

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  12/10/2025
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 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)

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  12/10/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>C #: NJ00183386/398980, 2670006 Based on observation, interview, medical record review, and review of other pertinent facility documentation on 12/9/25 and 12/10/25, it was determined that the facility failed to consistently document and maintain a complete medical record regarding toileting, bowel &amp; bladder continence/incontinent care for residents in accordance with the facility's policy and standard of care. This deficient practice was identified for 2 of 2 residents (Resident #4 and Resident #5) reviewed. The facility also failed to document when a resident was sent out of the facility for further evaluation after an allegation of a fall. This deficient practice was identified for 1 of 2 residents (Resident #5) reviewed and was evidenced by the following: 1. According to the admission Record (AR) Resident #4 was admitted with diagnoses that included but were not limited to: type II diabetes, osteoarthritis, right artificial hip joint, and hypertension. The comprehensive Minimum Data Set (MDS), an assessment tool, dated 11/3/25, revealed a Brief Interview of Mental Status (BIMS) of 15 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS indicated that the resident required substantial assistance with toileting. Review of Resident #4's Baseline Care Plan, revealed that the resident required a one person assist with toileting. Review of Resident #2's DSR and progress notes (PN) for February 2025 lacked any documentation about the care that was provided to the resident on the following dates: Bladder Continence-Day Shift (7 AM - 3 PM): 2/10/25, 2/11/25-Evening Shift (3 PM - 11 PM): 2/9/25, 2/10/25-Night Shift (11 PM - 7 AM): 2/10/25, 2/11/25 Bowel Continence-Day Shift (7 AM - 3 PM): 2/10/25, 2/11/25-Evening Shift (3 PM - 11 PM): 2/9/25, 2/10/25-Night Shift (11 PM - 7 AM): 2/10/25, 2/11/25 Bowel Movements-Day Shift (7 AM - 3 PM): 2/10/25, 2/11/25-Evening Shift (3 PM - 11 PM): 2/9/25, 2/10/25-Night Shift (11 PM - 7 AM): 2/10/25, 2/11/25. According to the admission Record (AR) Resident #5 was admitted with diagnoses that included but were not limited to: cerebral infarction, heart failure, abnormalities of gait and mobility, and cognitive communication deficit. The comprehensive Minimum Data Set (MDS), an assessment tool dated 10/17/25, revealed a Brief Interview of Mental Status (BIMS) of 13 out of 15, which indicated that Resident #5 was cognitively intact. Further review of the MDS indicated that the resident required partial assistance with toileting transfer and was fully dependent in toileting hygiene. Review of Resident #5's Baseline Care Plan, revealed that the resident required a one person assist with toileting. Review of Resident #5's DSR and progress notes for October 2025 lacked any documentation to show that care was provided to the resident on the following dates: Bladder Continence-Evening Shift (3 PM - 11 PM): 10/19/25 Bowel Continence-Evening Shift (3 PM - 11 PM): 10/19/25 Bowel Movements-Evening Shift (3 PM - 11 PM): 10/19/25 Further review of the Resident #5's medical record revealed an incident report (IR) dated 10/24/25 at 12PM, which stated that the resident was transported out of the facility for further evaluation. The record stated, At the time of the event, the resident had already been transported. A corresponding post transfer summary from the outside facility provider confirmed that the resident was evaluated at their facility on 10/24/25. A review of Resident #5's Universal Transfer Form (UTF) dated 10/24/25, did not include the time of transfer. A review of Resident #5's PN revealed a note dated 10/24/25 at 12:49 PM, which indicated that the resident returned to the facility. Further review of the PN did not indicate when the resident left the facility. During interview on 12/9/25 at 6:59 AM, with Licensed Practical Nurse (LPN #1), the LPN stated that Certified Nursing Assistants (CNA) were responsible for documenting incontinent care in the electronic medical record. LPN #1 stated that documenting this was important because it captured the efforts being made to ensure that residents were free from sores and rashes. LPN #1 further stated that there should be no blanks, and that nurses and supervisors were responsible for ensuring that the CNAs are documenting. During interview on 12/9/25 at 11:04 AM with the Unit Manager (UM #1), she stated that CNAs were primarily responsible for monitoring residents for incontinent bowel and bladder and that they were to document in the electronic system. UM #1 stated that documentation was important to show that efforts were being made to prevent skin breakdown. UM #1 stated that it was the responsibility of the UM to ensure that documentation was completed. During an interview on 12/9/25 at 1:14 PM with the Director of Nursing (DON), the DON stated that CNAs were primarily responsible for monitoring residents for incontinent care and that they were to document in the electronic system. The DON further stated that the purpose of this documentation was to reflect that care was being provided. In the presence of the surveyor the DON reviewed the corresponding DSR sheets for Resident #4 and Resident #5 and confirmed that there were blanks as indicated above. During a telephone interview on 12/10/25 at 2:58 PM CNA #1 the CNA stated that</p>		