

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	

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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	
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 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Complaint #: 398977Based on record review, interview, and document review, the facility failed to notify the physician of a resident's refusal to have an immediate (STAT) laboratory test on [DATE] and [DATE]; failed to obtain a Urine with Culture and Sensitivity (C&amp;S) test when ordered on [DATE]; failed to monitor the resident after reports of nausea without emesis for three days, decreased appetite secondary to the nausea, and continued diarrhea; and failed to act upon a critically high white blood cell (WBC) count for one of 16 sampled residents (Resident (R) 7). These failures caused serious harm or death to R7.The facility's Director of Nursing (DON) and the Regional Nurse Consultant (RNC) were informed on [DATE] at 8:00 PM an Immediate Jeopardy (IJ) existed at F684: Quality of Care related to the failure of notifying the physician of the resident's refusal of laboratory tests, failing to monitor the resident after reports of nausea without emesis for three days, decreased appetite secondary to the nausea, and continued diarrhea; and failing to act upon a critically high WBC count. The Immediate Jeopardy began on [DATE], the date of the R7's first refusal of the laboratory test.The facility provided an acceptable Removal Plan on [DATE] at 4:32 PM. The Removal Plan consisted of the facility educating the licensed nurses on the documentation and provider notification requirements when residents refuse diagnostic testing or exhibit changes in condition, acute changes in condition protocol and documentation requirements, and honoring resident's /family rights to transfer to hospital when requested, including the obligation to inform the providers and document the decision in the electronic medical record (EMR). Through interviews and review of staff education documentation, the survey team removed the IJ, effective [DATE] at 5:00 PM.Review of R7's New Jersey Department of Health Certificate of Death, revealed the resident's causes of death were, . Immediate Cause a. Suspected Sepsis .Due to (or as a consequence of) b. diarrhea . Due to (or as a consequence of) c. hypokalemia . It was recorded the interval between the onset of the suspected sepsis and diarrhea and death was two days.Review of R7's undated Face Sheet, located under the Profile tab in the EMR, indicated R7 was admitted to the facility with diagnoses that included myelodysplastic syndrome, anemia, and acute congestive heart failure.Review of R7's AUTM Admit/Readmit Screener 1.0 -V 8, dated [DATE] and located under the Evaluation tab of the EMR, indicated R7 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R7 was cognitively intact.Review of R7's Provider Progress Note, located under the Progress Note tab in the EMR and dated [DATE], revealed R7 was seen by Physician's Assistant (PA) 1. PA1 documented R7's [NAME] Blood Count (WBC) was 2.5. PA1 documented, . healthy-appearing, well-nourished . no acute distress . monitor CBC . Review of R7's Physician's Order, located under the Orders tab in the EMR and dated [DATE], indicated an order for a STAT Complete Blood Count (CBC) and Basic Metabolic Panel (BMP).The review of laboratory logs, dated [DATE] at 7:29 PM and [DATE] at 6:01 AM, provided by the facility, revealed that R7 refused the laboratory draw on both dates.Review of R7's entire EMR revealed no documented evidence that the physician was notified of the refusals.Review of R7's Provider Progress Note, dated [DATE] and located under the Progress Notes tab of the EMR, revealed R7 reported abdominal pain to PA2. The PA recorded the patient reported lower abdominal pain, nausea, and mild dysuria. A urinalysis (UA) with culture and sensitivity was ordered.Review of R7's entire EMR revealed no documented evidence that a specimen was collected for the UA or that the physician was notified that the specimen was not collected.Review of R7's Nursing Progress Note, dated [DATE] at 11:08 AM and located under the Progress Note tab in the EMR, indicated R7 had . decreased appetite for 2 days, and diarrhea for 3 days . It was recorded that the on-call provider was called, and Imodium was ordered for use after every diarrhea episode.Review of R7's Nursing Progress Note, dated [DATE] at 11:16 AM and located under the Progress Notes tab of the EMR, revealed, . on call physician ordered STAT labs cbc, bmp .Review of R7's Lab Results Report, dated [DATE], with a collection time of 11:31 AM and provided by the facility, revealed R7 had a WBC count of 26.4 thousand per cubic millimeter (K/CU.MM). The normal reference range was documented as 3.5 to 11.0 K/CU.MM. The lab result report indicated the results were called to Licensed Practical Nurse (LPN) 10, who then read the results back to the laboratory staff member.Review of R7's Nursing Progress Note, dated [DATE] at 6:58 PM and located under the Progress Notes tab of the EMR, revealed, . stat labs completed . WBC Count . 