STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
F0000	INITIAL COMMENTS Intake ID#: 3065497 Survey Dates: 7/1/26 to 7/14/26 Census: 135 Sample size: 27 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		07/30/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	Corrective Action: On 7/2/26 U. S. FOIA (b) (2) discarded all items in the unit pantry refrigerator that were not labeled or properly stored. The U. S. FOIA (b) (2) contacted maintenance director to conduct a temperature check of the 300 unit refrigerator; U. S. FOIA (b) (2) determined the refrigerator was at the accurate temperature of 40 degrees, the inaccurate thermometer was discarded. On 7/6/26 the U. S. FOIA (b) (2) conducted an in-service on hand hygiene with the Activity Aide. On 7/7/26 the U. S. FOIA (b) (2) conducted a training with U. S. FOIA and additional dietary staff on proper hand hygiene procedure. U. S. FOIA and dietary aides were able to verbalize and perform and accurate return demonstration of proper handwashing and proper use of hand sanitizer. Identification of Residents at Risk: All residents have the potential to be affected by the spread of infection/ food-borne illness; residents can be identified on the resident roster. Systemic Change: On 7/2/26 the Director of Nursing conducted an	08/06/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069

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F0812 SS = F	Continued from page 1 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food-borne illness. This deficient practice was evidenced by the following: 1.) On 07/02/26 at 9:40 AM, the surveyor entered the facility's kitchen and conducted an interview with the U. S. FOIA (b) (2)) who stated dietary staff wash their hands at the two designated hand washing sinks. The U. S. FOIA further stated that the nursing staff and dietary staff were both responsible for maintaining the nursing unit pantries. At 10:02 AM, the surveyor, accompanied by the U. S. FOIA observed the following in the kitchen: At the handwashing sink, the U. S. FOIA washed her hands for 11 seconds. The U. S. FOIA stated staff should wash their hands for 20 seconds to remove any debris and ensure a thorough wash. 2.) On 07/02/26 at 9:20 AM, the surveyor, accompanied by the U. S. FOIA (b) (2) , observed the following in the 100 Unit pantry: In the freezer, there was: - A 16.9-ounce (oz) bottle of orange soda that was previously opened and was not labeled with a resident's name or date. - Two 16.9-oz bottles of water (one that was previously opened, one that was sealed) that were not labeled with a resident's name or date. - A 16.9-oz bottle of root bear that was previously opened and not labeled with a resident's name or date. - A 4-oz container of ice cream that was opened, without a lid, with a layer of frost on the top of the ice cream. - A sealed frozen peanut butter and jelly sandwich that was not labeled with a resident's name or dated.	F0812	Continued from page 1 in-service with the 11-7 Nurses & Supervisors on correct procedure for checking the pantry refrigerator and freezer for accurate temperature and discarding any item out of date or not labeled correctly. Signs were placed on all 3 pantry refrigerators stating all items placed in the refrigerator need to be labeled with name and date. On 7/7/26 the U. S. FOIA (b) (2) conducted a facility wide in-service on proper storage and labeling required for the pantry refrigerators. On 7/7/26 the U. S. FOIA (b) (2) conducted education/ training on proper handwashing techniques during meal pass with Nursing and Activity department. An audit will be conducted and documented monthly by U. S. FOIA (b) (2), or designee, to evaluate that proper handwashing practices are being implemented throughout the facility. A minimum of 10 staff members will be observed each month. Individual staff members will be addressed as needed based upon results of audit. Audits will be submitted to U. S. FOIA monthly for one year. An audit will be conducted and documented weekly by Unit Managers, or designee, checking all pantry refrigerators and freezers for accurate temperature and assure that all items are labeled and within date. Any discrepancies will be addressed immediately. Audits will be submitted to DON monthly for review for one year. Quality Assurance: The DON will submit a quarterly audit report to the Licensed Nursing Home Administrator (LNHA) and the Quality Assurance Performance Improvement (QAPI) Committee for one year.	08/06/2026

