

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/07/2024
NAME OF PROVIDER OR SUPPLIER  Autumn Lake Healthcare at Salem County		STREET ADDRESS, CITY, STATE, ZIP CODE  438 Salem-Woodstown Road Salem, NJ 08079	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50919</p> <p>Complaint #: NJ00179130</p> <p>Based on interviews, medical record review, and review of other pertinent facility documents on 11/07/2024 and 11/08/2024, it was determined that the facility failed to develop a Care Plan (CP) for a resident that had a diagnosis of Diabetes (high blood sugar levels) and was admitted to the facility with elongated(long) toenails. The facility also failed to follow its policy titled Care Plans, Comprehensive Person-Centered. This deficient practice was identified for 1 of 7 residents (Resident #2) reviewed for care plans.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the Admission Record (AR), Resident #2 was admitted to the facility on [DATE] with diagnoses which included but were not limited to, Diabetes, Major Depressive Disorder, and Unspecified Dementia (general decline in cognitive abilities that affects a person's ability to perform everyday activities).</p> <p>A review of Resident #2's most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 10/27/2024 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognition was severely impaired. Revealed under Section I that resident had an active diagnosis of Diabetes.</p> <p>A review of Resident #2's medical record document titled [NAME] (AUTM) Admit/Readmit Screener 1.0-V7 with an effective date of 01/18/2024 and signed date of 01/18/24 revealed under Comments, elongated toenails.</p> <p>A review of Resident #2's CPs did not reveal a focus that addressed Resident #2's diabetes and elongated toenails.</p> <p>During an interview with the surveyors on 11/08/2024 at 10:50 AM, Licensed Practical Nurse (LPN#1) stated that the Unit Manager (UM) was responsible for developing and updating a resident's care plan. LPN#1 further stated the care plan was important for a resident's safety and prevention. LPN #1 stated if a care plan needed to have interventions added she would notify the UM.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the surveyors on 11/08/2024 at 11:15 AM, the UM stated that she typically updated a resident's CP every quarter and as needed. The UM stated if a resident was a new admission, she would implement the baseline CP and the MDS coordinator would do the comprehensive CP. The UM further stated The baseline CP was a check off sheet. This is where I would check off if a resident was diabetic. The UM further stated that the information she would check off on the baseline care plan would then be transferred to the comprehensive CP. The UM stated that she was responsible for updating the nursing portion of a resident's CP. The UM stated, I do not recall doing a CP for Resident #2's toenails. The UM further stated that if a resident had diabetes there should be a CP in place that addressed the diabetes. The UM stated that it was important that the CP was updated so that the correct interventions were in place to care for the resident's needs.</p> <p>During an interview with the surveyors on 11/08/2024 at 1:21 PM, the Director of Nursing (DON) stated that the nurse, UM, or MDS Coordinator should have caught if a care plan was not initiated for a resident. The DON confirmed that Resident #2 did not have a care plan that addressed diabetes or elongated toenails. The DON further stated Yes, there should have been a care plan that addressed the resident's diabetes and elongated toenails. The DON confirmed that the facility's care plan policy was not followed.</p> <p>Review of the facility policy titled Care Plans, Comprehensive Person-Centered dated 07/2024 revealed under Policy Statement, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Revealed under Policy Interpretation and Implementation, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>NJAC 8:39-11.2 (a)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50919</p> <p>Complaint #: NJ179130</p> <p>Based on interviews, medical record review, and review of other pertinent facility documents on 11/07/2024 and 11/08/2024, it was determined that the facility failed to follow standards of clinical practice regarding a.) ensuring a resident was seen by the Podiatrist in a timely manner, b.) ensuring a resident care plan (CP) was developed for a resident that had a diagnosis of Diabetes and was admitted to the facility with elongated (long) toenails, and c.) immediate notification to the Physician of abnormal urine culture results.</p> <p>This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed and evidenced by the following:</p> <p>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.</p> <p>Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or 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 prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem.</p> <p>According to the Admission Record (AR), Resident #2 was admitted to the facility on [DATE] with diagnoses which included but were not limited to, Diabetes (high blood sugar levels), Major Depressive Disorder, and Unspecified Dementia (general decline in cognitive abilities that affects a person's ability to perform everyday activities).</p> <p>A review of Resident #2's most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 10/27/2024 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognition was severely impaired.</p> <p>A review of Resident #2's CPs did not reveal a focus that addressed Resident #2's diabetes and elongated toenails.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #2's medical record document titled [NAME] (AUTM) Admit/Readmit Screener 1.0-V7 with an effective date of 01/18/2024 and signed date of 01/18/24 revealed under Comments, elongated toenails.</p> <p>A review of Resident #2's podiatry consult with a visit date of 10/07/2024 revealed under chief complaint, elongated toenails. Revealed under Subjective, Additional Comments: New diabetic patient seen today at the request of the facility for diabetes foot care. Revealed under Treatments, Additional Comment: the nails were debrided to patient's tolerance. Revealed under Assessment that the resident was at risk for complication without treatment of the toenails.</p> <p>A review of Resident #2's urine culture report revealed a collection date of 09/05/2024 at 6:00 AM, a reported date of 09/07/2024 at 2:12 PM. The urine culture report further revealed a reviewed by date of 09/11/2024 at 1:27 PM by the Unit Manager (UM) indicating the facility was notified that Resident #2 had an abnormal urine culture result.</p> <p>A review of Resident #2's Progress Notes (PNs) revealed that on 09/14/2024 the nurse reviewed the urine culture result with the physician and a telephone order was obtained for antibiotic therapy.</p> <p>During an interview with the surveyors on 11/08/2024 at 11:15 AM, the UM stated that the expectation was that if the nurse observed a resident with long or overgrown toenails, they had to notify her. The UM stated she would then notify the Unit Clerk that the resident needed to be scheduled for the Podiatrist. The UM stated that the floor nurses and herself were responsible for notifying the Physician of abnormal urine culture results.</p> <p>During an interview with the surveyors on 11/08/2024 at 1:21 PM, the Director of Nursing (DON) stated that the nurses documented skin assessment findings in the resident's chart and then notified podiatry if a resident's toenails needed to be cut. The DON stated that the nurse should have notified the Physician in the interim to get a treatment order in place. The DON stated it was considered a delay in treatment if the nurse seen a concern during an assessment and did not address it. The DON stated that the process for laboratory notification was that the laboratory called the facility and notified the nurse of the abnormal urine culture results. The DON stated the expectation was that the nurse was responsible for calling the Physician immediately after receiving the abnormal results. The DON stated that the nurse, UM, or MDS Coordinator should have identified if a care plan was not initiated for a resident. The DON confirmed that Resident #2 did not have a care plan that addressed diabetes or elongated toenails. The DON further stated Yes, there should have been a care plan that addressed the resident's diabetes and elongated toenails. The DON confirmed that the facility's care plan policy was not followed.</p> <p>Review of the undated facility job description titled Charge Nurse/Staff Nurse revealed under Duties and Responsibilities, initiate request for consultation or referral. Examine the resident and his/her record and charts, and discriminate between normal and abnormal findings, in order to recognize when to refer the resident to a physician for evaluation, supervision, or directions. Discuss findings with the Unit Manager. Consult with the resident's physician in providing the resident's care, treatment, rehabilitation as necessary. Notify the resident's attending physician and next of kin when there is a change in the resident's condition. Inform the Unit Manager of any changes that need to be made on the care plan. Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility job description titled Nursing Unit Manager revealed under Major Duties and Responsibilities, Ensure compliance with current applicable federal, state, and local regulations and facility policies and procedures. Assists in the development of written preliminary and comprehensive assessments of the nursing needs of each resident.</p> <p>NJAC 8:39-27.1(a)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50919</p> <p>Complaint #: NJ00179130</p> <p>Based on interviews, medical record review, and review of other pertinent facility documents on 11/07/2024 and 11/08/2024, it was determined that the facility failed to provide foot care and services for a resident that had a diagnosis of Diabetes (high blood sugar levels) and was admitted to the facility with elongated (long) toenails on 01/18/2024 and was not seen by a Podiatrist until 10/07/2024. The facility also failed to follow its policy titled Podiatry Services. This deficient practice was identified for 1 of 1 resident (Resident #2) reviewed for foot care.