

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315513</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE SUBACUTE AT AUTUMN LAKE HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>113 ROUTE 73</b> <b>VOORHEES, NJ 08043</b>
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F 000	INITIAL COMMENTS  Complaint #:167433, 168139, 169792, 170417, 171092, 172503, 173710, 175830, 177212  Survey Date: 10/30/2024  Census: 105  Sample: 22 + 3 closed records  A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)  §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		11/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  11/14/2024
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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.

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F 636	<p>Continued From page 1</p> <p>(viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was</p>	F 636	1. Resident # 241 have had their		

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F 636	<p>Continued From page 2</p> <p>determined that the facility failed to complete a comprehensive Minimum Data Set (MDS), an assessment tool, within 14 days of resident admission to the facility. This deficient practice was identified for 1 of 25 sampled residents, (Resident #241) and was evidenced by the following:</p> <p>On 10/24/2024 at 09:55 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #241. The surveyor accessed the MDS tab in the EMR and reviewed the following:</p> <p><b>NJ Ex Order 26,4b1</b> Admission/Medicare - 5 Day Status: "In Progress"</p> <p>In addition, review of the "Next Tracking/Dischrg" bar revealed that Resident #241's ARD (assessment reference date) was <b>NJ Ex Order 26,4b1</b> and was "5 days overdue."</p> <p>On 10/29/2024 at 09:42 AM, the surveyor conducted an interview with the facility <b>US FOIA (b)</b>. The surveyor asked the <b>US FOIA (b)</b> what the timeframe for completion of a comprehensive admission assessment for residents was admitted to the facility. The <b>US FOIA (b)</b> told the surveyor that the residents admitted are either mostly Medicare or private insurance. We do get some Medicaid. The <b>US FOIA (b)</b> went on to explain that a 5-day assessment must be completed within 14 days of admission. The surveyor asked the <b>US FOIA (b)</b> to look up Resident #241's comprehensive admission assessment in the EMR. The <b>US FOIA (b)(6)</b> after viewing Resident #241's MDS admission assessment told the surveyor, "I haven't completed the admission assessment." The surveyor asked the <b>US FOIA (b)</b></p>	F 636	<p>comprehensive Minimum Data Set assessments (MDS) completed.</p> <p>2. All residents have the potential to be affected by the same deficient practice and can be identified on the resident roster. The Regional MDS Coordinator conducted a 90 day look back to ensure comprehensive MDS assessments were completed timely, all overdue comprehensive MDS assessments have been completed. No other deficient practice identified. By completion date</p> <p>3. The <b>US FOIA (b)(6)</b> and MDS consultants were in-serviced on or before completion date by the Regional MDS coordinator on the federal regulation for completing comprehensive MDS assessments within 14 days of the Assessment Reference Date (ARD.) Census changes will be reviewed in the facility daily meeting to ensure that comprehensive MDS assessments are completed timely. An additional MDS coordinator was hired to assist the current MDS coordination.</p> <p>4. The Regional MDS coordinator or facility MDS Coordinator will conduct 10 audits monthly of comprehensive MDS assessments to ensure they are completed within 14 days the ARD X3 months, or until substantial compliance is achieved. the results of these audits will be presented at the monthly quality assurance meeting to ensure compliance for 3 months</p>		

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F 636	Continued From page 3 <p><b>US FOIA (b)(6)</b> if the MDS admission assessment was overdue and the MDS coordinator replied, "Yes, according to the admission date, the admission assessment should've been completed on <b>NJ Ex Order 26.4b1</b>."</p> <p>On 10/29/2024 at 1:20 PM, the <b>US FOIA (b)(6)</b> confirmed to the surveyor that the admission assessment should have been completed on or before the <b>NJ Ex Order 26.4b1</b> and stated that they had a <b>US FOIA (b)(6)</b> recently had resign.</p> <p>A review of the facility policy titled MDS 3.0 Completion, undated, revealed the following:</p> <p>2. Types of OBRA (Omnibus Budget Reconciliation Act of 1987) Assessments:</p> <p>b. Admission Assessment - completed within 14 days of admission counting the day of admission as day #1 when:</p> <p>i. The resident has no prior admission, or</p> <p>ii. The prior admission was less than 14 days and no admission assessment was completed during the prior admission, or</p> <p>iii. Prior admission ended with a Discharge Return Not Anticipated; or</p> <p>iv. Prior admission ended with a Discharge Return Anticipated and re-entry occurred &gt; 30 days after the discharge date.</p> <p>NJAC 8:39-11.2(e)</p>	F 636			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning	F 655		11/30/24	

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F 655	<p>Continued From page 4</p> <p>§483.21(a) Baseline Care Plans</p> <p>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <ul style="list-style-type: none"> <li>(i) Be developed within 48 hours of a resident's admission.</li> <li>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- <ul style="list-style-type: none"> <li>(A) Initial goals based on admission orders.</li> <li>(B) Physician orders.</li> <li>(C) Dietary orders.</li> <li>(D) Therapy services.</li> <li>(E) Social services.</li> <li>(F) PASARR recommendation, if applicable.</li> </ul> </li> </ul> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <ul style="list-style-type: none"> <li>(i) Is developed within 48 hours of the resident's admission.</li> <li>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</li> </ul> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <ul style="list-style-type: none"> <li>(i) The initial goals of the resident.</li> <li>(ii) A summary of the resident's medications and dietary instructions.</li> <li>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</li> </ul>	F 655			

