STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 ROUTE 73 VOORHEES, NJ 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
F 000	INITIAL COMMENTS Complaint #: NJ175045 Census: 124 Sample Size: 4 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	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ00175045 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that meet each resident's physical, [redacted] and [redacted] needs for a resident with a history of [redacted] This deficient practice was identified for 1 of 3 residents reviewed for quality of care, (Resident #3) and was evidenced by the	F 684	F Tag 684 Corrective Action The intervention of hourly checks was implement on [redacted] on [redacted] Identification of At-Risk Resident The facility has determined all identified fall risk residents have the potential to be affected by this deficient practice.	8/29/24

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

Electronically Signed | 09/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING _____ B. WING _____	C 07/30/2024

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

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F 684	Continued From page 1 following: Review of the Electronic Medical record revealed the following: According to the "Admission Record," Resident #3 was admitted to the facility on [redacted] with diagnoses which included but not limited to: [redacted]. A review of the Minimum Data Set (MDS), an assessment tool dated [redacted], showed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted]. The MDS also showed Resident #3 required [redacted] with [redacted]. A review of the Baseline Care Plan (BCP) indicated on [redacted] revealed, Resident #3 was on [redacted] by staff and [redacted] in placed on bed. Resident #3 required [redacted] with [redacted]. The Surveyor reviewed the Facility Reportable Event (FRE) dated [redacted] for Resident #3, that was provided by the facility. The FRE revealed that on [redacted], the day shift staff noted Resident #3 on the [redacted] next to the resident's bed. An attempt to interview Resident #3, who was [redacted] of the event. The facility was notified by the family that the resident was [redacted] for "some time", per a video monitoring device that was recording at that time. This device was placed in the room with the	F 684	Systemic Change The identified LPN has been terminated from the facility. All staff were in-serviced regarding monitoring residents and not closing doors unless resident has requested the door closed. The #1 CNA that gave inaccurate information regarding fall risk monitoring was re-in-serviced. The [redacted] were appropriate and remained in place for resident #3. An audit of residents with recent falls has been conducted to determine if any other residents have experienced the same practice and no other issues were found. Quality Assurance The DON/designee will review all incidents during morning clinical meetings ongoing and will report findings to administrator daily. All identified deficient practices in nursing□s performance will be addressed immediately and reported to the QA committee quarterly over the next year.	

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	315513	A. BUILDING _____ B. WING _____	C 07/30/2024

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

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F 684	Continued From page 2	F 684		

resident by the family with the facility's permission. The family reported to the staff that the resident was "[NJ Ex Order 26.] prior to [NJ Ex Order 26]. The family member reported that the nurse assigned to the resident had closed the door instead of checking on the resident based on the facility's policy for [NJ Ex Order 26.4(b)(1)] on residents identified for the need for regular [NJ Ex Order 26.4(b)] due to history of [NJ Ex Ord] The reportable also revealed that the family requested that the resident be sent out to the hospital. The resident was sent out to the hospital and did not return to the facility. The facility determined the staff that was on that night was a License Practical Nurse #2 (LPN), that worked for an outside agency that was used by the facility to supplement staffing for the assigned floor. The FRE indicated that LPN#2 had reported to the day shift staff nurse that Resident #3 was [NJ Ex Order 26.4(b)(1)] other residents prompting her to close the resident's door.

On 07/30/24 at 10:31a.m., the Surveyor interviewed Certified Nurse Assistant #1 (CNA) who stated that [NJ Ex Order 26] resident should be monitor every [NJ Exec Order 26.4b1].

On 07/30/24 at 1:44 p.m., the Surveyor interviewed LPN #5, he stated that he found the resident [NJ Ex Order 26.4(b)(1)] on the [NJ Ex Order 26.4]. He took the resident's vital signs and [NJ Ex Order 26.4(b)(1)] was done. LPN #5, also spoke to a family member from the monitoring device at that time. The [U.S. FOIA (b) (6)], (who is no longer at the facility) also came into the room and completed a physical and [NJ Ex Order 26.4(b)(1)] assessment on Resident #3. There were no [NJ Ex Order 26.] noted and the resident was [NJ Ex Order 26.4(b)(1)]. The resident had [NJ Ex Order 26.4(b)(1)] located on each side of the bed due to history of [NJ Ex Or]. The family