</p> <p>This deficient practice was evidence by the following:</p> <p>According to the Admission Record (AR), Resident #2 was admitted to the facility on [DATE] with diagnoses which included but were not limited to, Diabetes, Major Depressive Disorder, and Unspecified Dementia (general decline in cognitive abilities that affects a person's ability to perform everyday activities).</p> <p>A review of Resident #2's most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 10/27/2024 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognition was severely impaired. Revealed under Section I that resident had an active diagnosis of diabetes.</p> <p>A review of Resident #2's medical record document titled [NAME] (AUTM) Admit/Readmit Screener 1.0-V7 with an effective date of 01/18/2024 and signed date of 01/18/24 revealed under Comments, elongated toenails.</p> <p>A review of Resident #2's podiatry consult with a visit date of 10/07/2024 revealed under chief complaint, elongated toenails. Revealed under Subjective, Additional Comments: New diabetic patient seen today at the request of the facility for diabetes foot care. Revealed under Treatments, Additional Comment: the nails were debrided to patient's tolerance. Revealed under Assessment that the resident was at risk for complication without treatment of the toenails.</p> <p>During a tour of the C/D wing on 11/07/2024, the surveyors observed that Resident #2's right great toenail, right second toenail, left great toenail, left fourth toenail, and left fifth toenail were slightly overgrown and had a yellow discoloration to them.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the surveyors on 11/08/2024 at 10:50 AM, the Licensed Practical Nurse (LPN#1) stated that Resident #2 was not vocal about if anything was bothering him/her and if him/her had foot pain. LPN #1 stated she observed the resident's feet and had him/her seen by the Podiatrist in October. LPN #1 further stated that the podiatrist came and cut Resident #2's toenails. LPN #1 stated that she was unsure of when the resident was moved to her wing. LPN #1 further stated that when Resident #2 came to her wing that he/she had long toenails. LPN#1 stated that the nurse was responsible for notifying the Unit Clerk when a resident needed to be seen by the Podiatrist. LPN#1 further stated the Unit Clerk was responsible for scheduling the resident for the Podiatrist. LPN #1 stated that the in-house Podiatrist came to the facility every two months and if a resident needed to be seen sooner, they would be seen by an outside Podiatrist.</p> <p>During an interview with the surveyors on 11/08/2024 at 11:15 AM, the Unit Manager (UM) stated that the expectation was that if the nurse observed a resident with long or overgrown toenails, they had to notify her. The UM stated she would then notify the Unit Clerk that the resident needed to be scheduled for the Podiatrist. The UM stated that if it was an emergency the resident could be seen by an outside podiatrist. The UM stated she did not observe Resident #2's toenails. The UM stated she was aware that Resident #2 was seen by the Podiatrist in October. The UM further stated, Resident #2 was a priority because LPN #1 told me that his/her toenails were long. The UM stated she could not remember when Resident #2 was transferred to her unit. The UM stated she could not recall whether Resident #2 came to her unit with overgrown toenails. The UM stated that when a resident was admitted directly to Long Term Care (LTC) there is an order for podiatry. The UM stated that Resident #2 had come from the sub-acute unit prior to coming to her unit.</p> <p>During an interview with the surveyors on 11/08/2024 at 1:21 PM, the Director of Nursing (DON) stated that the nurses documented skin assessment findings in the resident's chart and then notified podiatry if a resident's toenails needed to be cut. The DON stated that the nurse should have notified the Physician in the interim to get a treatment order in place. The DON stated it was considered a delay in treatment if the nurse saw a concern during an assessment and did not address it. The DON stated she did not know Resident #2 specifically. The DON further stated it was delay in treatment if Resident #2 was admitted in January and did not see the podiatrist until October especially if he/she was a diabetic.</p> <p>Review of the undated facility policy titled Podiatry Services revealed under Policy Interpretation and Implementation, Foot healthcare and podiatry services are available to all residents requiring routine and emergency podiatry care. The unit manager/unit secretary will be responsible for making necessary appointments. All requests for routine and emergency podiatry services should be directed to the nursing secretary to assure that appointments can be made in a timely manner. Residents with identified foot issues will be promptly referred to podiatry.