26.4 . Review of R7's Nursing Progress Note, input by LPN9 on [DATE] at 12:16 AM as a late entry for [DATE] at 7:03 PM, revealed, . patient endorses loose watery stool w/ [with] loss of appetite, [positive] nausea [without] emesis x 3 days . patient further endorsed decreased appetite 2/2 [secondary to] nausea . Review of a Nurse</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	

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 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	
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 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Complaint #: 398975Based on record review, interview, and document review, the facility failed to consistently provide pain management for one of 16 sampled residents (Resident (R)16). R16 was admitted to the facility with diagnoses including pancreatic adenocarcinoma and had admitting orders for pain medications, in particular Dilaudid (an opioid pain medication used to treat moderate to severe pain), and staff failed to administer the medication as ordered. R16 had pain levels up to a 10 (on a zero to 10 scale, with 10 being the most intense pain possible). This failure of R16 not receiving the ordered medication for pain caused harm and increased the likelihood for a painful death.The facility's Administrator, Director of Nursing (DON) and Regional Nurse Consultant (RNC) were informed on 09/25/25 at 7:40 PM an Immediate Jeopardy (IJ) existed at F697 Pain Management related to the failing to manage R16's pain when they did not consistently provide physician ordered pain medications as ordered to R16. The Immediate Jeopardy began on 12/31/24, when R16 was admitted to the facility with physician orders for Dilaudid.The facility provided an acceptable Removal Plan on 09/26/25 at 11:45 AM. The removal plan consisted of education to the licensed nurses on the facility's policy for Pain Management, what to do when physician ordered medications are unavailable for administration, the use of Pyxis for the immediate availability of narcotics on admission, documenting pain scores before and after the pain medication administration and documenting the effectiveness within the required timeframes for PRN medications used for pain, and education on any resident experiencing unmanaged pain, the nurse will call the physician for alternate orders, and the resident will be provided alternate physician ordered medications to ensure relief until the prescribed narcotic is available. An acceptable removal plan was verified onsite on 09/26/25 at 2:40 PM. Findings Include: Review of R16's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), and review of the Hospital Discharge Summary, located under the MISC (Miscellaneous) tab in the EMR, indicated R16 was admitted to the facility in 12/2024 at 10:30 PM with diagnoses that included pancreatic adenocarcinoma, an upper gastrointestinal bleed, portal vein thrombosis, esophagitis, unspecified without bleeding, and esophageal varices without bleeding. The resident had a [NAME] Roth I Gastroduodenostomy (surgical procedure where the lower portion of the stomach is removed and then connected to the duodenum (first part of small intestine), which was complicated by a biliary leak.Review of R16's admitting Physician Orders, located under the Orders tab in the EMR, revealed orders for medications including Dilaudid 2 milligrams (mg), give 0.5 tab (tablet) every four hours as needed for mild pain, and acetaminophen 325 mg three tabs every four hours as needed for moderate to severe pain.Review of R16's Medication Administration Record MAR, dated 01/2025 and located under the Orders tab of the EMR, revealed R16's Dilaudid 2mg every four hours was to be administered at 1:00 AM, 5:00 AM, 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM.Review of R16's Nursing Progress Note, located under the Progress Note tab in the EMR and dated 01/01/25 at 1:35 PM, revealed, . patient stating in high level of pain. Called pharmacy at 1300 [1:00 PM] to confirm they received the patient's medication Rx [prescription]. medication should be delivered no later than 1800 [6:00 PM]. On call physician . prescribed a PRN [as needed] for Tramadol [an