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F 684	Continued From page 3 requested to the facility staff to send Resident #3 to the hospital for an evaluation. On 07/30/24 at 2:24 p.m., the Surveyor interviewed U.S. FOIA (b) (6)), who stated Resident #3 was a NJ Ex Order 26 and was NJ Ex Order 26.4(b)(1) in all aspects of care. The U.S. FOIA (b) stated LPN #5 reported that Resident #3 was NJ Ex Order 26.4(b)(1) and in need of assistance and the night shift nurse LPN #2 had gone and closed the resident door. The U.S. FOIA (b) stated that LPN #2 was suspended immediately and was not permitted to work at the facility anymore. The U.S. FOIA (b) stated that when residents NJ Ex Order 26.4(b)(1) the incident was considered NJ Ex Ord. A review of the facility's policy 'Purposeful Rounding". "Policy statement". Purposeful rounding is an initiative approach to the care of an identified resident that involves regularly checking on the resident to address their anticipated needs, prevent problems, and enhance their overall well-being. Frequency of Rounding: The established process of an individual schedule for purposeful rounding is determined by the IDT team may varies depending on the needs of the residents and which can include but not limited to hourly every 30 minutes, and every 15 minutes. NJAC 8:39-27.1(a).	F 684		

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	04007	A. BUILDING: _____ B. WING _____	C 07/30/2024

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

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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: Complaint #NJ00175045 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for17 of 21 day shifts as follows: 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 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	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. Additional agencies have been contracted to attain the appropriate staff ratios for the facility census. New staff tracking program up and running to mainstream staffing efforts. Identification of At-Risk Resident	8/29/24

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

Electronically Signed | 09/06/24

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S 560	Continued From page 1 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. As per the "Nurse Staffing Report" completed by the facility for the 3 weeks of staffing from 02/04/2024 to 02/24/2024, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one direct care staff member to every 10 residents for the evening shifts as documented below: -02/04/24 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/05/24 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -02/06/24 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -02/08/24 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -02/09/24 had 13 CNAs for 113 residents on the day shift, required at least 14 CNAs.	S 560	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: 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. Tap Check payout system implemented for staff to receive daily pay as incentive to employing more staff. An autumn tracking system has been implemented for transparency with staff regarding open shifts and bonuses available. Overtime is made available to all current employees. A new staffing coordinator has been implement with CNA experience to have better relationships with employees. Quality Assurance The DON or designee will review staffing levels daily to ensure that we have adequate staffing. Findings will be	

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S 560	Continued From page 2 -02/10/24 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/14/24 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/15/24 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/16/24 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/17/24 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/18/24 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -02/19/24 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -02/20/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -02/21/24 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/22/24 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/23/24 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/24/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. 2. For the 3 weeks of staffing prior to survey from 03/17/2024 to 04/06/2024, the facility was deficient in CNA staffing for residents on 3 of 21 day shifts as follows: -03/30/24 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. -04/02/24 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs. -04/03/24 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs.	S 560	reported to the administrator daily and reviewed with the QA committee quarterly until substantial compliance is obtained. 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 to the QA committee on a quarterly basis x 4 quarters.	

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S 560	Continued From page 3 3. For the 2 weeks of Complaint staffing prior to survey from 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in CNAs to total staff on 4 of 14 evening shifts as follows: -07/14/24 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -07/15/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -07/16/24 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -07/17/24 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/18/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/18/24 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. -07/19/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/19/24 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -07/20/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/21/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -07/22/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/22/24 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -07/23/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/23/24 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs. -07/24/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/25/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/26/24 had 11 CNAs for 98 residents on the	S 560		

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S 560	Continued From page 4 day shift, required at least 12 CNAs. -07/27/24 had 11 CNAs for 98 residents on the day shift, required at least 12 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)
315513	A. Building B. Wing	9/19/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 ROUTE 73 VOORHEES, NJ 08043

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 F0684 Reg. # 483.25 LSC	Correction Completed 08/29/2024	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
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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	
7/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
04007 Y1	Y2	9/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 ROUTE 73 VOORHEES, NJ 08043

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 08/29/2024	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
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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 7/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO