identified by reviewing the resident's medical records. Systemic Change All CNA's, licensed nurses, and Unit Mangers were	01/20/2026

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

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

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F0842 SS = D	Continued from page 1 (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and	F0842	Continued from page 1 re-educated by staff development on: *Mandatory documentation of toileting, bowel and bladder continence/incontinent care every shift *Prohibition of blank entries in the electronic record *Nursing responsibility to verify CNA documentation daily *Required documentation when a resident is sent out of the facility, including time of transfer, reason for transfer, destination, and return time on 1/20/2026 A Universal transfer documentation in-service was conducted by staff development for all licensed personnel emphasizing accountability and regulatory expectations Unit managers will review CNA documentation and universal transfer forms for anyone transferred out daily in morning clinical meeting and report findings to Director of Nursing. The facility reinforced its charting and documentation and universal transfer form policies with all clinical staff by staff development on 1/20/2026 Quality Assurance The director of nursing/designee will audit 5 resident records weekly for 12 weeks, then monthly for 9 months, to ensure: *Complete CNA documentation of all ADLs *No blank entries in the electronic medical record The director of nursing/designee will review the transfers out of the facility the next day in morning clinical meeting for completion of the universal transfer form, the transfer includes all information and then upload to misc. in pcc. The Director of nursing will report all audit findings monthly to QAPI committee and Quarterly to QAA committee over the next 12 months.	01/20/2026

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F0842 SS = D	Continued from page 2 resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: C #: NJ00183386/398980, 2670006 Based on observation, interview, medical record review, and review of other pertinent facility documentation on 12/9/25 and 12/10/25, it was determined that the facility failed to consistently document and maintain a complete medical record regarding [redacted] & [redacted] care for residents in accordance with the facility's policy and standard of care. This deficient practice was identified for 2 of 2 residents (Resident #4 and Resident #5) reviewed. The facility also failed to document when a resident was [redacted] of the facility for further evaluation after an [redacted] of a [redacted] This deficient practice was identified for 1 of 2 residents (Resident #5) reviewed and was evidenced by the following: 1. According to the Admission Record (AR) Resident #4 was admitted with diagnoses that included but were not limited to: [redacted], and [redacted]. The comprehensive Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed a Brief Interview of Mental Status (BIMS) of [redacted] out of 15, which indicated that the resident was [redacted]. Further review of the MDS indicated that the resident [redacted] with [redacted]. Review of Resident #4's Baseline Care Plan, revealed that the resident [redacted] a [redacted] with [redacted]. Review of Resident #2's DSR and progress notes (PN) for [redacted] lacked any documentation about the care that was provided to the resident on the following dates: [redacted] -Day Shift (7 AM – 3 PM): [redacted]	F0842	Continued from page 2 Any trends of non-compliance will result in immediate corrective counseling and re-education. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	01/20/2026

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F0842 SS = D	Continued from page 3 -Evening Shift (3 PM – 11 PM): NJ Exec Order 26.4b1 -Night Shift (11 PM – 7 AM): NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 -Day Shift (7 AM – 3 PM): NJ Exec Order 26.4b1 -Evening Shift (3 PM – 11 PM): NJ Exec Order 26.4b1 -Night Shift (11 PM – 7 AM): NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 -Day Shift (7 AM – 3 PM): NJ Exec Order 26.4b1 -Evening Shift (3 PM – 11 PM): NJ Exec Order 26.4b1 -Night Shift (11 PM – 7 AM): NJ Exec Order 26.4b1 2. According to the Admission Record (AR) Resident #5 was admitted with diagnoses that included but were not limited to: NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26. NJ Exec Order 26.4b1 The comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, revealed a Brief Interview of Mental Status (BIMS) of NJ Ex out of 15, which indicated that Resident #5 was NJ Exec Order 26.4b1 NJ Exec Or. Further review of the MDS indicated that the resident NJ Exec Order 26.4b1 with NJ Exec Order 2 NJ Exec Order 2 and was NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1. Review of Resident #5's Baseline Care Plan, revealed that the resident NJ Exec Order 26 a NJ Exec Order 26.4b1 NJ Exec Orc with NJ Exec Order 26 Review of Resident #5's DSR and progress notes for NJ Exec Order 26.4b1 lacked any documentation to show that care was provided to the resident on the following dates: NJ Exec Order 26.4b1 -Evening Shift (3 PM – 11 PM): NJ Exec Order 26 NJ Exec Order 26.4b1 -Evening Shift (3 PM – 11 PM) NJ Exec Order 26.4 NJ Exec Order 26.4b1	F0842		01/20/2026

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F0842 SS = D	Continued from page 4 -Evening Shift (3 PM – 11 PM): [redacted] Further review of the Resident #5's medical record revealed an incident report (IR) dated [redacted] at 12PM, which stated that the resident was [redacted] of the [redacted] for further evaluation. The record stated, "At the time of the event, the resident had already been [redacted] ..." A corresponding post [redacted] summary from the [redacted] facility provider confirmed that the resident was evaluated at [redacted] facility on [redacted]. A review of Resident #5's Universal Transfer Form (UTF) dated [redacted], did not include the time of [redacted]. A review of Resident #5's PN revealed a note dated [redacted] at 12:49 PM, which indicated that the resident [redacted] to the facility. Further review of the PN did not indicate when the resident [redacted] the facility. During interview on 12/9/25 at 6:59 AM, with Licensed Practical Nurse (LPN #1), the [redacted] stated that Certified Nursing Assistants (CNA) were responsible for documenting [redacted] care in the electronic medical record. LPN #1 stated that documenting this was important because it captured the efforts being made to ensure that residents were free from [redacted] and [redacted] LPN #1 further stated that there should be no blanks, and that nurses and supervisors were responsible for ensuring that the CNAs are documenting. During interview on 12/9/25 at 11:04 AM with the Unit Manager (UM #1), she stated that CNAs were primarily responsible for monitoring residents for NJ Exec Order 26.4b1 and that they were to document in the electronic system. UM #1 stated that documentation was important to show that efforts were being made to prevent [redacted]. UM #1 stated that it was the responsibility of the [redacted] to ensure that documentation was completed. During an interview on 12/9/25 at 1:14 PM with the U.S. FOIA (b)(6)), the [redacted] stated that CNAs were primarily responsible for monitoring residents for incontinent care and that they were to document in the electronic system. The [redacted] further stated that the purpose of this documentation was to reflect that care was being provided. In the presence of the surveyor the [redacted] reviewed the corresponding DSR sheets for Resident #4 and Resident #5 and confirmed that there were blanks as indicated above.	F0842		01/20/2026

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F0842 SS = D	Continued from page 5 During a telephone interview on 12/10/25 at 2:58 PM CNA #1, the U.S. FOIA stated that CNAs were responsible for monitoring residents for incontinence and that they were to document in the electronic system. CNA #1 further stated occasionally forgetting to document. During a follow-up interview with U.S. FOIA on 12/10/25 at 3:58 PM, the U.S. FOIA stated that a resident's medical record should include documentation of all details relevant to a resident's care, including the time when a resident was sent out of the facility. A review of the facility's undated "Charting and Documentation" policy revealed that all services provided to a resident were to be documented in the medical record. Under the "Policy Interpretation and Implementation" section, the policy noted that documentation was to be complete and accurate. A review of the facility's undated "Universal Transfer Form" policy revealed that all information provided on the UTF would be complete and accurate. NJAC 8:39-27.1(a); 35.2(d)3	F0842		01/20/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 1/29/26 in relation to the 12/10/25 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		01/29/2026

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