opioid pain medication used to treat moderate to severe pain] 50 mg PO [by mouth] q 6hr [every six hours].Review of R16's MAR, dated 01/01/25 at 1:35 PM, revealed R16 received three 325mg acetaminophen tablets for a pain level of 8. The MAR indicated the medication was ineffective. However, further review of R16's entire clinical record revealed no documented evidence that the resident received the Tramadol at this time.Review of R16's eMAR Medication Administration Note, dated 01/01/25 at 2:48 PM, revealed, . Follow-up Pain Scale was: 3 minimal relief noted . Review of R16's MAR, dated 01/02/25 at 1:20 AM and located under the Orders tab of the EMR, revealed the resident's pain level was noted to be a 7. It was recorded that R16 was administered Tramadol 50 mg one tab. This was documented as being effective at 1:42 AM, but no pain level was documented. This was the first documented evidence that R16 received Tramadol, approximately 12 hours after receiving the order. Further review of R16's MAR, dated 01/02/25 at 11:51 AM and located under the Orders tab of the EMR, revealed the resident's pain level was noted to be 10. It was recorded that the resident was administered Dilaudid, 2mg, give 0.5 tab. This was the first documentation that R16 had been administered Dilaudid, and it was approximately 35 hours after arriving at the facility. Review of R16's Practitioner Note, with a date of service of 01/02/25 at 9:56 PM and located under the Progress Notes tab of the EMR, revealed, . Presented to [hospital name] ED with coffee ground emesis. Was found in work up to have esophagitis but no bleeding, and had an open G [gastrostomy] tube done. During the procedure was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	

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 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	
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 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Complaint #: 398975Based on record review, interview, and document review, the facility failed to acquire pain medications as ordered by the physician for one of 16 sampled residents (Resident (R)16). R16 was admitted to the facility with diagnoses including pancreatic adenocarcinoma and had admitting orders for pain medications, in particular Dilaudid (an opioid pain medication used to treat moderate to severe pain), and staff failed to acquire the medication. This failure of R16 not receiving the ordered medication for pain caused harm and increased the likelihood for a painful death.The facility's Administrator, Director of Nursing (DON), and Regional Nurse Consultant (RNC) were informed on 09/25/25 at 7:40 PM an Immediate Jeopardy (IJ) existed at F755 Pharmacy Services related to the failure of not acquiring physician ordered pain medications which R16 had ordered since admission to the facility on [DATE]. The Immediate Jeopardy began on 12/31/24, the date of R16's admission to the facility.The facility provided an acceptable Removal Plan on 09/26/25 at 11:45 AM. The removal plan consisted of education to the licensed nursing staff on the Medication Procurement and Pharmacy Services Policies, timeframes for pharmacy notification when medications are not delivered, if ordered pain medications are unavailable, the nurse will immediately notify the Supervisor; if unresolved, the issue will be escalated to the DON, and if still unresolved, the Medical Director will be contacted without delay, use of the Pyxis for immediate availability of narcotics at admission, and for any resident experiencing unmanaged pain, the nurse will place a call to the physician for alternate orders, and the resident will be provided alternate physician ordered medication to ensure relief until the prescribed narcotic is available. Through interviews, and review of staff education needs, the survey team removed the IJ, effective 09/26/25 at 2:40 PM. Review of R16's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), and review of the Hospital Discharge Summary, located under the MISC (Miscellaneous) tab in the EMR, indicated R16 was admitted to the facility on [DATE] at 10:30 PM with diagnoses that included pancreatic adenocarcinoma, an upper gastrointestinal bleed, portal vein thrombosis, esophagitis, unspecified without bleeding, and esophageal varices without bleeding. The resident had a [NAME] Roth I Gastroduodenostomy (surgical procedure where the lower portion of the stomach is removed and then connected to the duodenum (first part of small intestine) with this being complicated by a biliary leak.Review of R16's admitting Physician Orders, located under the Orders tab in the EMR, revealed orders for medications