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F0812 SS = F	Continued from page 2 In the refrigerator, there was: - A 16.9-oz frozen bottle of water that was previously opened and was not labeled with a resident's name or date. - A 4.5-oz container of yogurt with an expiration date of 06/17/26. - A 20-oz bottle of flavored sports drink that was previously opened and was not labeled with a resident's name or date. At that time, the [redacted] stated that the night shift nurse was responsible for checking the unit pantry refrigerator for expired food and making sure all food and drinks were labeled with the resident's name, room number, and date it was put into the refrigerator to ensure the resident's get the correct, unexpired food. The [redacted] then removed all of the above-mentioned items and discarded them. On 07/02/26 at 9:31 AM, the surveyor, accompanied by Regisered Nurse/Unit Manager (RN/UM) #1, observed the following in the 300 Unit pantry: In the refrigerator, there was a thermometer on the top shelf that read 40 degrees Fahrenheit (F) and a thermometer on the middle shelf that read 26 F. At that time, RN/UM #1 stated the night shift nurse was responsible for checking the pantry refrigerator temperature to ensure the food stays at a safe temperature. On 07/02/26 at 9:43 AM, the surveyor, accompanied by RN/UM #2, observed the following in the 200 Unit pantry: In the freezer, there was: - Two 16.9-oz bottles of water that were previously opened and were not labeled with a resident's name or date. - A 128-oz container of frozen water ice that was previously opened and was not labeled with a resident's name or date.	F0812		08/06/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0812 SS = F	Continued from page 3 - A chocolate covered pretzel that was sealed in plastic and was not labeled with a resident's name or date. In the refrigerator, there was a 14-oz sealed bottle of protein shake that was not labeled with a resident's name or date. At that time, RN/UM #2 stated the night shift nurse was responsible for ensuring all food was labeled with the resident's name, room number, and date it was put into the refrigerator to ensure the resident receives the correct, unspoiled food. 3.) On 07/06/26 at 11:20 AM, during the lunch meal service, the surveyor observed the U. S. FOIA (b) (2) in the main dining room repeatedly running her fingers through her hair which extended below her waist between assisting residents with opening straws, handing out utensils and condiments, and pouring beverages. The [redacted] did not perform hand hygiene between touching her hair and providing direct assistance to residents during the meal service observation. At 11:54 AM, the surveyor interviewed the [redacted] who stated that during the meal service, she was responsible for transporting residents to the dining room, handing out drinks, and cutting up food. The [redacted] further stated that staff were to perform hand hygiene upon entering the dining room and between handing out food items to prevent the spread of germs. At that time, the surveyor informed the [redacted] of the surveyor's observation and the [redacted] stated she should have performed hand hygiene after touching her hair. At 11:56 AM, the surveyor interviewed RN/UM #2 who stated that staff were supposed to perform hand hygiene before and after passing out food to residents to prevent the spread of germs. The [redacted] further stated that staff should perform hand hygiene if they touch their hair or body. On 07/07/26 at 12:31 PM, the surveyor interviewed the U. S. FOIA (b) (2)) who stated staff must wash their hands for 20 to 30 seconds to prevent the spread of infection. The [redacted] further stated that during meal pass, staff should perform hand hygiene	F0812		08/06/2026

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F0812 SS = F	Continued from page 4 between touching surfaces, themselves, or residents to prevent the spread of infection. When asked about the unit pantries, the [redacted] stated the night shift nurse was responsible for discarding any items that were not labeled or dated to prevent spoilage, and to check the refrigerator temperatures to ensure food is maintained at the correct temperature. A review of the facility's "Hand Hygiene" policy, dated January 2026, included, "Hand hygiene technique when using soap and water:... Rub hands together vigorously for at least 20 seconds…" A review of the facility's "Foods Brought by Family/Vistors," policy, dated August 2024, included, "Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item, and the 'use by' date." The policy further included, "The nursing staff will discard perishable foods on or before the 'use by' date." A review of the facility's "Supplement & Pantry Refrigerator" policy, dated January 2026, included the following: "Food brought in by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food. -Food is to be labeled with date of delivery. -Food may be stored in the refrigerator for 3 days. Food will be discarded after 3 days. The nursing staff will check the refrigerator and freezer each night shift for accurate temperatures, adjustments to be made as needed. The nursing staff will check the refrigerator and freezer on each night shift for expired items. Any items found expired, prepared food >3 days old, prepared food without a labeled date, or anything not in proper storage container will be discarded." A review of the facility's "Supplement Refrigerator & Freezer Temperature Log" for the 300 Unit, dated July 2026, included, "Refrigerator temperature must be maintained between 36 and 40 degrees Fahrenheit."	F0812		08/06/2026

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F0812 SS = F	Continued from page 5 A review of the facility's "Hand Hygiene During Meal Pass Policy," dated, January 2026, included, "Perform hand hygiene… before serving food or beverages…between residents… after touching environmental surfaces… after coughing, sneezing, or touching the face…" NJAC 8:39-17.2(g)	F0812		08/06/2026
F0814 SS = D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to have a cover over the opening of 3 of 3 garbage dumpsters. This deficient practice was evidenced by the following: On 07/01/26 at 10:20 AM, the surveyor, accompanied by the U.S. FOIA (b)(6)), observed the facility's designated garbage disposal area. There were three garbage dumpsters that each had two lids. All three of the garbage dumpsters each had one lid open, exposing trash bags inside. At that time, the U.S. FOIA stated the garbage dumpsters should be closed to prevent anything from entering the dumpsters. On 07/08/26 at 10:22 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated the staff were responsible for ensuring the dumpster lids were closed at all times for infection control purposes. A review of the facility's "Food-Related Garbage and Refuse Disposal" policy, dated January 2026, included, "Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter."	F0814	Corrective Action Immediately closed and secured all open lids on the three (3) exterior garbage dumpsters located in the facility's designated garbage disposal area. Placed instructional signage directly at the dumpster site detailing requirements for keeping dumpster lids closed at all times to maintain proper infection control and vector control. Provided extension pole at the dumpster location to assist staff in opening and closing the dumpster lids safely and effortlessly. Identification of At-Risk Resident No residents were identified as affected by this deficient practice. All residents in the facility have the potential to be affected by these deficient practices. Systemic Change Conducted multiple in-service trainings for Dietary and Housekeeping staff regarding proper waste disposal, proper closure of dumpster lids after each use, and maintaining a sanitary dumpster perimeter in accordance with facility policy. Staff educated on the designated use of the extension pole to ensure all dumpster lids remain securely closed when not actively loading trash. The Dietary Director and Housekeeping Directors will conduct a weekly audit of the dumpster lids. Quality Assurance A quarterly review of the audits will be conducted and documented by the Food Service Director or designee and the Housekeeping Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. Results of the review will be reported to the Administrator as	08/05/2026

