STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 08857**

(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 NJ #: 164726, 166672, 168050, 169735, 170064, 170351, 170683, 171427 Survey Date: 10/1/24 to 10/8/24 Census: 105 Sample: 23 + 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 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 688	Resident #10 [NJ Exec Order 26] was immediately	11/23/24

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

Electronically Signed | 10/31/2024

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F 688	Continued From page 1 and review of other facility documentation, it was determined that the facility failed to: a.) consistently follow a physician's order for the application of a NJ Exec Order 26.4b1 of a wheelchair for a resident with deNJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) b.) follow the residents individualized comprehensive care plan (ICCP), and c:) consistently document accountability for the placement of the device. The deficient practice was identified for 1 of 1 resident (Resident #10) reviewed for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) This deficient practice was evidenced by the following: On 10/01/24 at 11:40 AM, the surveyor observed Resident #10 in his/her wheelchair in the dayroom without a NJ Exec Order 26.4b1 of the wheelchair. On 10/02/24 at 11:35 AM, the surveyor observed the Resident in his/her wheelchair in the dayroom without aNJ Exec Order 26.4b1 of the wheelchair. The surveyor reviewed Resident #10's electronic Medical Record (eMR). A review of the resident's Admission Record revealed diagnoses that included but were not limited to: NJ Exec Order 26.4b1 A review of the resident's Quarterly Minimum Data Set (MDS), a tool used to facilitate the management of care, dated NJ Exec Order 2, revealed a Brief Interview for Mental Status (BIMS) score of	F 688	applied to his wheelchair(w/c) per the physician order and the plan of care. On 10/9/24 The affected resident for the deficient practice w/c NJ Ex Order 26.4(b)(1) order was reviewed by the Director of Nursing (DON) and updated the order to reflect on the treatment administration record for accountability. Resident # 10 did not have any negative outcome from the deficient practice. On 10/9/24, An audit was done by the DON on all residents with positioning devices for the deficient practice. No issues found from the audit. Identification of others with the potential to be affected: Facility residents discharge from therapy services with positioning devices to have the potential to be affected. This can be identified by reviewing the Medical Record Systemic Change: On 10/9/24 DON began education with the nursing staff (Registered Nurse, Licensed Practical Nurse, Certified Nurse Assistant) on the following: All positioning devices /splints orders will be documented on the treatment administration record, KARDEX/Tasks for accountability per the physician orders the residents plan of care. (2) Maintaining proper positioning and body alignment. Monitoring of Corrective Measures: The Unit Managers (UM) will audit and review the Treatment Administration Records to ensure that all residents with splint, and positioning devices orders are completed and documented per physician orders Daily for 4 weeks weekly x 4 weeks, then	

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F 688	Continued From page 2 NJ Exec Order 26.4b1, which indicated a NJ Exec Order 26.4b1 A review of the NJ Ex Order 26.4(b)(1) Order Summary Report, revealed a physician's order (PO), dated NJ Ex Order 26, for NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 daily morning." A review of the NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR), did not reflect the above PO. A review of the ICCP, dated NJ Ex Order 26, revealed a care plan for " NJ Exec Order 26.4b1 " The goals revealed "[name redacted] will maintain or NJ Ex Order 26.4(b)(1) function over next quarter." Further review revealed the intervention "Apply NJ Exec Order 26.4b1 ." A review of the U.S. FOIA (b)(6) "Tasks" revealed a Task: "Apply NJ Exec Order 26.4b1 for NJ Ex Order 26.4(b)(1) when resident in wheelchair." Further review of the "Tasks" from the dates of NJ Exec Order 26.4b1 revealed no documented accountability for placement of this device for 13 out of 30 days reviewed. There was no documented accountability for NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) On 10/02/24 at 12:23 PM, the surveyor observed Resident #10 in the day room, awaiting lunch, in his/her wheelchair at a table without a NJ Exec Order 26 The surveyor interviewed the U.S. FOIA (b)(6)) and together observed the resident in his/her wheelchair. She acknowledged that there was NJ Exec Order 26.4b1 of the wheelchair. The U.S. FOIA (b)(6)	F 688	monthly x 4 months. Any issues found will be addressed immediately and reported to the DON. Findings from the audit will be reported to the administrator as well as the quality Assurance Committee quarterly for 6 months or until compliance is met.	

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F 688	Continued From page 3	F 688		

stated that the purpose of the device was for [redacted] and it was the responsibility of the [redacted] to apply the device when they transfer the resident to his/her wheelchair. She stated that she was "not sure if it should be on the TAR" for accountability. She further acknowledged that if the device was evidenced in the [redacted] "Tasks," that it would have been the [redacted] responsibility to document accountability that the device was in place. The surveyor and the [redacted] reviewed the "TASKs" in the eMR, and she acknowledged that there were multiple omissions to account for [redacted] placement of the [redacted] device from dates [redacted] through [redacted], including [redacted]. She also stated that it should have been both the nurse and therapists' responsibility to oversee this process. The surveyor and [redacted] went to Resident #10's room which revealed the [redacted] (black in color) in the top of the resident's closet. In addition, she stated that the [redacted] assigned to the resident today was new and did not have access to the eMR and "TASKs," and therefore he probably did not know the resident required the [redacted]. She further stated, "we should have told him to apply the [redacted] The [redacted] stated that the staffing coordinator should have provided the [redacted] with access to the eMR and "TASKs."

On 10/02/24 at 1:45 PM, the surveyor interviewed the [redacted] who stated that he had worked at the facility one day in [redacted] and this was his first day back since then. He stated that he requested access to the eMR from the [redacted], who then requested the same from the staffing coordinator. He stated that up until this point he still had no access to the eMR. The [redacted] further acknowledged that he had no knowledge that the resident required a [redacted] to the [redacted] of the wheelchair and that "no one told him."

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F 688	Continued From page 4 On 10/02/24 at 2:03 PM, the surveyor interviewed the staffing coordinator. She verified that it was the [U.S. FOIA (b)(6)] first day and that he should have received eMR access. She stated that she was "mostly" responsible to set up access for the [redacted] prior to the start date. The U.S. FOIA (b) (6) stated that in the event it could not have been done timely, the U.S. FOIA (b)(6) [redacted] had the ability to gain access as well. She further stated she was "busy but that is no excuse." The U.S. FOIA (b) (6) acknowledged the [U.S. FOIA (b)(6)] requested access for the [U.S. FOIA (b)] and that she had not done so yet. On 10/03/24 at 9:00 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]. She stated that the [U.S. FOIA (b)(6)] for the [NJ Exec Order 26.4(b)] of the wheelchair was for [NJ Ex Order 26.4(b)(1)] and that the resident tends to lean due to [NJ Ex Order 26.4(b)]. She stated that the device was trialed, and it was "successful." She also stated that it was the responsibility of the [U.S. FOIA (b)] to apply the [NJ Exec Order 26] and account for that in the "TASKs" section of the eMR. She further stated that nursing should oversee this process to ensure placement and accountability, and she was not sure if the PO should have also been on the TAR. She stated that the resident was discharged from therapy on [NJ Ex Order 26.4(b)]. On 10/08/24 at 9:40 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) in presence of survey team as well as the [U.S. FOIA (b)(6)] and the U.S. FOIA (b)(6) She acknowledged that the [U.S. FOIA (b)(6)] had not been in place as the surveyor observed and was not accounted for on the TAR. The [U.S. FOIA (b)(6)] acknowledged that the staffing coordinator should have gotten the [U.S. FOIA (b)] access to the eMR and provided it to nursing prior to the	F 688		

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F 688	Continued From page 5 CNAs arrival. In addition, he stated that he also had the ability to acquire access. The [redacted] stated that in the event eMR access was not available that nursing should have given the [redacted] a verbal report of the resident's needs. A review of the facility policy "Activities of Daily Living (ADLs)" dated February 2024, included "The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable." A review of the facility policy "Assistive Devices and Equipment" dated July 2024, included the following: "Our facility maintains and supervises the use of assistive devices and equipment for residents." "Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents." "Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the residents care plan." "Staff and volunteers are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents." A review of the facility policy "Care Plans, Comprehensive Person-Centered" dated July 2024, included "A comprehensive, person-centered care plan that includes	F 688		

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F 688	Continued From page 6 measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." NJAC 8:39-27.1(a)	F 688		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication administration times to accommodate for a resident's [NJ Exec Order 26] scheduled times. The deficient practice was identified for one (1) of one (1) resident, (Resident #151) reviewed for [NJ Exec Order 26] services and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by	F 698	The Unit Manager reviewed all physician orders for Resident # 151 with the attending physician and orders were received and plotted according to the affected resident [NJ Ex Order 26.4(] scheduled days and times. Resident # 151 did not have any negative effect from the deficient practice. Identification of Resident at Risk: The facility has determined that all residents who receive dialysis have the potential to be affected. This can be identified by reviewing the residents medical records/ Medication Administration Record. Actions taken/systems put into place to reduce the risk of future occurrence include the following: The Director of Nursing , audited all residents receiving dialysis medication	11/23/24

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F 698	Continued From page 7 a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 10/2/24 at 1:00 PM, the surveyor interviewed Resident #151 in their room. The resident stated that they go to NJ Exec Order 26.4b1 and was usually picked up after 3 PM and would return to the facility around 9 PM. The resident stated that the nurses brought them their medication. The resident was unable to speak to which medications and what times they received their medications. The surveyor reviewed the medical record for Resident #151. A review of the resident's Admission Record revealed diagnoses which included but not limited to, NJ Exec Order 26.4b1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated	F 698	administration Records to ensure medications orders reflect the resident□s dialysis scheduled days and times. No issues were found from the audit. ON 10/9/24, An in-service education program was conducted by the Director of Nursing with the Unit Managers, Licensed practical Nurse and Registered nurses regarding reviewing and documenting medications according to the residents dialysis scheduled days and times. The UM will bring admission charts to clinical meeting for review, to ensure medication /treatment order are documented accurately. Education will be completed on 11/15/24 How the corrective action(s) will be monitored to ensure the practice will not recur. The DON/designee will do a random audit of two residents receiving dialysis weekly 4 weeks, biweekly for 4 weeks` and then monthly for 4 months The pharmacy consultants will review all residents receiving dialysis monthly. Any issues found form the audits will be addressed immediately and reported to the administrator as well as the quality Assurance Committee Quarterly for 6 months or until compliance is met.	

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F 698	Continued From page 8 NJ Exec Order 26 reflected the resident had a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1, indicating that the resident had an U.S. FOIA (b) [redacted] A review of the resident's interdisciplinary care plan (IDCP) revealed as a focus that the resident received NJ Exec Order 26.4b1 (same as NJ Exec Order 26.4b1 [redacted]) due to NJ Exec Order 26.4b1. An intervention/task included but was not limited to, that the resident received NJ Ex Order 26.4(MWF with a NJ Ex Order time of 4:15 PM and pick up time of 3:15 PM and to offer the resident a dinner tray upon returning from NJ Exec Order 26. The goal reflected that the resident would not have signs and symptoms of complications from NJ Exec Order 26. The IDCP had not indicated any interventions regarding medication times. A review of the resident's NJ Exec Order 26 book, that was kept on the unit, reflected that NJ Exec Order 26 was scheduled for 'NJ Exec Order 26.4b1 pick up time" and "chair time" was 4:15 PM and "treatment 4 hours." In addition, the dialysis book contained a 'NJ Exec Order 26.4b Communication Form" for the dates of NJ Exec Order 26.4b1 that were completed indicating that the resident had received [redacted] on those days. A review of the resident's Order Summary Report for active orders as of NJ Exec Order 26.4b revealed a physician's order (PO) dated NJ Exec Order 26.4 for the following: -'U.S. FOIA (b)(6) [redacted]) Give 1 tablet by mouth two times a day (BID) for NJ Exec Order 26.4b1 [redacted]) Give	F 698		

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F 698	Continued From page 9	F 698		

NJ Exec Order 26.4b1

NJ Exec Order 26.4b1

Administer with meals."

-'NJ Exec Order 26.4b1

There were no PO indicating medications to be administered on NJ Ex Order 26.4(days and NJ Ex Order 26.4(b)(1) days or changes in administration times on NJ Ex Order 26.4(and NJ Ex Order 26.4(b)(1) days.

A review of the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) electronic medication administration record (eMAR) for the POs listed above indicated medication administration times that occurred during the time that the resident was out of the facility at NJ Exec Order 26.4b1 . The eMAR revealed the following:

-on NJ Ex Order 26.4(the doses for NJ Exec Order 26.4b1 all indicated for administration the number 5 which corresponded to the code chart "hold/see nurses notes."

-on NJ Exec Order 26.4b1

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F 698	Continued From page 10 and NJ Exec Order 26.4b1 which corresponded to the code chart "other/see nurses notes." A review of the resident's corresponding electronic progress notes (EPN) revealed the following: -on NJ Ex Order 26.4(an eMAR Administration Note for 21:25 (9:25 PM) indicated for NJ Exec Order 26.4b1 -on NJ Ex Order 26.4(b) an eMAR Administration Note for 16:39 (4:39 PM) indicated for NJ Exec Order 26.4b1 On 10/4/24 at 11:19 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who verified that Resident #151 on MWF was picked up from the facility at approximately 3:15 PM for NJ Ex Order 26.4(b) The U.S. FOIA (b) stated that she was able to administer all the resident's medications during her shift which was 7 AM to 3 PM. The U.S. FOIA (b) added that when the resident was out to NJ Ex Order 26.4(then medications should not appear on the eMAR for administration. The U.S. FOIA added that if a medication was on the eMAR when the resident was out to U.S. FOIA (b)(6) then the time of the medication should be changed. On 10/4/24 at 1:00 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that medication times should be reviewed with the physician and adjusted to accommodate the resident being out of the facility at U.S. FOIA (b)(6) . The surveyor, with the U.S. FOIA (b)(6) reviewed the eMAR for Resident #151. The U.S. FOIA (b)(6) acknowledged that NJ Exec Order 26.4b1	F 698		

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F 698	Continued From page 11	F 698		

NJ Exec Order 26.4b1 had times of administration when the resident was out to NJ Exec Order 26.4b The U.S. FOIA (b)(6) stated that those medications should not have an administration time when the resident was at NJ Ex Order 26.4(b) The U.S. FOIA (b)(6) stated, "I have to fix that." The U.S. FOIA (b)(6) added that Resident #151 was recently readmitted to the facility and the prior admission had the medication times adjusted. The U.S. FOIA (b)(6) explained that upon readmission the nurses should have compared the medication times and obtained a PO for those medications to accommodate when the resident was out to NJ Ex Order 26.4(b)

On 10/7/24 at 11:50 PM, the surveyor interviewed the U.S. FOIA (b)(6) who acknowledged that upon the resident's readmission the medications were not timed to accommodate when the resident went out to NJ Ex Order 26.4(b) The U.S. FOIA (b)(6) added that a chart review should have been completed to make sure the medications were timed correctly.

On 10/8/24 at 12:25 PM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated that medication times need to be adjusted to accommodate NJ Ex Order 26.4(times. The U.S. FOIA added that she would make that recommendation during her chart review. The U.S. FOIA also stated that her last chart review was NJ Ex Order 26.4(and the resident was readmitted just last week.

A review of the facility policy updated July 2024 for Administering Medications provided by the U.S. FOIA (b), reflected that medications are to be administered in a timely manner as prescribed. Further review of the policy reflected, " Medications are administered within one (1) hour of their prescribed time, unless otherwise

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 08857**

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F 698	Continued From page 12 specified (for example, before and after meal orders)." A review of the facility policy dated as revised February 2023 for Hemodialysis provided by the U.S. FOIA (b) reflected that "This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician's orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis." In addition, the policy reflected that "The facility will ensure that the physician's orders for dialysis include: ...f. Any medication administration or withholding of specific medications prior to dialysis treatments."	F 698		
F 755 SS=D	NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		11/23/24

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F 755	Continued From page 13 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ00169735, NJ00170064 and NJ00170351 Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards of practice by not ensuring that a.) medications were administered to a resident in a timely manner as ordered by a physician, (Resident #72). This was identified for one (1) of eight (8) residents, reviewed for medication management. and b.) a [redacted] was available for administration and accurately documented as per a physician's order in the electronic medication administration record (Resident #87). This was identified for one (1) of eight (8) residents, reviewed for medication management. The deficient practices were evidenced by the following: Reference: New Jersey Statutes Annotated, Title	F 755	The unit manager(UM) performed a Medication Cross Match on resident # 72 and # 87. The physician was notified. Identification of other residents having the potential to be affected All residents with daily routine medication orders have the potential to be affected by this practice. Measures to Prevent Recurrence: On 11/4/24, the DON re-educated the staff nurses on the following: 1. The facility policy on administering medications in accordance with the physician orders, including any required time frame, right dosage, right time, right method (route) of administration. 2. Medications found to be at (10) doses or less will be reordered following the facility□s medication reorder system 3. The nurse assigned to the medication	

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F 755	Continued From page 14 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 10/1/24 at 10:32 AM, the surveyor interviewed Resident #72 in their room. The resident stated that they were [NJ Ex Orde] but had [NJ Ex] [redacted]. The resident stated that they knew all their medications and what time they were due. The resident added that they had to make sure that they received their NJ Ex Order 26.4(b)(1) before they ate and that sometimes was late getting their medications. The resident added that they knew specifically in NJ Ex Order 26.4(b)(1) they had received their medications late. On 10/2/24 at 8:27 AM, during the morning	F 755	cart will perform a medication cross match. 4. Licensed nurses will notify the UM/supervisor and contact the pharmacy if a medication is not available or received by the pharmacy. The medical provider must be contacted and informed of unavailable medications. The complete education date is 11/23/24 Monitoring of Corrective Measures: The DON /Pharmacy consultant/ designee will complete random audits of 4 residents on each unit weekly for 8 weeks and then monthly for 4 months to ensure medications are administered in a timely manner according to the physician order and medications are available for administration via medication cart and back up supply. Any issues found from the audit will be addressed immediately and reported to the Administrator as well as the Quality Assurance Committee quarterly for 6 months or until compliance is met.	