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F 655	<p>Continued From page 5</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to develop and implement a baseline care plan (BCP) within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident. This deficient practice was identified for 2 of 25 sampled residents (Resident #90, #241) and was evidenced by the following:</p> <p>1.) According to the Admission Record, Resident #90 was admitted to the facility with diagnoses including but not limited to: NJ Ex Order 26.4b1</p> <p>[REDACTED]</p> <p>A review of the [facility initials] Baseline Care Plan -V4 revealed that there are seven (7) sections to the baseline care plan as follows:</p> <ol style="list-style-type: none"> <li>1. General Information and Initial Goals</li> <li>2. Functional abilities</li> <li>3. Health conditions</li> <li>4. Dietary</li> <li>5. Therapy</li> <li>6. Social Services</li> <li>7. BCP summary and signatures.</li> </ol> <p>A review Resident #90's baseline care plan revealed that section #2 and #3 were not completed within 48 hours of admission. The</p>	F 655	<p>A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Residents #90 and #241 no longer reside in facility. Staff were immediately in-serviced on baseline care plan completion.</p> <p>B. Identify other residents who have the potential to be affected by the same deficient practice and what actions are taken:</p> <ol style="list-style-type: none"> <li>1. All new admission residents could have the potential to be affected by deficient practice.</li> <li>2. An audit of all new admissions in the last 30 days will be completed to verify a Baseline Care Plan has been completed.</li> </ol> <p>C. Measures/systematic changes put in place to ensure that the deficient practice does not recur:</p> <ol style="list-style-type: none"> <li>1. The Director of Nursing will in-service the interdisciplinary team on the policy and procedure for baseline care plans by completion date</li> </ol> <p>D. Monitoring of corrective action to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> <li>1. Director of nursing or designee will audit all new residents' charts for Baseline Care Plan being completed within 48 hours of admission. Audit will be weekly on new admission baseline care plans for one month then monthly for two months or until substantial compliance is achieved.</li> <li>2. The Administrator will be responsible for overseeing all audits of findings and</li> </ol>		

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F 655	<p>Continued From page 6</p> <p>BCP summary was incomplete, Signature of Resident and Representative was blank, as well as representative signature and date. The only staff who signed was the <b>US FOIA (b)(6)</b> and <b>US FOIA (b)(6)</b>.</p> <p>2.) On 10/23/2024 at 11:24 AM during the initial tour of the facility Resident #241 told the surveyor that he/she had <b>NJ Ex Order 26.4b1</b>, but they removed it yesterday and I haven't <b>NJ Ex Order 26.4b1</b>. It's been almost 24 hours.</p> <p>According to the Admission Record Resident #241 was admitted to the facility with the following but not limited to diagnoses: <b>NJ Ex Order 26.4b1</b></p> <p>[REDACTED]</p> <p>A review of the [facility initials] Baseline Care Plan - V4 revealed that there are seven (7) sections to the baseline care plan as follows:</p> <ol style="list-style-type: none"> <li>1. General Information and Initial Goals</li> <li>2. Functional Status</li> <li>3. Health Conditions</li> <li>4. Dietary</li> <li>5. Therapy</li> <li>6. Social Services</li> <li>7. BCP Summary and Signatures.</li> </ol> <p>On 10/24/2024 at 10:13 AM, the surveyor reviewed the baseline care plan for Resident #241. During the review of the baseline care plan on this date revealed that sections 1-7 were not completed within 48 hours of admission.</p> <p>On 10/29/2024 the surveyor again reviewed the</p>	F 655	will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.		

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F 655	<p>Continued From page 7</p> <p>baseline care plan for Resident #241 via the EMR. On this date the baseline care plan revealed that sections 1-7 had been completed on <b>NJ Ex Order 26-401</b>.</p> <p>During an interview with the surveyor on 10/28/2024 at 12:27 PM, Licensed Practical Nurse (LPN #1) When is the baseline care plan to be completed. LPN #1 said LPN's don't do the care plans. The Unit Manager is responsible for the care plans.</p> <p>During an interview with the surveyor on 10/28/2024 at 12:33 PM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) said baseline care plan should be initiated by the admitting nurse. I will then go in and make corrections as needed. We have up to 48 hours for base line to be completed. Dietary, therapy and nursing complete this and I make sure it is signed and completed. I make sure the whole baseline care is appropriate and then I sign as completed.</p> <p>During an interview with the survey team on 10/29/2024 at 01:44 PM, the <b>US FOIA (b)(6)</b> was asked when is the baseline care plan to be completed. The <b>US FOIA (b)(6)</b> replied within 48 hours of admission. The <b>US FOIA (b)(6)</b> confirmed the timeframe of 48 hours for completion of the baseline care plan. The surveyor questioned what is expected to be on a baseline care plan. The <b>US FOIA (b)(6)</b> replied initial assessment and care needs until comprehensive cae plan is done. It does not carry over to the comprehensive care plan, it is a tool and some of the items trigger and then carry over to comprehensive care plan.</p> <p>A review of a facility policy titled Baseline Care</p>	F 655			

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F 655	Continued From page 8 Plan with revised date of October 2022 revealed under the Policy Statement section The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. Under the Policy Interpretation and implementation section 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission., b. Include the minimum healthcare information necessary to properly care for a resident including but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders iv. Therapy Services. v. Social services.... Under 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed.	F 655			
F 656 SS=E	NJAC 8:39-11.2(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 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	F 656		11/30/24	

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F 656	<p>Continued From page 9</p> <p>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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to develop an individualized person-centered comprehensive care plan to address the needs of the resident for 4 of 25 sampled residents (Resident #1, #6, #96, and #99). This deficient practice was evidenced by the following:</p>	F 656	<p>Corrective Action</p> <p>Care plan(s) of the residents identified #6, # 1, 96, and #99 were reviewed and updated as indicated. Residents #1, # 96, and #99 have been discharged from the facility</p> <p>Identification of At-Risk Resident</p> <p>The facility determined that all residents</p>		