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F0814 SS = D	Continued from page 6 NJAC 18:39-19.3(b)	F0814	Continued from page 6 well as the Quality Assurance committee at their quarterly meeting for one year	08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 08/11/2026 in relation to the 07/14/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SOUTHGATE B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069

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K0000 Bldg. 02	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/13/2026 and 07/14/2026 and Autumn Lake Health Care at Southgate was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Autumn Lake Health Care at Southgate is a single-story building that was built in the 1980's. It is composed of Type V (111) construction and is fully sprinklered. The facility is divided into 8 - smoke compartments. The facility has a 500 Kilowatt diesel Emergency Generator that powers approximately 100% of the building per the Director of Maintenance.The current occupied beds are 135 of 152.	K0000		07/30/2026
K0353 SS = F Bldg. 02	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K0353	Corrective Action: The 2" drain pipe leak on the 100/200 dry sprinkler system was repaired, tested, and verified to be fully operational with no further leakage. We received an updated report reflecting compliance. The wheelchair clutter obstructing access to the Inspectors' Test Valves (ITVS) for the 100/200 wet and dry systems was immediately cleared way, restoring full, clear access to all test valves and the contractor was able to come back in and access. We received an updated report reflecting compliance. All dust-loaded sprinkler heads, obstructed heads, and spare sprinkler cabinet inventory deficiencies noted in the report were remediated. Identification of At-Risk Resident: All 135 residents in the facility have the potential to be affected by this deficient practice. Systemic Change: The [redacted] was in-serviced 8/5 by the [redacted] (as stated on the in-service sheet) on NFPA 25 inspection access requirements, and mandatory spare sprinkler	08/05/2026

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K0353 SS = F Bldg. 02	Continued from page 1 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations and review of facility provided documentation on 07/13/2026 and 07/14/2026 in the presence of the facility [U. S. FOIA (b) (2)] it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) 101, 2012 Edition, Section 9.7.5, 9.7.7, 9.7.8 NFPA 25, 2011 Edition. This deficent practice had the potential to affect the 135 Residents and was evidenced by the following: Findings included: A review of the last Quarterly Sprinkler Inspections since the last Re-Certification of 02/24/2025 revealed the following, 07/02/2026 quarterly inspection deficiencies: - Cannot access Inspectors' Test Valves for 100/200 Wet & Dry Systems due to wheelchair clutter in the room. - Need to have access to I.T.V.S. - *2" Drain Leaks on 100/200 Dry System needs to be fixed. No corrective action report provided during survey. - 2" Drain Test, Dispatcher number not recorded. Note4d 'XRPL" 04/03/2026 quarterly inspection deficiencies: - Cannot access Inspectors' Test Valves for 100/200 Wet & Dry Systems due to wheelchair clutter in the room. - Need to have access to I.T.V.S. - *2" Drain Leaks on 100/200 Dry System needs to be fixed.No corrective action report provided during survey. Observations on the two-day tour (07/13/2026 and 07/14/2026) include the following issues: 1) The following Resident rooms were observed to have sprinklers spray discharge pattern obstructed 16" away from a 24" deep T.V.:Resident room [NJ Ex Orde], Resident room #[NJ Ex Ord] Resident room [NJ Ex Orde] Resident room #[NJ Ex O], resident room [NJ Ex Order2]) Resident room [NJ Ex Orde] and Resident room [NJ Ex Ord] sprinklers had the frame and deflector loaded with dust.3) The 300 Unit Electrical room sprinkler (frangible glass bulb) was obstructed and loaded with dust. Observation inside the spare sprinkler the facility failed to include the following spare sprinkler heads for each type and temperature ratings for the sprinkler heads observed during the two-day building tour: Fusible Link (Sidewall), Recessed, Quick Response / Standard Response Pendent / Different temperature ratings, or sprinkler wrench for each type of sprinkler. The U. S. FOIA (b) (2) were informed of the deficient practice on 07/14/2026 during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.1 (c), -31.2 (e).NFPA 25	K0353	Continued from page 1 cabinet inventory standards. The [U. S. FOIA] instituted a monthly physical audit checklist to verify that all test valves remain clear, sprinkler heads remain clean/unobstructed, and spare sprinkler stock and wrenches match all installed head types. Quality Assurance: The Director of Maintenance (DOM) or designee will perform monthly audits of the sprinkler system, test valve access, and vendor inspection reports to maintain continuous compliance. The DOM will submit a quarterly audit report to the Licensed Nursing Home Administrator (LNHA) and the Quality Assurance Performance Improvement (QAPI) Committee for one year	08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SOUTHGATE B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069