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medication administration observation with the U.S. FOIA (b)(6)), the surveyor observed Resident #72 at their room door in a wheelchair calling out to the U.S. FOIA (b). The U.S. FOIA (b) stated that she would be giving medications to the resident next.

The surveyor reviewed the medical record for Resident #72.

A review of the resident's Admission Record revealed diagnoses which included but not limited to:NJ Exec Order 26.4b1

A review of the most recent annual comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4, reflected the resident had a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1 indicating that the resident had an NJ Exec Order 26.4b1.

A review of the resident's interdisciplinary care plan (IDCP) revealed as a focus that the resident has NJ Ex O and an intervention/task included but was not limited to, " NJ Ex Order 26.4(b)(1 medication as ordered by doctor." Additionally, another focus was that the resident has NJ Ex Order 26.4(b)(1)) with an intervention/task to "Give U.S. FOIA (b)(6) medications as ordered."

A review of the resident's Medication

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Administration Audit Report (MAAR) revealed that on NJ Exec Order 26.4b1 Resident #72 had received their medications out of the allowed time range of one hour before or 1 hour after the time of administration as ordered by the physician. The report reflected the following for NJ Ex Order 26.4(b)(1):

NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1)) had a scheduled time of 9 AM and had an administration time of 11:36 AM and a documented time of 11:41 AM.

NJ Exec Order 26.4b1 had a scheduled time of 2 PM and had an administration time of 3:52 PM and a documented time of 4:53 PM.

-NJ Exec Order 26.4b1) had a scheduled time of 5:05 PM and had an administration time of 6:51 PM and a documented time of 6:51 PM.

U.S. FOIA (b)(6) NJ Ex Order 26. had a scheduled time of 5:15 PM and had an administration time of 6:51 PM and a documented time of 6:51 PM.

NJ Exec Order 26.4b1 had a scheduled time of 5:30 PM and had an administration time of 6:51 PM and a documented time of 6:51 PM.

Further review of the MAAR reflected the following for NJ Exec Order 26.4b

had a scheduled time of 8:15 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM.

NJ Exec Order 26.4b1 l) had a scheduled time of 8:15 AM and had an administration time of 11:14 AM and a

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F 755	Continued From page 17 documented time of 11:14 AM. -NJ Exec Order 26.4b1 had a scheduled time of 8:30 AM and had an administration time of 11:13 AM and a documented time of 11:13 AM. -NJ Exec Order 26.4b1 (NJ Ex Order 26.4(b)(1)) had a scheduled administration time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. -NJ Exec Order 26.4b1 had a scheduled time of 9AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. -NJ Exec Order 26.4b1 had a scheduled time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. NJ Exec Order 26.4b1 had a scheduled time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. NJ Exec Order 26.4b1 had a scheduled time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. NJ Exec Order 26.4b1 had a scheduled time of 9am and had an administration time of 11:12 AM and a documented time of 11:13 AM. -NJ Exec Order 26.4b1 had a scheduled time of administration for 9 AM and had an administration time of 11:12 and a documented time of 11:13 AM. NJ Exec Order 26.4b1 had a scheduled time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. NJ Exec Order 26.4b1) had a scheduled time of 9 AM and had an administration time of 11:14 AM and a documented time of 11:14 AM. U.S. FOIA (b)(6) had a	F 755		

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F 755	Continued From page 18 scheduled time of 5 PM and had an administration time of 10:46 PM and a documented time of 10:47 PM. NJ Exec Order 26.4b1) had a scheduled time of 7 PM and had an administration time of 9:16 PM and a documented time of 9:48 PM. [redacted] NJ Ex Order 26.4(b)(1) had a scheduled time of 9:05 PM and had an administration time of 10:47 PM and a documented time of 10:47 PM. A review of the NJ Ex Order 26.4(b)(1) electronic medication administration record (eMAR) revealed nurse's initials that signified that the above medications were administered at their scheduled times. This contradicted the above administration times. A review of the electronic progress notes (ePN) had not revealed that there was any indication of a need for the above medications to be administered outside of the time of administration that was ordered by the physician. On 10/4/24 at 3:12 PM, the survey team met with the U.S. FOIA (b)(6) and the [redacted] and reviewed the above concern regarding late medication administration for Resident #72 on NJ Ex Order 26 4 and NJ Ex Order 26.4(. The U.S. FOIA (b) stated that she would have to review. The U.S. FOIA (b) was unable to speak to whether audits were reviewed to ensure and identify accurate medication administration times documented on the eMAR. On 10/7/24 at 11:50 AM, the surveyor interviewed the U.S. FOIA (b) who stated that Resident #72 had been on NJ Ex Order 26.4(b)(1) for [redacted] NJ Exec Order 26.4b1	F 755		

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[redacted] in [redacted] The [redacted] added that the nurses should be signing the eMAR after the medication was administered and should not be administering or documenting late. The [redacted] acknowledged that according to the MAAR the above medications were administered late.

A review of the facility policy updated July 2024 for Administering Medications provided by the [redacted] reflected that medications are to be administered in a timely manner as prescribed. Further review of the policy reflected, "Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)." In addition, the policy reflected, "If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose."

2. On 10/3/24 at 11:56 AM, the surveyor interviewed Resident #87 in their room. The resident stated they felt that the nurses frequently ran out of their medication, [redacted]. The resident also stated that they were supposed to receive the [redacted] every four (4) hours. The resident added that the nurses would tell them that they were waiting for the pharmacy to deliver the medication. The resident then stated this past weekend there was a problem on Sunday and Monday with getting the [redacted] The resident stated, "On Monday morning at 9 AM and 1 PM the nurse did not have any[redacted], so I did not receive any until 5 PM." The resident further stated that "I was okay because I have a [redacted] I can take in between, and I took that at [redacted] The resident also stated that

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they thought it was odd that the nurse could not get the [NJ Exec Order 26.4b1] because usually the nurses would tell them that they had to go to the backup when they did not have the [NJ Exec Order 26.4b1] in the medication cart.