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F 656	<p>Continued From page 10</p> <p>1). On 10/23/2024 at 11:04 AM during the initial tour of the facility the surveyor observed Resident #1 who was seated on their bed eating breakfast.</p> <p>According to the admission record Resident #1 was admitted to the facility with the following but not limited to diagnoses: <b>NJ Ex Order 26.4b1</b></p> <p>[REDACTED]</p> <p>A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated <b>NJ Ex Order 26.4b1</b>, revealed under section Section V the following areas were to be care planned as checked off in column B: <b>NJ Ex Order 26.4b1</b></p> <p>[REDACTED]</p> <p>On 10/28/2024 at 10:38 AM the surveyor conducted a review of the electronic medical record (EMR) of Resident #1. The EMR revealed under the care plan tab that Resident #1 had a comprehensive care plan that consisted <b>NJ Ex Order 26.4b1</b>. The comprehensive care plan had the following Focus: The resident has <b>NJ Ex Order 26.4b1</b>. Date Initiated: <b>NJ Ex Order 26.4b1</b>. Resident #1's care plan Goal was the resident will verbalize <b>NJ Ex Order 26.4b1</b> through the review date. Date Initiated: <b>NJ Ex Order 26.4b1</b>. Target Date: <b>NJ Ex Order 26.4b1</b>. Cancelled Date: <b>NJ Ex Order 26.4b1</b>. A further review of the comprehensive care plan (CP) revealed that Resident #1 had no care planned</p>	F 656	<p>have the potential to be affected by this deficient practice. An audit was conducted of all current residents in the facility to review their comprehensive care plans for completion</p> <p>Systemic Change All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's policy and procedure for developing comprehensive care plans. In-service was completed on the timeline for completion of comprehensive care plan once the comprehensive MDS has been completed. The facility will follow the MDS calendar for required MDS completion and a 7-day timeframe for comprehensive care plan completions. Quality Assurance Care plans will be reviewed weekly in accordance with the care plan review schedule by the interdisciplinary team. All care plans will be updated as indicated.</p> <ol style="list-style-type: none"> <li>1. Director of nursing or designee will audit all new residents' charts for Comprehensive Care Plan being completed within 7 days of completion of comprehensive MDS. An audit will be conducted weekly on Comprehensive care plans for one month then monthly for two months or until substantial compliance is achieved.</li> <li>2. The Administrator will be responsible for overseeing all audits of findings and will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention</li> </ol>		

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F 656	<p>Continued From page 11</p> <p><b>NJ Ex Order 26.4b1</b>. There were no other Focus areas on the CP for Resident #1 prior to discharge from the facility.</p> <p>2.) Resident #99 was reviewed by the surveyor for activities of daily living. On 10/24/2024 at 12:43 PM the surveyor reviewed Resident #99's EMR. A review of the Admission Record revealed that Resident #99 was admitted to the facility with the following but not limited to diagnoses: <b>NJ Ex Order 26.4b1</b></p> <p><b>NJ Ex Order 26.4b1</b></p> <p>A review of the MDS dated <b>NJ Ex Order 26.4b1</b>, revealed that according to Section V of the MDS, Resident #99 was <b>NJ Ex Order 26.4b1</b> for the following care areas according to column B: <b>NJ Ex Order 26.4b1</b></p> <p><b>NJ Ex Order 26.4b1</b></p> <p>On 10/24/2024 at 01:02 PM, the surveyor reviewed Resident #99's individualized comprehensive care plan. The care plan revealed that Resident #99 had only one (1) care planned area (<b>NJ Ex Order 26.4b1</b>).</p> <p>3.) On 10/23/2024 at 11:50 AM, during the initial tour, Resident #6 was identified by the nurse as having <b>NJ Ex Order 26.4b1</b>.</p> <p>A review of Resident #6's Admission Record revealed that he/she had a diagnosis that included but not limited to, <b>NJ Ex Order 26.4b1</b></p> <p><b>NJ Ex Order 26.4b1</b></p>	F 656	<p>or amendment of plan.</p> <p>Audit records will be reviewed by risk management/QA committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.</p>	

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F 656	<p>Continued From page 12</p> <p><b>NJ Ex Order 26.4b1</b></p> <p>A review of the most recent comprehensive MDS dated <b>NJ Ex Order 26.4b1</b>, under section V: Care Area Assessment (CAA) Summary; the following care areas were identified as <b>NJ Ex Order 26.4b1</b> in the Individual Comprehensive Care Plan: <b>NJ Ex Order 26.4b1</b></p> <p>A review of Resident #6's Individualized Comprehensive Care Plan with an initiation date <b>NJ Ex Order 26.4b1</b>, only included the following focus areas: [resident name] is <b>NJ Ex Order 26.4b1</b></p> <p>The CP further showed a Focus area of <b>NJ Ex Order 26.4b1</b> [resident name] is at <b>NJ Ex Order 26.4b1</b> due to <b>NJ Ex Order 26.4b1</b>.</p> <p>4.) A review of Resident # 96's EMR was completed on <b>NJ Ex Order 26.4b1</b> at 08:35 AM, as follows:</p> <p>According to the Admission Record Resident #96 was admitted to the facility with diagnoses including but not limited to: <b>NJ Ex Order 26.4b1</b></p> <p>A review of the most recent comprehensive MDS dated <b>NJ Ex Order 26.4b1</b>, revealed under section V the CAA Summary under A. <b>NJ Ex Order 26.4b1</b> the</p>	F 656		

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F 656	<p>Continued From page 13</p> <p>following areas were triggered <sup>NJ Ex Order 26.4b1</sup></p> <p>[REDACTED]</p> <p>A review of Resident #96's Individualized Comprehensive Care Plan revealed a Focus area of [resident name] has a potential <sup>NJ Ex Order 26.4b1</sup></p> <p>[REDACTED] The CP also showed a Focus area of [resident name] is <sup>NJ Ex Order 26.4b1</sup> his/her recreational choice. There were no other Focus areas that were identified in section V for care planning decision. There were no other Focus areas prior to Resident #96's discharge from the facility.</p> <p>During an interview with the surveyor on 10/28/2024 at 12:33 PM, the Licensed Practical Nurse /Unit Manager (LPN/UM #1) said I was told to open it (CP) once the base line care plan is closed out within 48 hours of admission and then the comprehensive care plan is opened. LPN/UM #1 confirmed that the baseline care plan is closed out 48 hours after admission. When questioned as to what should be on the CP LPN/UM #1 said that is done as related to patient. If they are on psychotropic meds, anticoagulant, diagnoses and whatever else arises while they are here. LPN/UM #1 went on to say also Skin, ADL's, pain, catheter, ostomies, ABT, PICC line. I believe it is with in 21 days of patient being here the comprehensive care plan needs to be completed.</p>	F 656		