(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
K0281 SS = E Bldg. 02	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observations interview and review of facility provided documentation on 07/13/2026 and 07/14/2026 in the presence of the facility U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to ensure that illumination of the means of egress for 4 of 12 exit discharges was provided in accordance with NFPA 101: 2012 Edition, Sections 7.8.1.4 and 19.2.8.This had the potential to affect the 135 Residents and was evidenced by the following: A review of the facility provided lay-out identified there are 12 designated exit discharge doors (illuminated exit signs above doors) that residents, visitors and staff could use in the event of an emergency. Observations during the two-day building tour revealed the following:1) Designated exit discharge door next to Resident room # NJ Ex Orde [redacted] had a single bulb emergency lighting fixture.2) Designated exit discharge door next to Resident room NJ Ex Orde [redacted] had a single bulb emergency lighting fixture.3) Designated exit discharge door inside the front lobby waiting area to the left side had no outside emergency light fixture for illumination.4) Designated exit discharge door inside the front lobby waiting area to the right side had no outside emergency light fixture for illumination. During an interview the U. S. FOIA (b [redacted] confirmed the findings at the times of observations. The U. S. FOIA (b) (2) were informed of the deficient practice on 07/14/2026 during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.2 (e).	K0281	Corrective Action: On August 7, 2026, the facility replaced the single-bulb emergency lighting fixtures at the designated exit discharge doors next to Resident Room NJ Ex Orde [redacted] and Resident Room NJ Ex Orde [redacted] with dual-bulb emergency lighting fixtures. For the two designated exit discharge doors outside the front lobby waiting area (left and right sides), the facility obtained an approved quote from the electrician to install dedicated exterior emergency lighting fixtures, with the installation scheduled for completion on August 17, 2026. Identification of At-Risk Resident: All 135 residents in the facility have the potential to be affected by this deficient practice. Systemic Change: The Maintenance Director added a weekly audit of all facility egresses to ensure continued compliance. Quality Assurance: A quarterly review of the audits will be conducted and documented by the Maintenance Director. Audit findings will be reported to the Administrator as well as the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 12 months to ensure continued compliance.	08/17/2026
K0321 SS = E Bldg. 02	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K0321	Corrective Action: Immediately removed the device blocking the Admissions Department / Medical Records room corridor door open, allowing the fire-rated door to self-close and latch properly to maintain required smoke-resisting separation. Identification of At-Risk Resident:	08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SOUTHGATE B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069

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K0321 SS = E Bldg. 02	Continued from page 3 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observations 07/13/2026 and 07/14/2026 in the presence of the facility's [redacted] it was determined that the facility failed to ensure 1 of 8 fire-rated doors inspected to hazardous areas were separated by smoke resisting partitions in accordance with National Fire Protection Association (NFPA) 101, 2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice had the potential to affect the 135 Residents and was evidenced by the following: Observations on 07/14/2026 in the presence of the facility [redacted] at approximately 9:31 AM, an inspection of the Admissions Department/Medical records room was performed. The inspection revealed that the	K0321	Continued from page 3 All 135 residents in the facility have the potential to be affected by this deficient practice. Systemic Change: Conducted an in-service training for all Admissions Staff, as well as all facility staff, specifically emphasizing that fire-rated and corridor doors to hazardous areas must never be propped or blocked open. The Director of Maintenance (DOM) or designee instituted a weekly physical audit to ensure the door is not propped or blocked open and that self-closing mechanisms function correctly. Quality Assurance: The Director of Maintenance or designee will compile weekly door audit findings and submit a quarterly report to the Administrator and the Quality Assurance Performance Improvement (QAPI) Committee for one year.	08/05/2026

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K0321 SS = E Bldg. 02	Continued from page 4 corridor door was blocked in the open position. The surveyor observed multiple combustible boxes filled with medical records. The room was larger than 50 square feet. The [redacted] confirmed the finding at the time of observation The [redacted] were informed of the deficient practice on 07/14/2026 during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39-31.2 (e).	K0321		08/05/2026
K0345 SS = E Bldg. 02	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on review of facility provided documentation on 07/13/2026 and 07/14/2026 in the presence of the facility [redacted] it was determined that the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with National Fire Protection Association (NFPA) 72 national Fire Alarm and signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems, had the potential to affect the 135 Residents and was evidenced by the following: Findings included:A record review on 07/13/2026 at approximately 11:45 AM, of the facility provided mandatory inspections for the previous 17 months revealed the following Semi-Annual (every 6 months) Fire Alarm and Detection systems: 08/08/2025, no sensitivity testing performed.02/05/2026, no sensitivity testing performed. "Sensitivity test 04/30/2026", included the following:04/2026 Work Order, statement "All devices passed sensitivity test, will send full report ASAP" Print out, included the following: L15001 3.00% to alarm, 10 to dirty. Set to: Day=Low Night=LowL15002 3.00% to alarm, 10 to dirty. Set to: Day=Low Night=LowL15003 3.00% to alarm, 10 to dirty. Set to: Day=Low Night=LowL15004 3.00% to alarm, 10 to dirty. Set to: Day=Low Night=LowL15005 3.00% to alarm, 10 to dirty. Set to: day=Low Night=Low Smoke detector Sensitivity Test.	K0345	Corrective Action: The facility immediately obtained and reviewed the full, complete Smoke Detector Sensitivity Test Report for all 1 of 1 fire alarm systems. The report confirms device list, manufacturer acceptable sensitivity ranges, and passing results/certificates for all facility smoke detectors, verifying full compliance. Identification of At-Risk Resident: All residents residing in the facility have the potential to be affected by fire safety system testing non-compliance. Systemic change The facility established a standardized documentation archiving protocol requiring that all third-party vendor fire safety and sensitivity testing work orders are accompanied by full, formal certification reports prior to completion sign-off The [redacted] was re-inserviced updated to ensure no service ticket is closed without attached device-level test logs and pass/fail certificates. The [redacted] will audit all fire alarm and Life Safety vendor inspection documentation monthly to verify that complete certificates and detailed reports are maintained on site. Quality Assurance: Audit findings will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) Committee for 6 months to ensure continued compliance.	08/05/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069

