STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315271	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Memorial Bridge	201 Fifth Avenue Penns Grove, NJ 08069

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	COMPLAINT#: 2659218 Based on interview, review of medical records and other pertinent facility documents on 11/6/25 and 11/7/25, it was determined that the facility failed to implement and monitor weekly weights upon admission in accordance with professional standards of practice. This deficient practice was identified for 1 of 4 residents (Resident #1) reviewed and was evidenced by the following: Resident #1 was not at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: fracture of left pubis, hypertension, and myocardial infarction (decreased or complete cessation of blood flow to a portion of the myocardium). According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 10/16/25, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. During a review of Resident #1's electronic medical record on 11/6/25 at 1 PM, the surveyor viewed recorded weights for the resident as follows:-10/20/25 [2:52 PM] 171.8 pounds (lbs.)-10/11/25 [9:00 PM] 172.0 lbs.-10/11/25 [2:56 PM] 172.0 lbs.-10/11/25 [2:56 PM] 172. 0 lbs. At that time, the surveyor took a screenshot of the weights to be referenced during interviews while waiting for the facility to provide printed documentation of the resident's recorded weights to the surveyor as requested. A review of Resident #1's October 2025 Progress Notes (PN), revealed a Nutrition Note dated 10/15/25 at 2:04 PM, that indicated the resident's admission weight was obtained at the facility and that weekly weights were to be followed. The resident's nutrition goals included wt [weight] stability. A further review of the PN revealed a Nursing Note dated 10/29/25 at 7:12 PM, written by the Licensed Practical Nurse (LPN #1), that indicated that the family expressed immediate concerns including fluid retention and the resident's overall care. It further indicated that the Nursing Supervisor (NS) conducted a full body assessment and noted that the resident weighed 209 lbs., and that swelling was noted to the resident's lower extremities. There were no additional weights documented in the resident's electronic medical record at the time of the review. The surveyor attempted to conduct a telephone interview with LPN #1 but was not successful. During an interview with Certified Nursing Assistant (CNA #1), on 11/6/25 at 1:50 PM, she stated that part of the CNA duties included obtaining resident weights on the day of admission, the next day after that, and then weekly for four weeks. CNA #1 stated that CNA's receive a list of their residents that needed weights when they came on shift and then after the weight was obtained, the information was provided to the nurse. CNA #1 further stated that any refusals were also to be reported to the nurse. CNA #1 further stated that she recalled Resident #1 and that she worked on 10/29/25, however, she stated that she did not assist with obtaining the weight on that shift. During an interview with the LPN Unit Manager (UM) on 11/6/25 at 2:08 PM, she stated that resident weights were obtained upon admission, the next day, and then weekly for four weeks, unless otherwise indicated. The LPN UM stated that obtaining weights were important to quickly identify any acute issues that may be going on with a resident. The LPN UM also stated that any refused weights should have a corresponding nursing note. In the presence of the surveyor, the LPN UM reviewed the documented weights in the electronic medical record for Resident #1 and she stated that there should have been a weight taken in between 10/11/25 and 10/20/25, and weekly thereafter until discharge. The LPN UM stated that she did not know why the weights were not taken, but that they should have been. In the presence of the surveyor, the LPN UM also reviewed the PN dated 10/29/25 which reflected a weight of 209 lbs. The LPN UM stated she was not aware that the resident had a weight gain to that extent. During an interview with the Registered Dietitian (RD) on 11/6/25 at 2:58 PM, she stated that she visited the facility weekly and that she reviewed the weights with the UMs. The RD stated that a resident's weight was taken immediately upon admission and weekly for four weeks thereafter, unless otherwise indicated. The RD further stated that any resident that refused a weight, there should be documentation indicating why. The RD stated that she assessed Resident #1 on 10/15/25 and wrote a corresponding note that she reviewed in the presence of the surveyor. The RD reviewed the electronic medical record along with the 10/29/25 PN, and she stated that she was not aware of the 37 lb. weight gain that was significant. The RD further stated that she was not sure why the weights were not done in between 10/11/25 and 10/20/25, and weekly thereafter until discharge. During a telephone interview with the NS on 11/6/25 at 3:34 PM, she stated that upon admission, a resident's weight was taken and then weekly for four weeks. The NS stated that all weights were provided to the RD for review. The NS confirmed that she was the supervisor working on the evening of 10/29/25. The NS stated that while she was on the unit she recalled seeing Resident #1's family on the unit

