STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Salem County	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2569972Based on interviews, medical record review, and review of other pertinent facility documents on 7/28/2025, it was determined that the facility failed to notify a resident's physician of a low blood sugar result, and to follow facility policy titled Notification of Changes. This deficient practice was identified for (Resident #7), 1 of 3 residents reviewed and was evidenced by the following:A review of the closed Electronic Medical Record (EMR) was as follows:According to the admission Record (AR), Resident #7 was admitted to the facility on [DATE] with diagnoses which included but were not limited to Diabetes, Hypertension, and Chronic Pain Syndrome. The resident was discharged from the facility on 12/30/2024. According to the Minimum Data Set (MDS), an assessment tool dated 12/30/2024, Resident #7 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating the resident's cognition was intact. A review of Resident #7's Order Summary Report (OSR) included the following physician orders (Pos):Insulin Aspart Flex Pen Subcutaneous Solution Pen Injector 100 Unit/ml. Inject as per sliding scale: If blood sugar is 0-150=0 Units, 151-200=2 Units, 201-250= 4 Units, 251-300= 6 Units, 301-350= 8 Units, 351-400= 10 Units subcutaneously before meals for Diabetes. Call the Medical Doctor if blood sugar is below 70 or above 350. A review of Resident #7's Medication Administration Record (MAR) dated December 2024 revealed that; on 12/27/2024 at 4:30 PM, the resident's blood sugar was 52. A review of Resident #7's Progress Notes (PNs) for December 2024 did not show any documented evidence that the resident's physician was notified of the resident's blood sugar of 52 on 12/27/2024 at 4:30 PM.A review of the facility's incident report dated 12/28/2024, revealed that the Licensed Practical Nurse (LPN#1) who cared for Resident #7 failed to notify the physician of resident 's low blood sugar result. The surveyor attempted to interview (LPN#1) during the survey but the nurse was not available for an interview and did not return the surveyor's phone call. On 7/28/2025 at 12:05 PM, the surveyor interviewed a unit nurse (LPN #2) who stated that if the resident's blood sugar was less than the parameters listed in the physician's orders, she would notify the doctor. LPN #2 further stated that she would document in a progress note once the doctor was notified. LPN #2 indicated that it was important to call the doctor about a resident's low blood sugar to make them aware so they can determine the next course of action for the resident. On 7/28/2025 at 1:07 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the doctor should have been notified of the resident's blood sugar result of 52. The DON further stated that the nurse was responsible for notifying the doctor and writing a progress note. The DON indicated that the resident's blood sugar result should have been called to the doctor on the same day. The DON stated it was important to notify the doctor because the resident's medical condition could require immediate treatment. A review of the facility's undated policy titled Notification of Changes under Policy Statement, revealed that The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. NJAC 8:39-13.1(d)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. Building B. Wing	07/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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	315058	A. Building B. Wing	07/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record reviews, and review of other pertinent facility documentation on 7/28/2025, it was determined that the facility staff failed to consistently document in the Documentation Survey Report (DSR) the Activities of Daily Living (ADL) status and care provided to the residents. Also, the facility failed to follow its policy titled ADL Documentation Policy. This deficient practice was identified for 3 of 4 residents reviewed for ADL documentation. This deficient practice was evidenced by the following:1.According to the admission Record (AR), Resident #3 was admitted to the facility on [DATE] with diagnoses which included but were not limited to Quadriplegia (paralysis of all four limbs), Acute Respiratory Failure, and Dysphagia (difficulty swallowing).According to the Minimum Data Set (MDS), an assessment tool dated 5/15/2025, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicating the resident's cognition was intact. A review of Resident #3's DSR (an Activity of Daily Living Record) and progress notes revealed lack of documentation to indicate the resident's ADL care was provided and/or that the resident refused care on the following dates and shifts:Toilet Use:7:00 AM-3:00 PM shift on 7/3/2025, 7/11/2025, 7/16/2025, and 7/24/2025.3:00 PM-11:00 PM shift on 7/27/2025.11:00 PM-7:00 AM shift on 7/5/2025, 7/12/2025, 7/20/2025 and 7/21/2025.2. According to the AR, Resident #4 was admitted to the facility on [DATE] with diagnoses which included but were not limited to Bipolar Disorder, Dementia, and Hyperlipidemia (high levels of fat). According to the MDS, an assessment tool dated 6/14/2025, Resident #4 had a BIMS score of 00 which indicated the resident's cognition was severely impaired. A review of Resident #4's DSR and progress notes revealed lack of documentation to indicate the resident's ADL care was provided and/or the resident refused care on the following dates and shifts:Toilet Use:3:00 PM-11:00PM shift on 7/3/2025.11:00 PM-7:00 AM shift on 7/15/2025.3. According to the AR, Resident #7 was admitted to the facility on [DATE] with diagnoses which included but were not limited to Diabetes, Hypertension, and Chronic Pain Syndrome. The resident was discharged from the facility on 12/30/2024. According to the MDS, an assessment tool dated 12/30/2024, Resident #7 had a BIMS score of 15 out of 15, indicating the resident's cognition was intact. A review of Resident #7's DSR and progress notes revealed lack of documentation to indicate the resident's ADL care was provided and/or the resident refused care on the following dates and shifts:Toilet Use:7:00 AM-3:00 PM shift on 12/26/2024.11:00 PM-7:00 AM shift on 12/25/2024 and 12/27/2024.On 7/28/2025 at 12:00 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the CNAs were responsible for documenting the resident's ADLs in the computer. The CNA further stated that the ADLs should generally be documented by the end of the shift. The CNA indicated that if the ADL documentation was blank, it does not always mean that care was not given. The CNA stated that the ADL documentation should not be blank, and it was important to document the resident's ADLs to show the type of care the resident received and if there was a decline or improvement in the resident's ADLs. On 7/28/2025 at 1:07 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the CNAs use the Point of Care (POC), a mobile enable app that runs on wall mounted kiosks that enable care staff to document ADLs. The DON further indicated that the ADL documentation should be completed before the staff clock out for their shift. The DON stated that the Unit Manager (UM) was responsible for checking the ADL documentation to ensure it was completed. The DON stated that a blank space does not necessarily mean that the staff did not provide care. On 7/28/2025 at 1:36 PM, the surveyor interviewed the Unit Manager (UM) who stated I usually try my best to ensure that the POCs are completed. There are times, I can't check by 2 o'clock because I have meetings or get busy. The UM further indicated that she will usually follow up with the regular staff at some point to complete the documentation. The UM further indicated that if there was a blank space that it didn't necessarily mean the care was not provided but that the ADL documentation should have been completed. A review of the facility's undated policy titled ADL Documentation Policy revealed under Policy Statement, The purpose of this policy is to establish guidelines for the documentation of Activities of Daily Living (ADLs) in order to ensure accurate, timely, and comprehensive records that reflect the care provided to residents in our long-term care facility. Under Policy Interpretation and Implementation, 3. Responsibility: All nursing staff and caregivers are responsible for documenting ADLs as part of their daily care routines. Supervisors and management will regularly review documentation for compliance and accuracy.NJAC 8:39-35.2(d) (9)