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K0345 SS = E Bldg. 02	Continued from page 5 There was no smoke detector sensitivity test report, Device type, make/model, method of testing and manufactures' acceptable sensitivity range, Pass or fail and Certificate of smoke detectors available during survey. No documentation. The [U. S. FOIA (b) (2)] were informed of the deficient practice on 07/14/2026 during the Life safety Code survey exit at approximately 1:15 PM. NJAC 8:39-31.1 (c), -31.2 (e).	K0345		08/05/2026
K0920 SS = E Bldg. 02	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observations on 07/13/2026 and 07/14/2026 in the presence of the [U. S. FOIA (b) (2)], it was determined that the facility did not prohibit the use of power strips, as a substitute for adequate wiring,,, in accordance with NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2, NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (d), NFPA 99, 2012 LSC Edition, section 10.2.3.6 and 10.2.4. This deficient practice had the potential to affect the 135 residents in the facility and was evidenced by the following: Observations on 07/13/2026 at approximately 10:28 AM, the surveyor observed inside Resident room #[NJ Ex CM] had a refrigerator plugged into a multiple plug	K0920	Corrective Action: Immediately unplugged and removed the power strip in Room #[NJ Ex Order 26, 4B] and connected the refrigerator directly to the fixed wall outlet. Immediately unplugged the microwave from the power strip in the Admissions Department and connected the microwave directly to a dedicated wall outlet. Identification of At-Risk Resident: All 135 residents in the facility have the potential to be affected by this deficient practice. Systemic Change: The facility conducted in-service training for Maintenance, Nursing, Admissions, and all facility staff regarding NFPA electrical safety standards, prohibiting the use of power strips for high-draw appliances (such as refrigerators and microwaves) and prohibiting power strips as substitutes for fixed wiring. The [U. S. FOIA (b) (2)]) performed a facility-wide audit of all resident rooms and administrative offices to ensure no high-draw appliances are connected to power strips or extension cords. The maintenance staff instituted weekly environmental audits across all resident rooms and facility departments to verify ongoing compliance with electrical safety and power tap regulations. Quality Assurance: The DOM will submit a quarterly audit report to the Licensed Nursing Home Administrator (LNHA) and the Quality Assurance Performance Improvement (QAPI) Committee for one year.	08/05/2026

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K0920 SS = E Bldg. 02	Continued from page 6 power strip that was stored in the top drawer of a night stand and connected to an electrical outlet.. Observations on 07/14/2026 at approximately 9:31 AM, the surveyor observed inside the Admissions Department a microwave plugged into a multiple plug power strip connected to an electrical putlet. The [U. S. FOIA] confirmed the findings at the times of observations. The U. S. FOIA (b) (2) were informed of the deficient practice on 07/14/2026 during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.2 (e).	K0920		08/05/2026
K0211 SS = D Bldg. 02	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 07/13/2026 in the presence of the facility's [U. S. FOIA (b) (2)] [redacted] it was determined that the facility failed to maintain means of egress free of all obstructions to the full use in case of emergency, in accordance with the requirements on National Fire Protection Association (INFPA) 101, 2012 Edition, section 19.2.1, 19.2.2 through 19.2.11, 7.1.10.1 and 7.2.1. This deficient practice had the potential to affect the 135 Residents and was evidenced by the following: Findings included: At approximately 9:20 AM, the surveyor observed near the Resident Dining room an approximately 2-1/2 inch high absorbing/sponge type sock blocking the bottom of the designated exit discharge door.At that time, the surveyor interviewed the [U. S. FOIA], who stated it was there to stop the rainwater from coming into the building. At approximately 10:09 AM, the surveyor observed outside of designated exit discharge door next to Resident room [NJ Ex Orde] the following items were blocking the egress: 28 Full E-Type oxygen tank, 25 Empty E-Type oxygen tanks and 2 boxes of vinyl flooring being stored under the soffit of the roof. At approximately 10:40 AM, the surveyor observed outside of the designated exit discharge door next to	K0211	Corrective Action: The designated exit discharge doors near the Resident Dining Room, next to Resident Room # [NJ Ex O], and next to the [NJ Ex Order 26, 4B1] [redacted] were immediately and over the next 36 hours cleared. The obstructive items and equipment were removed to restore full, unobstructed egress. Identification of At-Risk Resident: All 135 residents residing in the facility have the potential to be affected by obstructed egress routes. Systemic Change: In-service training was also conducted for all staff regarding the requirement to keep all means of egress continuously maintained free of all obstructions. The Maintenance Director added a weekly audit of all facility egresses to ensure continued compliance. Quality Assurance: A quarterly review of the audits will be conducted and documented by the Maintenance Director Audit findings will be reported to the Administrator as well as the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 12 months to ensure continued compliance.	08/05/2026

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AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069