</p> <p>NJAC 8:39-27.1 (a)</p> <p>NJAC 8:39-27.2 (g)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50919</p> <p>Complaint #: NJ00179130</p> <p>Based on interviews, medical record review, and review of other pertinent facility documents on 11/07/2024 and 11/08/2024, it was determined that the facility failed to promptly notify the Physician of an abnormal urine culture result. The facility also failed to follow its policy titled Laboratory Services and Reporting. This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed for laboratory results.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the Admission Record (AR), Resident #2 was admitted to the facility on [DATE] with diagnoses which included but were not limited to, Diabetes (high blood sugar levels), Major Depressive Disorder, and Unspecified Dementia (general decline in cognitive abilities that affects a person's ability to perform everyday activities).</p> <p>A review of Resident #2's most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 10/27/2024 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognition was severely impaired.</p> <p>A review of Resident #2's urine culture report revealed a collection date of 09/05/2024 at 6:00 AM, a reported date of 09/07/2024 at 2:12 PM. The urine culture report further revealed a reviewed by date of 09/11/2024 at 1:27 PM by the Unit Manager (UM) indicating the facility was notified that Resident #2 had an abnormal urine culture result.</p> <p>A review of Resident #2's Progress Notes (PNs) revealed that on 09/14/2024 the nurse reviewed the urine culture result with the Physician and a telephone order was obtained for antibiotic therapy.</p> <p>During an interview with the surveyors on 11/08/2024 at 10:50 AM, the Licensed Practical Nurse (LPN#1) stated that when she received an abnormal urine culture result, she notified either the Nurse Practitioner (NP) or the Physician by phone or fax. LPN #1 further stated once the NP or Physician gave an order it was placed in the computer by the nurse. LPN #1 stated the lab result from 09/05/2024 was when the resident resided on the other unit. LPN #1 stated that the Physician had to be made aware of urine culture results right away or it would be considered a delay in resident care and the resident could end up with sepsis.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the surveyors on 11/08/2024 at 11:15 AM, the UM stated that the floor nurses and herself were responsible for notifying the Physician of abnormal urine culture results. The UM stated the Physician should be notified as soon as results were received. The UM stated that it was important to notify the Physician as soon as possible, so that the resident can get appropriate treatment. The UM stated, I believe Resident #2 had a UTI [Urinary Tract Infection] (an infection in any part of the urinary system) in September. The UM stated that urine cultures should have come back within three days. The surveyors showed the UM, resident #2's urine culture report and the UM stated, I could see it was delayed. The UM confirmed that seven days was a long time to not be started on antibiotics after the urine culture result was received.</p> <p>During an interview with the surveyors on 11/08/2024 at 1:21 PM, the Director of Nursing (DON) stated that the process for laboratory notification was that the laboratory called the facility and notified the nurse of the abnormal urine culture results. The DON stated the expectation was that the nurse called the Physician immediately after receiving the abnormal results. The DON stated the importance of the nurse calling the Physician immediately with abnormal lab results was so that the resident's issue could be corrected before it became an emergent situation. The DON further stated that the expectation was not for a nurse to notify the Physician seven days after an abnormal lab result was received. The DON stated this was not the facility policy. The DON stated she considered this a delay in a resident's treatment.</p> <p>During a telephone interview with the surveyor on 11/13/2024 at 3:20PM, the Physician stated that Resident #2 was his resident. The Physician stated he did not remember the date when the nurse notified him of Resident #2's urinalysis results. The Physician stated that the nurse was supposed to call him right away and let him know the resident's abnormal urinalysis results. The Physician stated This resident is a long term care resident and I don't see them as often, so the nurse has to let me know if something is abnormal.</p> <p>Review of the facility policy titled Laboratory Services and Reporting dated 10/22/2022 revealed under Policy Implementation and Interpretation, 7. Promptly notify the ordering Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist of laboratory results that fall outside the clinical reference range.</p> <p>NJAC 8:39-13.1 (d)</p>		