The surveyor reviewed the medical record for Resident #87.

A review of the resident's Admission Record revealed diagnoses which included but not limited to; [NJ Exec Order 26.4b1]

A review of the most recent quarterly comprehensive MDS, dated [NJ Exec Order 26.4b1] reflected the resident had a BIMS score of [NJ Exec Order 26.4b1], indicating that the resident had an [NJ Exec Order 26.4b1]

A review of the electronic Order Summary Report revealed a physician's order (PO) dated [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b1]"

A review of the [NJ Ex Order 26.4(b)(1)] eMAR revealed the above PO with administration times of [NJ Exec Order 26.4b1]. In addition, the eMAR revealed that on [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] the nurse entered the number "[NJ Exec Order 26.4b1]" for administration which corresponded with the chart code "Other/see nurses notes."

A review of the ePN dated [NJ Ex Order 26.4(b)(1)] at 9:00, titled eMAR Medication Administration Note for [NJ Exec Order 26.4b1] indicated "medication not given notified MD medication pending delivery from

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F 755	Continued From page 21 pharmacy." In addition, another eMAR Medication Administration Note dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 indicated "pharmacy notified, pending delivery. MD notified." A review of the NJ Ex Order 26.4(b)(1) Backup Box Medications Contents list provided by the U.S. FOIA (b)(revealed that NJ Exec Order 26.4b1 were available. A review of the removals from the NJ Ex Order 26.4(b)(1) backup box revealed the NJ Ex Order 26.4(b)(1) Countdown Sheet (NJ Ex Order 26.4(b)(for NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . In addition, NJ Exec Order 26.4b1 was removed on NJ Exec Order 26.4b1 and on NJ Exec Order 26.4b1 A review of the NJ Ex Order 26.4(b) for NJ Exec Order 26.4b1 reflected that there was removal of one (1) tablet from inventory on NJ Exec Order 26.4b1 In addition, NJ Exec Order 26.4b1 . A review of the NJ Exec Order 26.4b1 eMAR revealed the above PO and indicated that NJ Exec Order 26.4b1 was administered as a for the same dates and times listed above on the NJ Ex Order 26.4(b)(A review of the ePN for the same dates and times as the NJ Ex Order 26.4(b) had not indicated that NJ Exec Order 26.4b1 . There was no documentation that there was a PO	F 755		

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F 755	Continued From page 22 obtained allowing the administration of [redacted] for the dates and times indicated on the [redacted] On 10/4/24 at 11:52 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she was responsible for the medications for Resident #87 and worked at the facility on a regular basis. The [redacted] verified that the resident had a PO for [redacted] to be administered every four (4) hours. The [redacted] explained that the procedure was to order the [redacted] or any medication for refill before running out. The [redacted] stated that the U.S. FOIA (b)(6)) was available every Tuesday and Thursday and if a new prescription was needed then the [redacted] would write one. The [redacted] added that [redacted] was also in the facility backup supply but she tried not to use that because the [redacted] was a routine PO and should be available. On 10/4/24 at 3:12 PM, the survey team met with the U.S. FOIA (b)(6) and reviewed the above concern of [redacted] not being available on [redacted] and the use of the backup supply of [redacted]. The [redacted] stated that she would have to review. On 10/7/24 at 11:50 AM, the surveyor interviewed the [redacted] who acknowledged that the U.S. FOIA (b)(6) was not administered on NJ Exec Order 26.4b1 PM. The [redacted] further acknowledged that NJ Exec Order 26.4b1 were available in the backup supply and was unable to speak to why the nurse had not used the backup supply. In addition, the [redacted] stated that according to the [redacted] the removal of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 accounted for all the	F 755		

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F 755	Continued From page 23	F 755		

doses documented as administered on the eMAR for the same dates and times. The [U.S. FOIA (b)] added that the correct dose was administered. The [U.S. FOIA (b)(6)] acknowledged that the PO was for [NJ Exec Order 26.4b1] MG tablets and that according to the eMAR a 15 MG tablet was documented as administered for the same dates and times as the [NJ Ex Order 26.4(b)] indicated removals from the backup inventory for [NJ Exec Order 26.4b1]. The [U.S. FOIA (b)] was unable to speak to the documentation on the eMAR not matching what the physician ordered.

On 10/8/24 at 12:25 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that the dose of any medication as ordered by the physician had to match the dose being administered. The [U.S. FOIA] also stated that if the PO was for a [U.S. FOIA (b)(6)] then a new PO was needed to administer [NJ Exec Order 26.4b1] to make the total [NJ Exec Order 26.4b1]. The [U.S. FOIA] added that the eMAR must be signed for the actual doses being administered as ordered.

A review of the facility policy titled "Medication and Treatment Orders" provided by the [U.S. FOIA (b)] dated July 2024 reflected that "Drugs and biologicals that are required to be refilled should be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available." In addition, the policy reflected that "Orders for medications must include: a. name and strength of the drug;"

A review of the facility policy titled "Backup Medications and Controlled Medications in Long-Term Care Setting" provided by the [U.S. FOIA (b)] and updated 10-24 which reflected that "The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516 OLD BRIDGE, NJ 08857**

(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 755	Continued From page 24 facility will maintain a system for the secure management of backup and controlled medications to ensure availability while minimizing risks of misuse or diversion." In addition, for "Administration: Ensure that all staff are trained on the protocols for accessing and administering backup medications. Document administration in the resident's medical record." And "4. Documentation: Ensure administration of controlled medications are documented accurately in the resident's medical record and in a controlled substance log." The policy also revealed for "Administration: Ensure that all staff are trained on the protocols for accessing and administering backup medications. Document administration in the resident's medical record." And "4. Documentation: Ensure administration of controlled medications are documented accurately in the resident's medical record and in a controlled substance log." NJAC 8:39-11.2(b), 29.2 (a)(d), 29.4(k), 29.7(c)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation on 10/2/24, the surveyor observed two (2) nurses administer medications	F 759	Resident #72 Physician was notified of the deficient practice. No further order given. The License practical nurse with the deficient practice was in service through a competency evaluation by the Director of nursing (DON) on the facility	11/23/24