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K0211 SS = D Bldg. 02	Continued from page 7 the maintenance shop the following items were blocking the egress: three (3) wooden pallets, one (1) wheelchair, 1 Hoyer Lift, 10 Packaged Thermal Air Conditioner) PTAC) units, 20 boxes of LED fixtures, 1 Soiled Linen cart filled with cardboard, Wooden cart filled with combustible cardboard boxes stored under the soffit of the roof. The [U. S. FOIA] confirmed the findings at the times of observations. The [U. S. FOIA (b) (2)] were informed of the deficient practice on 07/14/2026 during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.2 (e).	K0211		08/05/2026
K0293 SS = D Bldg. 02	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observations on 07/13/2026 and 07/14/2026 in the presence of the [U. S. FOIA (b) (2)] it was determined that the facility failed to provide illuminated exit signs with the proper directional indicating arrows that leads to an exit discharge door.This deficient practice had the potential to affect the 135 Residents and was evidenced by the following: Observations on 07/13/2026 at approximately 10:07 AM, the surveyor observed an illuminated exit sign next to resident room [NJ Ex Ords] that had two (2) directional arrows. One directional arrow pointed to go to the right which leads to a storage room. This had the potential to confuse residents, visitors and staff in the event of an emergency. The [U. S. FOIA] confirmed the finding at the time of observation. The [U. S. FOIA (b) (2)] were informed of the deficient practice on 07/14/2026 during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.2 (e), -31.1 (c).	K0293	Corrective Action: The illuminated exit sign next to resident room # [NJ Ex O] was corrected immediately by removing/covering the incorrect right directional arrow, ensuring the exit sign clearly and accurately directs to the exit discharge door. Identification of At-Risk Resident: All 135 residents residing in the facility have the potential to be affected by improper directional exit signage. Systemic Change: The facility provided an in-service to the maintenance staff regarding proper directional exit signage. The maintenance checklist was updated to include monthly inspections of all exit sign directional arrows. Quality Assurance: The [U. S. FOIA D] or designee will report Audit findings to the Administrator and to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 12 months to ensure continued compliance.	08/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - SOUTHGATE** B. WING	(X3) DATE SURVEY COMPLETED **07/14/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0324 SS = D Bldg. 02	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 07/13/2026 in the presence of the facility's U. S. FOIA (b) (2)), it was determined that the facility failed to perform the Owners monthly inspections of the kitchen fire suppression system in accordance with the National Fire Protection Association (NFPA) 17A, 2009 edition, Section 7.2, 7.2.1 to 7.2.6. This deficient practice had the potential to affect the 135 Residents and was evidenced by the following: On 07/13/2026 at approximately 9:46 AM, during an inspection in the facility's kitchen, the surveyor observed on the kitchen suppression systems manual pull inspection tag that the system was semi-annually inspected March 2026 with no evidence of a monthly Owners inspection being performed and documented on the inspection tag for June 2026.At that time, a request was made to the NJ Ex Order who initialed the inspection for April and May 2026. The U. S. FOIA U. S. FOIA told the surveyor that person left the facility. The U. S. FOIA confirmed the finding at the time of observation. The U. S. FOIA (b) (2) were	K0324	Corrective Action: Upon identification, the U. S. FOIA (b) (2)) immediately completed the initial/sign-off documentation on the inspection tag which he had failed to sign off on when he inspected the system on June 29th. Identification of At-Risk Resident: All 135 residents in the facility have the potential to be affected by this deficient practice. Systemic Change: The U. S. FOIA (b) (2) conducted an in-service training with the U. S. FOIA (b) (2) regarding requirements for mandatory monthly inspections of the kitchen fire suppression system and proper documentation on the inspection tag. The maintenance assistant has been assigned primary responsibility for performing and signing off on the monthly kitchen fire suppression system inspections.The Director of Maintenance (DOM) will conduct a monthly audit of the kitchen fire suppression system inspection tag to verify that monthly inspections and sign-offs are completed accurately and on time. Quality Assurance: The DOM will submit a quarterly audit report to the Licensed Nursing Home Administrator (LNHA) and the Quality Assurance Performance Improvement (QAPI) Committee for one year..	08/06/2026

