

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>AUTUMN LAKE HEALTHCARE AT VOORHEES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1086 DUMONT CIRCLE</b> <b>VOORHEES, NJ 08043</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>Complaints: NJ176573, NJ180199</p> <p>Census: 117</p> <p>Sample: 4</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/05/2025

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>158336</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AUTUMN LAKE HEALTHCARE AT VOORHEES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1086 DUMONT CIRCLE</b> <b>VOORHEES, NJ 08043</b>
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S 000	<p>Initial Comments</p> <p>Complaints: NJ176573, NJ180199</p> <p>Census: 117</p> <p>Sample: 4</p> <p>The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.</p>	S 000		
S 560	<p>8:39-5.1(a) Mandatory Access to Care</p> <p>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documents on 12/09/2024, it was determined that the facility failed to ensure staffing ratios were met for 1 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents.</p> <p>Findings include:</p> <p>Reference: New Jersey Department of Health</p>	S 560	<p>S-560</p> <p>Completion Date 1/9/2025</p> <p>CORRECTIVE ACTION: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the</p>	1/9/25

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S 560	<p>Continued From page 1</p> <p>(NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>For the two weeks of staffing prior to complaint survey from 11/24/2024 to 12/07/2024, the facility was deficient in CNA staffing for residents on 1 of 14-day shifts as follows:</p> <p>On 12/01/24 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs.</p>	S 560	<p>schedule.</p> <p><b>IDENTIFICATION OF THE RESIDENTS AT RISK:</b> All residents have the potential to be at risk for deficient practice.</p> <p><b>SYSTEMIC CHANGE:</b> The facility Administrator has put in place a bonus structure as to help increase the levels of staffing according to census. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. In addition, the director of nursing or designee will meet daily with the staffing coordinator to ensure appropriate staffing.</p> <p><b>QUALITY ASSURANCE:</b> The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly until compliance is met.</p>	
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**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 158336	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/7/2025
Y1	Y2	Y3
NAME OF FACILITY AUTUMN LAKE HEALTHCARE AT VOORHEES		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 DUMONT CIRCLE VOORHEES, NJ 08043

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	01/09/2025	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/9/2024	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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