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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F 759	Continued From page 25 to five (5) residents. There were 31 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 6.45 %. This deficient practice was identified for one (1) of five (5) residents, (Resident #72), that were administered medications by one (1) of two (2) nurses. The deficient practice was evidenced as follows: On 10/2/24 at 8:27 AM, the surveyor observed the U.S. FOIA (b)(6) preparing to administer NJ Exec medications to Resident #72, which included NJ Exec Order 26.4b1 according to the electronic medication administration record (eMAR). The U.S. FOIA removed the NJ Exec Order 26.4b1 from the medication cart, removed the NJ Exec Order 26.4b1 At that time, the U.S. FOIA explained that Resident #72 NJ Exec Order 26.4b1 (meaning that the resident had an), was able to administer the NJ Exec O themself and was very involved and aware of their medications. On 10/2/24 at 8:52 AM, the surveyor observed the U.S. FOIA give the NJ Exec Order 26.4b1 to the resident who self-administered a dose of NJ Ex Order 26.4b and then the surveyor observed the U.S. FOIA give the resident the NJ Exec Order 26.4b1 who then self-administered a NJ Exec Order 26.4b1 The surveyor had not observed the U.S. FOIA (b) prime either the NJ Exec Order 26.4b1 before administration. (ERROR #1 and #2)	F 759	policy and proper procedure of NJ Ex Order 26.4(b)(1) administration. Identification of other residents having the potential to be affected. All residents receiving insulin pen administration have the potential to be affected by the deficient practice therefore, on 11/4/24, a re-education of staff nurses was started by the DON on insulin pen administration Measures/systems to prevent occurrence: the facility developed a system to include in all insulin pen administration physician order to prim prior to each use to avoid collecting air in the insulin reservoir. On 11/4/24, a re-education was started for all nurses through a competency evaluation on the proper technique of insulin pen administration. This education will be added to the new hire process, annually and as needed. Education completion date is 11/23/24 Monitoring of corrective Measures: The DON/Pharmacy consultant /designee will conduct Random medication administration audit for one nurse weekly on each shift for 4 weeks, then two nurses monthly for 3 months, then one nurse monthly on-going to ensure compliance with facility guidelines. Any issues found from the audit will be addressed immediately and reported to the Administrator, as well as the Quality Assurance Committee quarterly or until compliance is met.	

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	315381	A. BUILDING _____ B. WING _____	C 10/08/2024

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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F 759	Continued From page 26 The surveyor reviewed the medical records for Resident #72. A review of the resident's Admission Record reflected that the resident had diagnoses which included but not limited to, NJ Exec Order 26.4b1 [redacted] A review of the resident's Order Summary Report reflected the following: - a physician's order (PO) with an order date of NJ Ex Order 26 for NJ Exec Order 26.4b1 [redacted] in the morning for NJ Ex Or supervised self-administration NJ Ex Order 26.4(b)(1) ." - a PO with an order date of NJ Ex Order 26.4(b) for NJ Exec Order 26.4b [redacted] with unspecified complications supervised self-administration refrigerate until opening, store at room temp after opening, rotate sites." -a PO with an order date of NJ Exec Order 26.4b1 [redacted] with unspecified complications supervised self-administration Give 15 minutes prior to a meal or snack, refrigerate until opened."	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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F 759	Continued From page 27 A review of the eMAR reflected the above POs. On 10/3/24 at 8:30 AM, the surveyor interviewed the [redacted] who stated that she only performed a "test" on the insulin pen- injectors when "they were fresh out of the refrigerator." The [redacted] explained that the [redacted] were stored in the refrigerator until it was time to use the [redacted] and then it remained stored in the medication cart until it was finished. The [redacted] further explained that the "test" was done on the [redacted] by [redacted] and then seeing that the [redacted] comes out of the [redacted] The [redacted] stated that she had not "tested" the [redacted] before each [redacted] because she thought that would be wasting the [redacted] The [redacted] acknowledged that the "test" she had described was the same as [redacted] but was unaware that the [redacted] The [redacted] stated that she had been working at the facility for six (6) months and was unsure if there had been an inservice regarding [redacted]. The [redacted] also stated that she would have to do the priming of the [redacted] for Resident #72 because the resident had [redacted] On 10/3/24 at 9:10 AM, the surveyor interviewed the [redacted] via the telephone. The [redacted] stated that the [redacted] were required to be primed before each [redacted] The [redacted] added that she had done training in the past but not recently. The [redacted] also stated that there had been a handout regarding [redacted] that was posted in the medication room at one time. A review of an information sheet for [redacted]	F 759		

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	315381	A. BUILDING _____ B. WING _____	C 10/08/2024

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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F 759	Continued From page 28	F 759		

& Administration provided by the [U.S. FC] revealed for "Administration Techniques" "2. Priming the Pen ("airshot") a. Dial the specified amount of units. B. Orient the pen properly (point up-vertically-unless otherwise specified) and tap cartridge holder to collect air at the top c. Push the dose knob in until it stops. D. Priming is complete when a drop of insulin appears at the needle tip. E. If a drop of insulin does not appear, repeat priming steps; if no results, change the needle."

On 10/3/24 at 1:27 PM, the survey team met with the [U.S. FOIA (b)(6)]) and the [U.S. FOIA (b)(6)] The [U.S. FOIA (b)] acknowledged that the [NJ Exec Order 26.4b1] were to be [NJ Exec Order 26.4b1] by not following the manufacturer's specifications fo [NJ Exec Order 26.4b1] (ERROR #1 and #2)

On 10/4/24 at 3:12 PM, the surveyor team met with the [U.S. FOIA (b)(6)] . The [U.S. FOIA (b)] stated that instructions for prior to each injection was added to the eMAR.