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F 656	Continued From page 14  During an interview with the surveyor on 10/29/2024 at 11:36 AM, LPN/UM #2, stated that the Comprehensive Care Plan is due after 26 days. The LPN/UM #2 was unable to speak to the Care Area Assessment (CAA) Summary or its role in developing the Comprehensive Care Plan.  On 10/29/2024 at 01:53 PM, the surveyors team conducted an interview with the facility administrative staff which included the [US FOIA (b)(6)] [REDACTED] When interviewed both [US FOIA (b)(6)] agreed that any Care Area Assessment (CAA) areas that are triggered should be care planned. The [US FOIA (b)(6)] told the surveyors that comprehensive care plans should be completed within 7 days after the comprehensive assessment (MDS).  A review of a facility policy on 10/29/2024 at 10:07 AM, an undated facility policy titled, "Care Plans, Comprehensive Person-Centered," under #2: The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission."	F 656			
F 868 SS=D	NJAC 8:39-11.2(f) QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)  §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting	F 868		11/30/24	

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F 868	<p>Continued From page 15</p> <p>at a minimum of:</p> <ul style="list-style-type: none"> <li>(i) The director of nursing services;</li> <li>(ii) The Medical Director or his/her designee;</li> <li>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</li> <li>(iv) The infection preventionist.</li> </ul> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p> <ul style="list-style-type: none"> <li>(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.</li> </ul> <p>§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the <b>US FOIA (b)(6)</b> was at 1 of 1 Quality Assurance Performance Improvement (QAPI) quarterly meeting and that QAPI meetings were held on a quarterly basis .</p>	F 868	<p>Corrective Actions:</p> <p>1.To address the deficiency noted regarding the composition and functioning of the Quality Assurance Advisory Committee (QAA), the following corrective actions will be implemented</p>		

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F 868	<p>Continued From page 16</p> <p>This deficient practice was identified for 1 of the last 3 quarters and 2 of the last 3 quarters and was evidenced by the following:</p> <p>During a review of the facility QAPI 2024 book on 10/29/2024 at 08:44 AM, there was a sign in sheet with the topic of QAPI/QA Quarter 3. There was no signature or name for the [REDACTED] (US FOIA (b)(6)).</p> <p>On 10/29/2024 at 09:25 AM the surveyor requested all of the last 3 quarter sign in sheets from the [REDACTED] (US FOIA (b)(6)) who said "I came to the building in [REDACTED] and I asked where is the QAPI. There was nothing done since last year for QAPI." I have a QAPI that identified this concern for there being no QAPI. I provided all department heads and staff with education and power points to all staff on QAPI requirements in April of 2024. As new department heads and staff start they get trained and CNA's as well. We also have a QAPI board so families can see what we are doing.</p> <p>I sat with each department and assisted them to identify concerns, use audits, and process and structure changes. We met weekly for 1st month to make sure they are capturing the data and then we moved to monthly. When asked was there a quarterly meeting in July, the [REDACTED] (US FOIA (b)(6)) said "I guess we could have had a quarterly but the team wasn't there yet."</p> <p>A review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) undated revealed 2. the QAA committee shall be interdisciplinary and shall:</p> <ul style="list-style-type: none"> <li>a. consists at a minimum of: <ul style="list-style-type: none"> <li>i. The Director of Nursing</li> <li>ii. The Medical director</li> </ul> </li> </ul>	F 868	<p>Review and Revise QA/ QAPI Composition: The current membership of the QAA will be reviewed to ensure it includes a diverse representation, including clinical staff, administrative staff, residents, and family members. The revised committee will consist of an infection preventionist</p> <ol style="list-style-type: none"> <li>2. All residents have the potential to be affected by this deficient practice.</li> <li>3. Actions taken/systems put into place to reduce the risk of future occurrence include: <ul style="list-style-type: none"> <li>All department heads were in-serviced by the Regional Director of Nursing on following the federal guidelines for QAA committee.</li> <li>The QA committees will meet quarterly for meetings ongoing to review quality indicators and address any issues related to resident care and safety.</li> <li>The Administrator will provide formal reports to the governing body after each meeting. These reports will validate compliance.</li> <li>Administrator Responsible for revising the QAA membership and facilitating the meetings.</li> <li>The Administrator will be responsible for overseeing the implementation of the corrective actions and ensuring compliance.</li> <li>A yearly calendar of QAA meetings has been established to notify the committee in advance of the required meeting to ensure attendance of all parties.</li> </ul> </li> <li>4. How the corrective action(s) will be monitored to ensure the practice will not</li> </ol>		

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F 868	Continued From page 17  iii. At least 3 other members of facility staff, at least one of which must be the Administrator, owner, a Board Member or other individual in a leadership role and the Infection Preventionist. must meet at least quarterly, develop and implement appropriate plans of action to correct identified quality deficiencies.  NJAC 8:39-33.1(b)	F 868	recur: The Administrator will audit monthly for six months all the QAA meeting minutes, attendance, and reports provided to the governing body to ensure compliance with the new procedures. The governing body will review the QAA's Quarterly minutes these audits will be presented at the QA meeting to ensure compliance and reassessed for further action for 3 quaters		

New Jersey Department of Health

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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  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 pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 1) 9/24/2024 to 9/30/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts 2) 10/29/2024 to 11/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in CNAs to total staff on 1 of 7 evening shifts 3) 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts, deficient in CNAs to total staff on 2 of 7 evening shifts 4) 12/24/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts, deficient	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. 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 All residents have the potential to be	12/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/14/24