including Dilaudid 2 milligrams (mg), give 0.5 tab every four hours as needed for pain and acetaminophen 325 mg three tabs every four hours as needed for mild pain.Review of R16's Nursing Progress Note, located under the Progress Note tab in the EMR and dated 01/01/25 at 1:35 PM, revealed, . patient stating in high level of pain. Called pharmacy at 1300 [1:00 PM] to confirm they received patient's medication Rx [prescription] . medication should be delivered no later than 1800 [6:00 PM]. On call physician . prescribed a PRN [as needed] for Tramadol 50 mg PO [by mouth] q 6hr [every six hours] . Review of R16's entire clinical record revealed no documented evidence that the resident received Tramadol at that time.It was documented that the resident received three 325mg acetaminophen tablets which decreased the pain to a three at 2:48 PM. The nurse documented . minimal relief noted . The resident's pain was assessed to be a 7 on the day and night shifts on 01/01/25.Review of R16's Medication Administration Record (MAR), dated 01/02/25 at 1:20 AM and located under the Orders tab of the EMR, revealed the resident's pain level was noted to be 7, on a zero to 10 scale. It was recorded R16 was administered Tramadol 50 mg. This was documented as being effective at 1:42 AM, but no pain level was documented. Review of R16's MAR, dated 01/02/25 at 11:51 AM and located under the Orders tab of the EMR, revealed the resident's pain level was noted to be 10. It was recorded the resident was administered Dilaudid, 2mg give 0.5 tab. This is the first time the resident was provided Dilaudid, and it was approximately 35 hours after arriving at the facility.Review of the facility's Pyxis system (computerized medication dispensing machine used for emergency, first-dose, and other situations where medications are not readily available from the pharmacy) report, provided by the facility, revealed this dose of Dilaudid was taken from the facility's Pyxis system to administer to R16 at the documented time.Review of R7's Practitioner Note, with a date of service of 01/02/25 at 9:56 PM and located under the Progress Notes tab of the EMR, revealed, . Presented to [hospital name] ED with coffee ground emesis. Was found in work up to have esophagitis but no bleeding and had open G tube done. During procedure was found to have changes suggestive of recurrence of cancer and IR biopsy was positive for recurrent pancreatic CA [cancer]. Patient c/o [complained of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	

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 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	
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 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interview, and document review, the facility failed to have an ongoing quality assurance and performance (QAPI) program demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse effects; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities to address systematic failures in recognizing a decline in a resident's change in condition for one of 16 residents (Resident (R) 7) and failing to consistently provide pain management and failing to have Dilaudid pain medication ordered upon admission for one of 16 residents (R) 16). These incidents created serious harm for R7 and R16. The lack of acknowledging the failures had the potential to affect all residents at the facility. Review of the undated facility's policy titled, Quality Assurance and Performance Improvement (QAPI) indicated, . it is the policy of the facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides . 'Adverse Event' is an untoward, undesirable and usually unanticipated event that causes the death or serious injury, or the risk thereof . Medical errors and adverse events are routinely tracked. Facility staff monitor residents for medical errors and adverse events in accordance with established procedures for the type of adverse event . An investigation will be conducted on each identified medical error or adverse vent to analyze causes . Preventive actions and mechanisms will be implemented to prevent medical errors and adverse events, including feedback and education . Monitoring will be conducted to ensure desired outcomes are achieved and sustained .1. Review of R7's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated R7 was admitted to the facility in 12/2024 with the diagnosis of myelodysplastic syndrome, anemia, and acute congestive heart failure.Review of R7's AUTM Admit/Readmit Screener 1.0 -V 8, dated 12/30/24, indicated R7 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R7 was cognitively intact.The facility failed to notify the physician of