A review of the facility policy for Insulin Pen, dated as accessed April 2024, provided by the [U.S. FOIA (b)] reflected for "11. Procedure: .... h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears."

A review of the manufacturer specifications for Instructions for Use for [NJ Ex Order 26.4(b)(1)] revealed "People who are blind or have vision problems should not use the Pen without help

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F 759	Continued From page 29 from a person trained to use the Basaglar prefilled pen." In addition, the instructions reflected "Prime before each injection. Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin." A review of the manufacturer specifications for Instructions for Use for [redacted] revealed "Check the insulin flow Step 5: Small amounts of air may collect in the cartridge during normal use. You must do an airshot before each injection to avoid injecting air and to make sure you receive the prescribed dose of your medicine." NJAC 8:39-11.2(b), 29.2(d)	F 759		

NJ Ex Order 26.4(b)(1)

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061210	A. BUILDING: _____ B. WING _____	C 10/08/2024

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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S 000	Initial Comments Complaint # NJ00170683 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: NJ00170683 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 22 of 28 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents have the potential to be at risk for the deficient practice. SYSTEMIC CHANGE: The Facility Administrator has Contracted with additional staffing agencies to secure supplemental facility staffing. Hiring and	11/23/24

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

Electronically Signed | 10/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061210	A. BUILDING: _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 2/01/21: 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 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. The survey team requested staffing for the weeks from 12/19/2023 to 01/01/2024 and 09/15/2024 to 09/28/2024. The facility was deficient in CNA staffing for residents on 22 of 28 day shifts as follows: 1. For the 2 weeks of staffing from 12/19/2023 to 01/01/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -12/19/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/20/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/21/23 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs.	S 560	recruitment efforts including wage analysis and adjustments, pay for experience, online job listings and referral bonuses are being utilized to ensure marketplace competitiveness. Bonuses are offered to staff members and agency staff if there are shifts needing to be filled. In addition, the director of nursing will meet daily with the staffing coordinator to ensure appropriate staffing QUALITY ASSURANCE: The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061210	A. BUILDING: _____ B. WING _____	C 10/08/2024

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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S 560	Continued From page 2 -12/22/23 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/23/23 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/24/23 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/25/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/26/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/28/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/29/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/30/23 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/31/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/01/24 had 11 CNAs for 101 residents on the day shift required at least 13 CNAs. 2. For the 2 weeks of staffing prior to survey from 09/15/2024 to 09/28/2024, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -09/15/24 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/16/24 had 7 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/17/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/18/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/19/24 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/20/24 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/23/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 -09/24/24 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/25/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. On 10/02/24 at 09:30 AM, during an interview with the surveyor, the Staffing Coordinator (SC) stated she was aware of the CNA staffing ratios. She stated the facility usually met the staffing ratios with scheduling but "call outs sometimes were difficult to cover." The SC stated that staffing was discussed daily with the Director of Nursing and the Licensed Nursing Home Administration. A review of the facility's policy, "Staffing" updated and reviewed 6/20/24, revealed: "Policy Statement: Our Facility will provide sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment ...Policy Interpretation and Implementation: 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."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315381 Y1	A. Building B. Wing Y2	11/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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 F0688	Correction	ID Prefix F0698	Correction	ID Prefix F0755	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	11/23/2024	LSC	11/23/2024	LSC	11/23/2024
ID Prefix F0759	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(f)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/23/2024	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/8/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061210 Y1	A. Building B. Wing Y2	11/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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 11/23/2024	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
10/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING **01** B. WING _____	**10/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 08857**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facilities Survey and Field Operations on 10/02/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facilities Survey and Field Operations on 10/02/24 and the facility and 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 Occupancy. Autumn Lake Healthcare at Old Bridge is a one-story building with a partial basement that was constructed in 1973. It is composed of Type III (200) construction and is divided into six smoke compartments. The facility has a complete automatic sprinkler system (wet). The diesel generator powers 100% of the building. The number of occupied beds was 105 out of 120.	K 000		
K 321 SS=F	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.	K 321		10/31/24

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

Electronically Signed | 10/31/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING **01** B. WING _____	**10/08/2024**

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 08857**

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K 321	Continued From page 1 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A 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) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to separate hazardous areas from other parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. This deficient practice had the potential to affect staff and 52 residents. Findings include: Observations on 10/02/24 at 9:02 AM of the Storage Room located in the basement revealed two unsealed eight-inch overcuts around pipe penetrations in the ceiling.	K 321	The two unsealed eight-inch overcuts around pipe penetrations in the ceiling located in The Storage Room in the basement were sealed. An automatic door closer was installed in the Storage Room located by the Dietician's Office on the A Wing. All residents have the potential to be affected by this deficient practice. The U.S. FOIA (b) (6) was in serviced on ensuring that there are no penetrations in hazardous areas and that automatic door closers are installed in hazardous	

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	315381	A. BUILDING **01** B. WING _____	**10/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 08857**

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K 321	Continued From page 2 During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the finding and revealed the facility had recently replaced several drains on the first floor and was aware they needed to seal around the penetrations. Observations on 10/02/24 at 9:26 AM of the Storage Room located by the Dietician's Office on the A Wing revealed the door was closed and latched in the door frame. However, the door was not self-closing and did not have a self-closing device installed on the door ensuring continuous separation from the corridor. The room measured over 50 square feet (sf) in size and contained stored combustibles (paper products, cleaning supplies, cardboard boxes). During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the finding and revealed the facility had recently converted the room into a storage room.	K 321	areas. The maintenance director or designee will perform monthly audits for 6 months to ensure all hazardous areas are separated from other parts of the facility in accordance with NFPA 101 Life Safety Code. Findings of said audit will be reported to the Administrator and the QAPI committee at the quarterly meetings.	
K 324 SS=F	NJAC 8:39-31.2(e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324		10/31/24

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	315381	A. BUILDING 01 B. WING _____	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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K 324	Continued From page 3 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen rang-hood system in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition). This deficient practice had the potential to affect staff and all 105 residents. Findings include: Observation on 10/02/24 at 9:15 AM revealed the hood system, located in the Kitchen above the cooking equipment, was not grease tight. Two unsealed holes that were three inches in diameter each were observed near the filters. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was unaware of the unsealed holes in the hood system prior to the survey.	K 324	The two unsealed holes near the filters in hood system, located in the Kitchen above the cooking equipment were sealed. All 105 residents of the facility had the potential to be affected by this deficient practice. The U.S. FOIA (b) (6) was in serviced on ensuring compliance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. The Maintenance Director or designee will perform monthly audits on the kitchen hood system to ensure compliance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Findings of said audit will be reported to the Administrator and QAPI committee at the quarterly meeting.	