New Jersey Department of Health

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S 560	<p>Continued From page 1</p> <p>in CNAs to total staff on 1 of 7 evening shifts 5) 01/14/2024 to 01/20/2024, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts 6) 02/18/2024 to 03/09/2024, the facility was deficient in CNA staffing for residents on 17 of 21 day shifts, deficient in CNAs to total staff on 1 of 21 evening shifts 7) 04/07/2024 to 04/20/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts 8) 05/05/2024 to 05/11/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts, deficient in CNAs to total staff on 1 of 7 evening shifts 9) 08/11/2024 to 08/24/2024, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts, deficient in CNAs to total staff on 2 of 14 evening shifts 10) 09/01/2024 to 09/14/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts, deficient in CNAs to total staff on 7 of 14 evening shifts 11) 10/06/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts, deficient in CNAs to total staff on 5 of 14 evening shifts.</p> <p>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 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: 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</p>	S 560	<p>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. NJ Ex Order 26,461 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.</p> <p>Quality Assurance</p> <p>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</p>	
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE SUBACUTE AT AUTUMN LAKE HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>113 ROUTE 73 VOORHEES, NJ 08043</b>
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(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
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S 560	<p>Continued From page 2</p> <p>CNAs, and each direct staff member shall be signed in to work as a CNA 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.</p> <p>As per the Nurse Staffing Report (AAS-11) completed by the facility, the facility was deficient as follows:</p> <p>1. For the week of Complaint staffing from 09/24/2023 to 09/30/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:</p> <ul style="list-style-type: none"> <li>-09/24/23 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs.</li> <li>-09/25/23 had 7 CNAs for 85 residents on the day shift, required at least 11 CNAs.</li> <li>-09/26/23 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs.</li> <li>-09/28/23 had 8 CNAs for 79 residents on the day shift, required at least 10 CNAs.</li> <li>-09/30/23 had 6 CNAs for 78 residents on the day shift, required at least 10 CNAs.</li> </ul> <p>2. For the week of Complaint staffing from 10/29/2023 to 11/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows:</p> <ul style="list-style-type: none"> <li>-10/29/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs.</li> <li>-10/30/23 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs.</li> <li>-10/31/23 had 11 CNAs for 95 residents on the</li> </ul>	S 560	<p>reviewed with the QA committee quarterly for 1 quarter</p> <p>The administrator or designee will review the staffing schedule weekly to monitor the staffing ratio on all shifts weekly for 1 quarter The administrator will report findings to the QA committee on a quarterly basis</p>	
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2024</b>
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S 560	<p>Continued From page 3</p> <p>day shift, required at least 12 CNAs. -10/31/23 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -11/01/23 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/02/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -11/03/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -11/04/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.</p> <p>3. For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts and deficient in CNAs to total staff on 2 of 7 evening shifts as follows:</p> <p>-11/12/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -11/13/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/14/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/14/23 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -11/15/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/17/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/17/23 had 6 CNAs to 15 total staff on the evening shift, required at least 7 CNAs. -11/18/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs.</p> <p>4. For the week of Complaint staffing from 12/24/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows:</p>	S 560		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2024</b>
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S 560	<p>Continued From page 4</p> <p>-12/24/23 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. -12/25/23 had 7 CNAs for 84 residents on the day shift, required at least 10 CNAs. -12/27/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.</p> <p>5. For the 2 weeks of Complaint staffing from 01/14/2024 to 01/20/2024, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows:</p> <p>-01/14/24 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/16/24 had 4 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/17/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>-01/24/24 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -01/26/24 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.</p> <p>6. For the 3 weeks of Complaint staffing from 02/18/2024 to 03/09/2024, the facility was deficient in CNA staffing for residents on 17 of 21 day shifts and deficient in CNAs to total staff on 1 of 21 evening shifts as follows:</p> <p>-02/18/24 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -02/19/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/20/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/21/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -02/22/24 had 9 CNAs for 95 residents on the day</p>	S 560		

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S 560	<p>Continued From page 5</p> <p>shift, required at least 12 CNAs.</p> <p>-02/23/24 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.</p> <p>-02/24/24 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.</p> <p>-02/26/24 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-02/27/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-03/01/24 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-03/01/24 had 4 CNAs to 13 total staff on the evening shift, required at least 6 CNAs.</p> <p>-03/02/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-03/04/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-03/04/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-03/05/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-03/06/24 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs.</p> <p>-03/07/24 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs.</p> <p>-03/08/24 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>-03/09/24 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>7. For the 2 weeks of Complaint staffing from 04/07/2024 to 04/20/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows:</p> <p>-04/17/24 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs.</p> <p>-04/18/24 had 9 CNAs for 79 residents on the day</p>	S 560		

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S 560	<p>Continued From page 6</p> <p>shift, required at least 10 CNAs.</p> <p>8. For the week of Complaint staffing from 05/05/2024 to 05/11/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows:</p> <p>-05/05/24 had 8 CNAs for 79 residents on the day shift, required at least 10 CNAs. -05/05/24 had 4 CNAs to 11 total staff on the evening shift, required at least 5 CNAs. -05/06/24 had 7 CNAs for 79 residents on the day shift, required at least 10 CNAs. -05/07/24 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs. -05/08/24 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs. -05/10/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs.</p> <p>9. For the 2 weeks of Complaint staffing from 08/11/2024 to 08/24/2024, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts and deficient in CNAs to total staff on 2 of 14 evening shifts as follows:</p> <p>-08/11/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -08/11/24 had 5 CNAs to 13 total staff on the evening shift, required at least 6 CNAs. -08/12/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/12/24 had 6 CNAs to 15 total staff on the evening shift, required at least 7 CNAs. -08/13/24 had 9 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/14/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs.</p>	S 560		

New Jersey Department of Health

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S 560	<p>Continued From page 7</p> <p>-08/19/24 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs.</p> <p>-08/20/24 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs.</p> <p>10. For the 2 weeks of Complaint staffing from 09/01/2024 to 09/14/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts and deficient in CNAs to total staff on 7 of 14 evening shifts as follows:</p> <p>-09/01/24 had 7 CNAs for 84 residents on the day shift, required at least 10 CNAs.</p> <p>-09/03/24 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs.</p> <p>-09/04/24 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs.</p> <p>-09/05/24 had 7 CNAs to 20 total staff on the evening shift, required at least 10 CNAs.</p> <p>-09/06/24 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.</p> <p>-09/07/24 had 8 CNAs for 75 residents on the day shift, required at least 9 CNAs.</p> <p>-09/08/24 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs.</p> <p>-09/09/24 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs.</p> <p>-09/10/24 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs.</p> <p>-09/10/24 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.</p> <p>-09/11/24 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs.</p> <p>-09/12/24 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.</p> <p>-09/12/24 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs.</p> <p>-09/13/24 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.</p>	S 560		