R7's refusal to have an immediate (STAT) laboratory test on 12/30/24 and 12/31/24; failed to obtain a Urine with Culture and Sensitivity (C&amp;S) test when ordered on 12/31/25; failed to monitor the resident after reports of nausea without emesis for three days, decreased appetite secondary to the nausea, and continued diarrhea; and failed to act upon a critically high white blood cell (WBC) count for R7.In an interview on 09/22/25 at 12:50 PM, the Director of Nursing (DON) was asked the definition of an adverse effect and the DON stated, You don't get the expected outcome of a situation. The DON was asked if the event with R7 which occurred on 01/02/25 was an adverse outcome and the DON stated, Yes, it would. At this time, the surveyor requested the QAPI meeting minutes for January 2025. The DON returned at 1:00 PM and brought in a copy of the Performance Improvement - project assignment tool dated 01/28/25. The DON stated that the facility implemented a Performance Improvement Plan (PIP) through their quality assurance and performance improvement (QAPI) program regarding the unexpected death of R7 which had occurred in the facility on 01/02/25.Review of this PIP indicated the facility identified lack of documentation regarding adequate interventions and appropriate follow up in the EMAR [electronic medical administration record] system and PCC [Point Click Care] progress notes.Further review of the PIP identified Process to be implemented to reach an acceptable level of performance: 100% were to:-Re-educate staff on the timelines and accuracy of resident change in condition recognition-Re-educate staff on proper documentation and communication with MD [Medical Doctor]/NP [Nurse Practitioner]/PA [Physician Assistant]-Strengthening communication protocols between nursing, providers, and families-Implement clinical monitoring audit with IDT [Interdisciplinary Team] for each death-Strengthen 24-hour report review process by Unit Managers and DON-Initiate mortality review meetings with IDT for each death-Implement death log to be maintained and reviewed monthly in QAPIWith the results of these audits will be reviewed monthly by the Director of Nursing and will be reported monthly to the QAPI committee. Findings tracked, trends identified, and corrective actions revised as needed.Review of the Case Review Form (complete for EACH death) indicated the review for R7 indicated a review was conducted in the following areas:- .Date/Time of Death indicated 1/2/25 [sic]-Location Facility was marked-Code Status indicated FC [Full Code]-Advance Directives on file Yes was checked-Hospice/Palliative Care involved No was checked-Immediate Notifications &amp; [and] [sic]-Provider Notified at 1/2/25 [sic] was written in-Next of Kin/Representative notified at 1/2/25 [sic] was written in by was left blank-Hospice notified at was marked through-Coroner/Medical Examiner notified at family notification -</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2025
NAME OF PROVIDER OR SUPPLIER  The Subacute at Autumn Lake Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  113 Route 73 Voorhees, NJ 08043	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control was maintained during observation of medication administration for two of five residents (Resident (R)14 and R13) observed out of a total sample of 15 residents. This failure had the potential to introduce infections to the residents. 1. Review of R14's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R14 was admitted to the facility in 9/2025. Observation on 09/11/25 at 5:40 AM, revealed Licensed Practical Nurse (LPN)1 was observed with her bare index and middle finger inside of the medication cup which contained R14's medication. LPN1 administered the medications from the cup to R14. 2. Review of R13's undated Face Sheet located under the Profile tab in the EMR indicated R13 was admitted to the facility in 08/2025. During an observation on 09/11/25 at 5:49 AM LPN1 was observed with her index finger touching the inside of the medication cup. LPN1 administered the medications from the cup to R13. LPN1 did not have gloves on during this observation. During an interview on 09/11/25 at 5:50 AM, LPN1 stated, I should not have touched the inside of the medication cup with my bare fingers. During an interview on 09/11/25 at 9:48 AM, the Infection Preventionist (IP) stated, The nurse should never touch the inside of the medication cup with her bare hands or fingers prior to giving the medication. During an interview on 09/12/25 at 12:10 PM, the Director of Nursing (DON) stated, She [LPN1] should not have touched her bare fingers inside of the medication cup. NJAC 8:39-19.4 (a)(1)</p>		