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT #2659218 Based on interview, medical record review and review of other pertinent facility documentation on 11/6/25 and 11/7/25, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents documented physician visit progress notes at the time of each visit. This deficient practice was identified for 3 of 4 residents reviewed (Resident #1, #2, and #3), and was evidenced by the following:1.) Resident #1 was not at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record (AR) revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: fracture of left pubis, hypertension, and myocardial infarction (decreased or complete cessation of blood flow to a portion of the myocardium). According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 10/16/25, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. A review of Resident #1's electronic medical record on 11/6/25, did not include documentation of a visit from an attending physician. 2.) Resident #2 was observed seated in a wheelchair at the bedside. The resident denied having any concerns regarding care while at the facility. A review of the AR revealed that Resident #2 was admitted to the facility with diagnoses that included but were not limited to: cellulitis of left lower limb, obstructive sleep apnea, asthma, and hypertension According to the comprehensive MDS, dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. A review of Resident #2's electronic medical record on 11/6/25, did not include documentation of a visit from an attending physician. 3.) Resident #3 was observed seated in a wheelchair at the bedside. The resident denied any concerns regarding care received at the facility. A review of the AR revealed that Resident #3 was admitted to the facility with diagnoses that included but were not limited to: spinal stenosis (the narrowing of one or more spaces within your spinal canal), type II diabetes, and an anxiety disorder. According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 10/28/25, Resident #3 had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. A review of Resident #3's electronic medical record on 11/6/25, did not include documentation of a visit from an attending physician. During an interview with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) on 11/6/25 at 4:00 PM, the surveyor informed administration that they had not received the attending physician notes as requested for Residents #1, #2, and #3 from their most recent admission. The DON stated that she had reached out to the Attending Physician's (AP) office, who was also the facility's Medical Director, and she had not heard back from them yet. The DON further stated that some of their providers entered information directly into the electronic system and some forwarded their notes to be scanned in. The DON was unsure of how the AP entered their information, but that he came onsite weekly. The DON did not know why the notes were not there. After exiting the facility on 11/6/25, at 6:42 PM, the surveyor received an email containing AP progress notes from the DON as follows:-Resident #1, dated 10/29/25-Resident #2, dated 10/23/25-Resident #3, dated 10/23/25 During a telephone interview with the AP on 11/7/25 at 10:24 AM, the AP confirmed that he was also the facility's Medical Director. The AP stated that he visited the facility weekly, and he assessed new admissions, addressed acute concerns, and followed-up with monthly assessments during those times. The AP stated that he normally documented in the electronic medical record, however there had been a recent change with the login system and he had been using dictation and hand-writing his notes when he was back in his office. The AP stated that his expectation was that after completing, his office would fax the notes to the facility within a few days so that they could be added to the medical record. The AP stated that he was not sure what happened in the case of Resident #1, #2, and #3, but that the documentation should have been there. During an interview with the LNHA, the DON, and the Regional Nurse (RN) on 11/7/25 at 12:52 PM, they each agreed that the expectation was that physicians ensure that documentation is entered into the system within a reasonable amount of time. A review of the facility's undated Attending Physician Responsibilities policy, which revealed that each Attending Physician was responsible for, . Providing appropriate, timely and pertinent documentation. The policy further revealed that, The note should be written or entered at the time of the visit or, if dictated or otherwise prepared after the visit, should be returned to the facility for placement on the chart within a week. A review of the facility's undated Charting Error and/or Omissions, which revealed that the facility would maintain accurate medical records. NJAC 8:39-23.2 (b)