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S 560	<p>Continued From page 8</p> <p>-09/13/24 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs.</p> <p>-09/14/24 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.</p> <p>-09/14/24 had 5 CNAs to 13 total staff on the evening shift, required at least 6 CNAs.</p> <p>11. For the 2 weeks of Staffing prior to survey from 10/06/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts and deficient in CNAs to total staff on 5 of 14 evening shifts as follows:</p> <p>-10/06/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.</p> <p>-10/07/24 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs.</p> <p>-10/07/24 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.</p> <p>-10/08/24 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.</p> <p>-10/08/24 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs.</p> <p>-10/10/24 had 7 CNAs to 18 total staff on the evening shift, required at least 9 CNAs.</p> <p>-10/11/24 had 8 CNAs to 18 total staff on the evening shift, required at least 9 CNAs.</p> <p>-10/12/24 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.</p> <p>-10/13/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs.</p> <p>-10/14/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs.</p> <p>-10/15/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.</p> <p>-10/16/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs.</p> <p>-10/18/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p>	S 560		

New Jersey Department of Health

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S 560	<p>Continued From page 9</p> <p>During an interview with the surveyors on 10/29/2024 at 12:24 PM, the Staffing Coordinator stated that he/she was aware of the minimum staffing requirements for CNAs which is 1 to 8 residents for 7-3 shift, 1 to 10 for 3-11 shift and 1 to 14 for 11-7 shift. When asked if the facility meets those requirements, the Staffing Coordinator stated, "for the most part, yes."</p> <p>During an interview with the surveyors on 10/29/2024 at 12:40 PM, the Director of Nursing (DON) stated that he/she was aware of the minimum staffing requirements which he/she would know when he/she looked at the schedule. When asked if the facility meets those requirements, the DON stated, "we do our very best to meet the requirements."</p> <p>During an interview with the surveyors on 10/30/2024 at 11:20 AM, the DON stated that he/she was aware of the staffing ratio requirements for CNAs which is 1 to 8 residents for 7-3 shift, 1 to 10 for 3-11 shift and 1 to 14 for 11-7 shift.</p> <p>A review of facility policy updated and reviewed on 6/20/24 titled Staffing under Policy Interpretation and Implementation revealed the following: Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. One CNA to every eight residents for the day shift; One direct care staff member (RN, LPN, or CNA) to every 10 residents for the evening shift; and One direct care staff member (RN, LPN, or CNA) to every 14 residents for the night shift.</p>	S 560		



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S2315	<p>Continued From page 11</p> <p>to the municipal and county emergency management officials for their review. This deficient practice had the potential to affect 105 residents and was evidenced by the following:</p> <p>A documentation review of the facilities Emergency Preparedness (EP) plan revealed there was no county, municipal or state emergency management coordinators represented on the annual EP review signature sheet dated 10/28/24. There was no other documents indicating that the county, municipal or state emergency management officials participated in reviewing and updating the facilities EP plan during the last annual review .</p> <p>In an interview at the time, the Administrator and MD confirmed the findings.</p> <p>No further documentation was provided.</p> <p>The Administrator and MD were informed of the findings at the Life Safety Code survey exit conference on 10/29/24 at 2:10 PM.</p>	S2315	<p>Systemic Change The <b>US FOIA (b)(6)</b> was educated on the importance of meeting county and municipal emergency management coordinators to review the emergency preparedness plan and sign off on it.</p> <p>Quality assurance</p> <p>The maintenance director will review the disaster manual and emergency preparedness plan monthly for 3 the months. after that quarterly to ensure that all necessary signatures are on file and report to the QA committee with any issues.</p>	

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315513	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 12/12/2024	Y3
NAME OF FACILITY THE SUBACUTE AT AUTUMN LAKE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 F0636	Correction	ID Prefix F0655	Correction	ID Prefix F0656	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	11/30/2024	LSC	11/30/2024	LSC	11/30/2024
ID Prefix F0868	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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LSC		LSC		LSC	
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Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/30/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315513	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 12/12/2024	Y3
NAME OF FACILITY THE SUBACUTE AT AUTUMN LAKE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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).

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LSC	11/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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FOLLOWUP TO SURVEY COMPLETED ON 10/30/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04007	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/12/2024
NAME OF FACILITY THE SUBACUTE AT AUTUMN LAKE HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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	Correction	ID Prefix S2315	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-31.6(i)(1-2)	Completed	Reg. # _____	Completed
LSC _____	11/30/2024	LSC _____	11/30/2024	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 _____	_____
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/30/2024

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

PRINTED: 01/06/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315513</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE SUBACUTE AT AUTUMN LAKE HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>113 ROUTE 73 VOORHEES, NJ 08043</b>
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(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
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E 000	Initial Comments  This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS  A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/28/24 and 10/29/2024. The Subacute at Autumn Lake 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 Occupancies.  The nursing home building construction was stated to be in 2013, with no current major renovations or noted additions. It is a three story building Type V (111) construction and is fully sprinklered. The exterior 600 KW (diesel) generator does 100% of the building. The building has 12-smoke zones. The building has 2-elevators.  There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. 100% of the building.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>11/12/2024</b>
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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.