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K0324 SS = D Bldg. 02	Continued from page 9 informed of the deficient practice on 07/14/2026 during the Life safety code survey exit at approximately 1:15 PM. NJAC 8:39-31.2 (e), -31.6	K0324		08/06/2026
K0347 SS = D Bldg. 02	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is NOT MET as evidenced by: Based on observations on 07/14/2026 in the presence of the U. S. FOIA (b) (2) it was determined that the facility failed to provide smoke detector coverage in one (1) area that was open to the exit access corridor, in accordance with the National Fire Protection Association (NFPA) 101, 2012 Edition, section 19.3.6.1, NFPA 72. findings include: On 07/14/2026 at approximately 10;16 AM, an inspection inside the Fireside lounge (next to the U. S. FOIA (b) (2)) was performed. The surveyor observed no evidence of smoke detector coverage inside the approximately 9 feet by 15 feet lounge area that is open to the exit access corridor. The U. S. FOIA confirmed the finding at the time of observation. The NJ Ex Order 26, 4B1 were informed of the deficient practice on 07/14/2026 during the Life Safety Code swurvey exit at approximately 1:15 PM. NJAC 8:39 -31.1 (c), -31.2 (e).	K0347	Corrective Action: The U. S. FOIA (b) (2) on 8/6/26 approved an order with the fire protection vendor to install a new smoke detector inside the hallway to ensure proper coverage for spaces open to the exit access corridor. The installation was completed on 9/21/26. Identification of At-Risk Resident: All 135 residents in the facility have the potential to be affected by this deficient practice. Systemic Change: The U. S. FOIA (b) (2)) performed a facility-wide audit of all open spaces and lounges adjacent to exit access corridors to verify that adequate smoke detection coverage is present throughout the facility. In-service training was conducted on 8/3/26 by the U. S. FOIA (b) in overview of the regulation pertaining to proper smoke detection coverage in the facility, The Director of Maintenance (DOM) or designee will inspect all newly installed smoke detectors and conduct monthly audits of corridor-adjacent open spaces to ensure all required smoke detection devices remain present, operational, and properly maintained. Quality Assurance: The DOM will submit a quarterly audit report to the Licensed Nursing Home Administrator (LNHA) and the Quality Assurance Performance Improvement (QAPI) Committee for one year.	09/21/2026
K0741 SS = D Bldg. 02	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.	K0741	Corrective Action: Immediately cleaned, removed, and safely disposed of all cigarette butts and ashes found on the ground outside the discharge door near the maintenance shop. Identification of At-Risk Resident: All 135 residents in the facility have the potential to be affected by this deficient practice. Systemic Change: Review of security video surveillance was conducted to identify the individual responsible for smoking in the non-designated area. The identified employee was provided immediate mandatory in-service education and counseling regarding the facility's strict No Smoking Policy and proper smoking refuse disposal.	08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - SOUTHGATE** B. WING	(X3) DATE SURVEY COMPLETED **07/14/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
K0741 SS = D Bldg. 02	Continued from page 10 (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observations, interview and review of facility provided documentation on 07/13/2026 and 07/14/2026 in the presence of the facility [redacted], it was determined that the facility failed to prohibit smoking in non-smoking areas and failed to dispose of smoking refuse in a safe and sanitary manner. This deficient practice had to potential to affect the [redacted] Residents and was evidenced by the following: An observation on 07/13/2026 outside of the building next to the maintenance shop, at approximately 10:44 AM, the surveyor observed approximately 20 cigarette butts and ashes on the ground. There was no approved ash trays or a self-closing covered metal container for the disposal of cigarette butts and ashes.The surveyor observed on the discharge door leading to the outside maintenance area a sign posted on the door that reads: No smoking area.At that time, the surveyor asked the [redacted] was that a designated smoking area. The [redacted] replied "no." A review of the facility provided "Smoking Policy" reads in part:"No-Smoking signs shall be prominently displayed in no smoking areas.""Only facility-approved ashtrays, metal containers and other smoking equipment/paraphernalia shall be used. Metal container, with self-closing cover devices, shall be available in smoking areas." The [redacted] were informed of the deficient practice on 07/14/2026, during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.2 (e), -31.6.	K0741	Continued from page 10 As a preventive measure, in-service training was also conducted for all staff working in and around the maintenance and service discharge areas as well as all staff in the facility, emphasizing that smoking is strictly prohibited in non-designated areas and reinforcing designated smoking location protocols. The Director of Maintenance (DOM) or designee will perform weekly audits of the maintenance shop exit door area, to ensure the space remains free of smoking debris and that no-smoking rules are strictly followed. Quality Assurance: The DOM will submit a quarterly audit report to the Licensed Nursing Home Administrator (LNHA) and the Quality Assurance Performance Improvement (QAPI) Committee for one year.	08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/13/2026 and 07/14/2026. Autumn Lake Healthcare at Southgate was found to be in non-compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		07/30/2026
E0004 SS = E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan.	E0004	Corrective Action: The Emergency Preparedness Plan, including all associated policies and procedures, was thoroughly reviewed and updated by 8/5. A formal Table of Revisions was added to the front of the binder documenting the annual review, specific policy updates, and the date of completion. Identification of At-Risk Resident: All 135 residents residing in the facility have the potential to be affected by incomplete Emergency Preparedness documentation. Systemic Change: The facility updated its Emergency Preparedness administrative procedure to mandate that a Table of Revisions be updated immediately whenever policies are reviewed or revised. The Quality Assurance: The LNHA or designee will audit the Emergency Preparedness binder quarterly to ensure all policy updates and revision tables remain up to date. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 12 months to ensure continued compliance.	08/05/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
E0004 SS = E	Continued from page 1 The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on documentation review on 07/14/2026 it was determined that the facility failed to establish and maintain a comprehensive Emergency Preparedness Program, that is updated at least annually to include the date of review and any updates made to the emergency plan based on the review. The deficient practice had the potential to affect the 135 Residents and was evidenced by the following: Findings include: Documentation review of the book provided to the surveyor tilted Emergency Preparedness Plan, revealed last reviewed 08/25/2025 annual updates made to the plan based on the review, there was no documentation ("Table of Revisions") that the facility reviewed policies and procedures. The [redacted] were informed of the deficient practice on 07/14/2026 during the Life safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.2 (e).	E0004		08/05/2026
E0013 SS = E	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.	E0013	Corrective Action: The Emergency Preparedness Plan policies and procedures were thoroughly reviewed and updated. Specific written policies were added to address fire pump operations during power and water outages, and maintaining normal operations during power failure and water supply loss, and clarification of services supported by the emergency generator. Identification of At-Risk Resident: All 135 residents residing in the facility have the potential to be affected by incomplete Emergency Preparedness policies and procedures. Systemic Change: The facility updated its Emergency Preparedness administrative procedure to mandate that all policies and procedures are reviewed against the hazard risk assessment annually and whenever facility systems or equipment	08/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
E0013 SS = E	Continued from page 2 *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is NOT MET as evidenced by: Based on documentation review on 07/14/2026, it was determined that the facility failed to ensure that its policies and procedures aligned with the identified hazards within the facility's risk assessment and overall Emergency Preparedness Program. This deficient practice had the potential to	E0013	Continued from page 2 change. Quality Assurance: The DOM or designee will audit the Emergency Preparedness plan and policies quarterly to verify that all hazard-specific procedures and generator schedule documentations remain accurate and current. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 12 months to ensure continued compliance.	08/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069