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	315381	A. BUILDING **01** B. WING _____	**10/08/2024**

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 08857**

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K 324	Continued From page 4 NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an area not continuously occupied, smoke detection was installed at the main fire alarm control panel in accordance NFPA 101 (Life Safety Code) 2012 Edition, Section 9.6.1.8. This deficient practice could affect 105 residents. Findings include: An observation on 10/02/24 at 8:50 AM revealed the fire alarm control panel, located in the Office	K 341	A smoke detector was installed at the fire alarm control panel. All 105 residents have the potential to be affected by this deficient practice. The U.S. FOIA (b) (6) was in serviced to ensure that all areas requiring smoke detection are equipped with smoke detectors. The maintenance director or designee will perform monthly audits for 6 months to ensure that all areas requiring smoke detection are equipped with smoke	10/31/24

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K 341	Continued From page 5 Area by the Receptionist, was not equipped with smoke detection. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the room was not equipped with smoke detection and was not occupied continuously. According to the U.S. FOIA (b)(6), the area was only occupied between 7:00 AM and 8:00 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 341	detectors. Findings of said audit will be presented to the Administrator and QAPI committee at the quarterly meetings.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the sprinkler system in	K 353	The sprinkler heads that were over 50 years old were tested in accordance with	11/19/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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K 353	Continued From page 6 accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition), Section 5.3.1.1.1. This deficient practice had the potential to affect all 105 residents. Findings include: Review of the facility's sprinkler system's "5-Year Test Report," conducted on 05/19/24 by [Contracted Company Name], revealed the following compliance issues: "Found heads throughout building from 1967-1983" During an interview on 10/02/24 at 2:00 PM, the U.S. FOIA (b)(6) confirmed the finding and revealed the facility had not replaced the sprinklers over the past 50 years. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	the NFPA 25 standard for the inspection, testing and maintenance of water based fire protection systems (2011 edition), section 5.3.1.1.1. The sprinkler heads passed the inspection. All residents have the potential to be negatively affected by this deficient practice. The U.S. FOIA (b) (6) was in serviced on ensuring that the sprinkler system remains compliant with NFPA 25 section 5.3.1.1.1 The Maintenance Director or designee will audit all sprinklers heads quarterly for compliance with NFPA 25 section 5.3.1.1.1. Findings of said audit will be reported to the Administrator and QAPI committee at the quarterly meeting.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the stored-pressure fire extinguishers had a six-year internal examination	K 355	All fire extinguishers that were out of compliance were replaced by an outside vendor. See attached.	10/31/24

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	315381	A. BUILDING **01** B. WING _____	**10/08/2024**

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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 08857**

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K 355	Continued From page 7 and were equipped with a verification of service collar in accordance with NFPA 10 (Standard for Portable Fire Extinguishers) 2010 Edition Sections 7.3.1.2.1 and 7.3.3.2.2. The deficient practice had the potential to affect all 105 residents. Findings include: An observation on 10/02/24 at 9:17 AM revealed the fire extinguisher located in the Kitchen by the walk-in cooler had a manufacture date of 2009 marked on the bottom of the cylinder and did not have the Verification of Service Collar for the six-year internal examination around the neck of the container. An observation on 10/02/24 at 9:58 AM revealed the fire extinguisher located at the B-Wing Nurses' Station had a Verification of Service Collar around the neck of the container indicating the most recent six-year internal examination was conducted in 2016. An observation on 10/02/24 at 2:23 PM revealed the fire extinguisher located in the corridor across from the Dining Room had a Verification of Service Collar around the neck of the container indicating the most recent six-year internal examination was conducted in 2011. During an interview at the time of observations, the U.S. FOIA (b)(6) confirmed the findings and revealed the facility was unaware the six-year internal examination of the fire extinguishers was past due prior to the survey. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	All residents have the potential to be affected by this deficient practice. The Maintenance Director was in serviced on ensuring that all fire extinguishers that require examination have a six year internal examination and are equipped with a verification of service collar. The Maintenance Director or designee will perform monthly audits for 6 months and ongoing quarterly audits to ensure the fire extinguishers are inspected timely. Findings of said audit will be reported to the Administrator and QAPI committee at the quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke doors to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 8.5. The deficient practice had the potential to affect 52 residents. Findings include: An observation on 10/02/24 at 9:47 AM of the smoke doors, located in the corridor by Room 22, revealed a two-inch gap between the edges of the doors, allowing a passage for smoke to get through. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the finding and stated the facility had recently painted the door edges which might be preventing the doors from closing smoke tight.	K 374	The smoke doors located in the corridor by rm 22 was repaired and is functioning properly. 52 residents have the potential to be affected by this deficient practice. The U.S. FOIA (b) (6) was in serviced on maintaining properly functioning smoke doors. The Maintenance Director or designee will perform monthly audits on all smoke doors to ensure they are functioning properly. Findings of said audit will be presented to the Administrator and QAPI committee at the quarterly meetings for two quarters.	10/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	**111 ROUTE 516** **OLD BRIDGE, NJ 08857**

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K 374	Continued From page 9 NJAC 8:39-31.1(c), 31.2(e)	K 374		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315381 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT OLD BRIDGE	111 ROUTE 516 OLD BRIDGE, NJ 08857

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	10/31/2024	LSC K0324	10/31/2024	LSC K0341	10/31/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	11/19/2024	LSC K0355	10/31/2024	LSC K0374	10/31/2024
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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/8/2024	☐ YES ☐ NO