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K 000	Continued From page 1 The third floor C-wing section is currently closed resident rooms: (320 to 331) due to lack of census.	K 000			
K 293 SS=F	<p>The facility has 124 certified beds. At the time of the survey the census was 105.</p> <p>Exit Signage CFR(s): NFPA 101</p> <p>Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/29/24 in the presence of the <b>US FOIA (b)(6)</b> it was observed that the facility failed to identify two (2) sets of doors, with a sign on a door, which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall have a "No Exit" sign in accordance with NFPA 101: 2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following:</p> <p>1). At 12:10 PM. the surveyor and <b>US FOIA (b)(6)</b> observed on floor #3 that the center core double set of glass doors leading to the outside porch was not an exit, could be confused with an exit and did not have a "No Exit" sign.</p>	K 293	<p>Corrective Action</p> <p>The following areas were identified and corrected with the proper signage. NO EXIT(Pool/2nd floor Patio/3rd floor Balcony). Pictures to be provided.</p> <p>Identification of At-Risk Resident</p> <p>this deficient practice had the potential to affect all residents and staff personnel in the facility</p> <p>Systemic Change</p> <p>The <b>US FOIA (b)(6)</b> was educated</p>	12/1/24	

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K 293	Continued From page 2 2). At 12:30 PM, the surveyor and [US FOIA] observed on floor #2 that the center core double set of glass doors leading to the outside enclosed porch was not an exit, could be confused with an exit and did not have a "No Exit" sign.  In an interview at the time, the [US FOIA] confirmed the above findings.  The [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 10/29/24 at 2:10 PM.  NJAC 8:39-31.2(e)	K 293	on the importance of having NO EXIT signage on any doors that can be mistaken for an exit. The maintenance director placed proper signage on all necessary doors. Monthly walk through the building to assure proper signage in place  Quality assurance  The maintenance director or designee will be responsible for conducting rounds quarterly for 3 quarters in all areas that have the potential to have this deficient practice. The QAPI committee meets quarterly Results of these audits will be reviewed at the quality assurance and performance improvement committee for review and action as appropriate for 3 quarters .		
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 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.	K 321		12/1/24	

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K 321	<p>Continued From page 3</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>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)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/29/24 in the presence of the <b>US FOIA (b)(6)</b>, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice had the potential to affect 20 residents in that identified area, was observed for 3 of 6 doors in the back of the facility, and was evidenced by the following:</p> <p>Observations from 09:45 AM to 1:18 PM in the presence of the <b>US FOIA (b)(6)</b> revealed the following compromised doors:</p> <p>1). At 10:10 AM, the surveyor and <b>US FOIA (b)(6)</b> observed the set of doors to the storage room by stairway #2. When the doors were closed, there was a gap</p>	K 321	<p>Corrective Action</p> <p>Hazardous Areas, it was identified that the facility failed to ensure that fire rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions. the following areas were identified and corrected using door astragals; Boiler and fuel-fired Heater Rooms, Laundries, Maintenance shop, Soiled Linen Rooms, Trash Collection Rooms, &amp; Combustible Storage Rooms/Spaces. The maintenance director will check all fire rated doors for gaps and correct. I identification of At-Risk Resident Many residents and staff personnel have the potential to be affected by this deficient practice</p> <p>Systemic Change</p>	

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K 321	Continued From page 4 approximately 1/2-inch between the meeting edges that would not protect the exit/egress corridor from a smoke condition in that area.  2). At 10:20 AM, the surveyor and [US FOIA] observed the set of doors to the medical records office. When the doors were closed, there was a gap approximately 1/2-inch between the meeting edges that would not protect the exit/egress corridor from a smoke condition in that area.  3). At 10:28 AM, the surveyor and [US FOIA] observed the set of doors to the clean linen room. When the doors were closed, there was a gap approximately 1/2-inch between the doors that would not protect the exit/egress corridor from a smoke condition in that area.  The [US FOIA] confirmed the findings during the observation.  The [US FOIA (b)(6)] was informed of the findings at the Life Safety Code exit conference on 10/29/24 at 2:10 PM.	K 321	The [US FOIA (b)(6)] was educated on the importance of having all fire rated doors to hazardous areas self-closed, labeled and separated by smoke resisting partitions. All areas were identified and corrected using door astragals.  Quality assurance The maintenance director and department will be responsible for conducting weekly audits for one month and then monthly audits for 3 months in all areas that have the potential to have this deficient practice. Results of these audits will be reviewed at the quality assessment and performance improvement committee for review and action as appropriate for one quarter. The QAPI committee will monitor this for one quarter. The committee will determine if further action is needed.		
K 345 SS=F	NJAC 8:39-31.2 (e) Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		12/11/24	

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K 345	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 10/28/24 in the presence of the <b>US FOIA (b)(6)</b>, it was determined that the facility did not provide and maintain complete and accurate documentation, manufacturer's acceptable sensitivity range and testing of the fire alarm system in accordance with the requirements of NFPA 70: 2011 Edition and NFPA 72: 2010. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>At 10:30 AM, the <b>US FOIA (b)(6)</b> provided a fire alarm system smoke detector sensitivity report. The report was dated: 8/18/22 and did not have the facility name on the document. The sensitivity report was observed with no testing range for the specific system installed. The results were identified on the report, but it could not be determined what range is acceptable. The provided sensitivity report indicated "Dirty" (%) The range on the previous 8/18/22 report was from 0% to 72% with no indication on the report what was acceptable, including the required information including the make/model, method of testing and manufacturer's acceptable smoke sensitivity range and Pass or Fail recorded.</p> <p>The <b>US FOIA (b)(6)</b> was informed of the deficient practice at the Life Safety Code exit conference on 10/29/24 at 2:10 PM,.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72</p>	K 345	<p><b>Corrective Action</b> the facility got a new sensitivity report that includes the facility name on the document, that the sensitivity report has a testing range for the specific system installed with an acceptable range, including the make/model, method of testing and manufacturer's acceptable smoke sensitivity range and Pass or Fail.</p> <p><b>Identification of At-Risk Resident</b> This deficient practice had the potential to affect all residents and staff personnel in the facility.</p> <p><b>Systemic Change</b> The <b>US FOIA (b)(6)</b> was educated on the importance of having complete and accurate documentation manufacturers acceptable sensitivity range and testing of the fire alarm system . all reports updated</p> <p><b>Quality assurance</b> The maintenance director will conduct audits quarterly for 12 months on all reports to ensure that they are complete. Results of these audits will be reviewed at the quality assessment and performance improvement committee Quarterly for 4 quarters.</p>	12/1/24	
K 531 SS=F	Elevators CFR(s): NFPA 101	K 531			