(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
E0013 SS = E	Continued from page 3 affect the 135 Residents and was evidenced by the following: Findings include: A review of the facility provided Emergency Preparedness plan provided to the surveyor on 07/14/2026 revealed the book was reviewed 08/05/2026, Policy and procedure for Electric Fire pump loss of water supply/contamination of water and Electric:No written documentation related to the fire pump- loss Power and water outage.Fire watch did not include continuing normal operation of the building due to power failure and water outage. Policy and procedure for Generator no documentation of equipment and services supported by the emergency generator. The U. S. FOIA (b) (2) [redacted] were informed of the deficient practice on 07/14/2026 during the Life Safety Code survey at approximately 1:15 PM. NJAC 8:39 -31.6	E0013		08/06/2026
E0015 SS = E	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems.	E0015	Corrective Action: The Emergency Preparedness Plan policies and procedures for "Emergency Food Supply" and "Emergency Water" were updated on 08/05/2026. The policy now includes designated emergency menus and food quantities for residents and staff, a fully executed Memorandum of Understanding (MOU), and documented calculation formulas for water supply for residents, staff, and volunteers along with total stored water volume. Identification of At-Risk Resident: All 135 residents residing in the facility have the potential to be affected by incomplete Emergency Preparedness subsistence documentation. Systemic Change: The facility updated its Emergency Preparedness administrative procedure to mandate that all subsistence policies, emergency menus, vendor MOUs, and water storage calculations are reviewed and updated annually. Quality Assurance: The DOM or designee will audit the Emergency Preparedness subsistence policies and vendor MOUs quarterly to verify that all calculations, menus, and agreements remain current. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 12 months to ensure continued compliance.	08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
E0015 SS = E	Continued from page 4 (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is NOT MET as evidenced by: Based on review of facility provided documentation on 07/14/2026 it was determined that the facility failed to ensure that the policies and procedures pertaining to subsistence needs for residents and Staff were in accordance with Appendix Z, requirements for Long Term Care (LTC) facilities. This deficient practice had the potential to affect the 135 Residents and was evidenced by the following: Based on review of facility provided Emergency Preparedness Program documentation on 07/14/2026 last reviewed on 08/05/2025 revealed the following: Policy and Procedure for "Emergency Food Supply" Updates made to the plan based on the annual review. Memorandum of Understanding (MOU) was not documented. The policy did not include a menu and quantity of food for Residents, Staff. Policy and Procedure for "Emergency Water" did not include the calculation of water for Residents, Staff, Volunteers and volume of water stored. The U. S. FOIA (b) (2) [redacted] were informed of the deficient practice on 07/14/2026 during the Life Safety Code	E0015		08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
E0015 SS = E	Continued from page 5 survey exit at approximately 1:15 PM. NJAC 8:39 -31.6	E0015		08/05/2026
E0025 SS = E	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is NOT MET as evidenced by: Based on documentation review on 07/14/2026 it was determined that the facility failed to ensure that	E0025	Corrective Action: The Emergency Preparedness Plan policies and procedures for mutual aid arrangements were updated on 08/05/2026. Fully executed and updated Memorandums of Understanding (MOUs) for receiving facilities and emergency transportation providers were placed directly into the facility Emergency Preparedness Program book to ensure continuity of care in the event of evacuation or relocation. Identification of At-Risk Resident: All 135 residents residing in the facility have the potential to be affected by this deficient practice. Systemic Change: The facility updated its Emergency Preparedness administrative procedure to mandate that all receiving facility and transportation provider MOUs are reviewed and available in the EP Book during the annual plan review. Quality Assurance: The LNHA or designee will audit all facility and transportation MOUs quarterly to verify that all agreements remain current, and accessible in the plan. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for 12 months to ensure continued compliance.	08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
E0025 SS = E	Continued from page 6 the Emergency Preparedness Program failed to include updates to the Memorandum of Understanding (MOU). This deficient practice had the potential to affect the 135 Residents and was evidenced by the following: A review of the facility provided Emergency Preparedness Program book revealed that the book was last annual reviewed 08/05/2025.Mutual aid agreements "Receiving Facilities and Transportation". Policy reads "Evacuation and Relocation" and Transportation Planning to Enable evacuation/relocation and noted Memorandum of Understanding (MOU) updates made to the plan based on annual review. MOU for Facilities and transportation was not documented and available during survey. The [redacted] were informed of the deficient practice on 07/14/2026 during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.6.	E0025		08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - SOUTHGATE** B. WING	(X3) DATE SURVEY COMPLETED **10/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
K0000 Bldg. 02	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 10/2/2026 in relation to the 7/14/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		10/07/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD , CARNEYS POINT, New Jersey, 08069**

(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
E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 10/2/2026 in relation to the 7/14/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		10/07/2026

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 reverse for further 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