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K 531	Continued From page 6  Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/29/24 in the presence of the <b>US FOIA (b)(6)</b> it was determined that the facility failed to maintain elevator emergency communication for 2 of 2 passenger elevator telephones tested in accordance with NFPA 101: 2012 Edition, Sections 19.5.3, 9.4.2, 9.4.3 and ASME/ANSI A17.3. This deficient practice had the potential to affect all residents and was evidenced by the following:  At 11:49 AM, the <b>US FOIA</b> conducted a test of the emergency communication telephone system in the (2) facility passenger elevators. The emergency telephones did attempt to call an outside agency, but no one answered and the	K 531	Corrective Action The elevator vendor fixed the emergency telephone lines and tested them.  Identification of At-Risk Resident All residents and staff personnel have the potential to be affected by this.  Systemic Change The <b>US FOIA (b)(6)</b> was educated on the importance of the NFPA 101 requirements for elevator emergency communication. The maintenance director will test phones monthly to ensure they are working properly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315513</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/30/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE SUBACUTE AT AUTUMN LAKE HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>113 ROUTE 73 VOORHEES, NJ 08043</b>		
(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	
K 531	Continued From page 7 phone was then disconnected from any further communication.  In an interview at the time, the [REDACTED] stated there was a communication issue between the telephone vendor and the elevator company.  The [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 10/28/24 at 2:10 PM.  NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	Quality assurance The maintenance director will be responsible for conducting monthly audits for 3 months ensure that the communication lines in the elevator are operational. Results of these audits will be reviewed at the quality assessment and performance improvement committee quarterly for 1 quarter for any issues or concerns.		
K 712 SS=F	Fire Drills CFR(s): NFPA 101  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 10/28/24 in the presence of the [US FOIA (b)(6)] it was determined that the facility failed to conduct fire drills with varying activation types in accordance with NFPA 101: 2012 Edition, Sections 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced for 12 of 12 fire drills, had the potential to affect all residents in the facility	K 712	Corrective Action  Vendor was inserviced on conducting fire drill with varying activation. The maintenance director will check all drill reports for simulation of alarm transmissions.	12/1/24	

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K 712	Continued From page 8 and was evidenced by the following:  A document review on 10/28/24 with the [US FOIA], revealed the facility fire drill reports identified the method for the simulation of alarm transmission signals were not specific.  Date: type of alarm transmission signal: Pull, Smoke or Page  10/10/24 no transmission signal type. 9/17/24 no transmission signal type. 8/8/24 no transmission signal type. 7/14/24 no transmission signal type. 6/8/24 no transmission signal type. 5/10/24 no transmission signal type. 4/25/24 no transmission signal type. 3/25/24 no transmission signal type. 2/1/24 no transmission signal type. 1/10/24 no transmission signal type. 12/20/23 no transmission signal type. 11/7/23 no transmission signal type.  The findings were verified by the [US FOIA] at the time of record review. The [US FOIA] confirmed that the fire drills were not descriptive as to the type of device used to activate the fire alarm system, (pull, page and smoke) on the above dates.  The [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 10/29/24 at 2:10 PM.	K 712	Identification of At-Risk Resident all staff and residents have the potential to be affected by this.  Systemic Change  The [US FOIA (b)(6)] was educated on the importance of conducting fire drills with varying activation in accordance with NFP 101  Quality assurance The maintenance director will conduct audits quarterly for 12 months on all reports to ensure that the method of the alarm sounding is identified on the fire drill. Results of these audits will be reviewed at the quality assessment and performance improvement committee Quarterly for 4 quarters  the maintenance director will provide the administrator with a copy of the report. the administrator will make sure the method of alarm sounding will be maintained in every report going forward		
K 921 SS=F	NJAC 8:39-31.2(e) Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101  Electrical Equipment - Testing and Maintenance	K 921		12/1/24	

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NAME OF PROVIDER OR SUPPLIER  <b>THE SUBACUTE AT AUTUMN LAKE HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>113 ROUTE 73 VOORHEES, NJ 08043</b>		
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K 921	<p>Continued From page 9</p> <p>Requirements</p> <p>The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.</p> <p>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on document review and interview on 10/29/24 in the presence of the <b>US FOIA (b)(6)</b> it was determined that the facility did not provide policies and protocols for patient care related electrical equipment (PCREE) and non PCREE, conduct maintenance of electrical equipment and maintain a record log of all required testing, test results and repairs in</p>	K 921	<p>Corrective Action</p> <p>All electrical equipment in the facility was inspected to ensure that it is safe and in working order. All equipment was found to be in working properly.</p> <p>Identification of At-Risk Resident this deficient practice had the potential to</p>		

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K 921	<p>Continued From page 10</p> <p>accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. The deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>In an interview, the inspection record and log of electric beds in the facility, policies and protocols for patient care related electrical equipment was requested. <b>US FOIA (b)(6)</b> stated that patient care related electrical inspection and policy was not available.</p> <p>The <b>US FOIA (b)(6)</b> also stated that there was no inspection record, policies and protocols for non-patient care and patient care related electrical equipment for the facility at this time.</p> <p>The <b>US FOIA (b)(6)</b> was informed of the deficient practice at the Life Safety Code exit conference on 10/29/24 at 2:10 PM.</p> <p>NJAC 8:39-31.2(e) NFPA 99</p>	K 921	<p>affect all residents and staff personnel in the facility</p> <p><b>Systemic Change</b> The <b>US FOIA (b)(6)</b> was educated on the importance of conducting maintenance of electrical equipment and maintaining a record log of all required testing.</p> <p>The maintenance director will conduct audits quarterly for 12 months on all electrical equipment in the facility to ensure that it is working properly. Results of these audits will be reviewed at the quality assessment and performance improvement committee Quarterly for 4 quaters for any concerns.</p>		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315513	Y1	MULTIPLE CONSTRUCTION A. Building 01 - POWERBACK B. Wing	Y2	DATE OF REVISIT 12/12/2024	Y3
NAME OF FACILITY THE SUBACUTE AT AUTUMN LAKE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 _____ Reg. # NFPA 101 LSC K0293	Correction Completed 12/01/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0321	Correction Completed 12/01/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0345	Correction Completed 12/01/2024
ID Prefix _____ Reg. # NFPA 101 LSC K0531	Correction Completed 12/01/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0712	Correction Completed 12/01/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0921	Correction Completed 12/01/2024
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

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/30/2024	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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