

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

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 04/08/2026	
NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT SOUTHGATE				STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint 2738124, 2716737, 2703997, 2613536 Census: 133 Sample Size: 34 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 SURVEY.			F0000			04/23/2026

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
---	--	-------	-----------

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061706		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT SOUTHGATE				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
S0000	Initial Comments 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.		S0000			04/23/2026	
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint 2738124, 2716737, 2703997, 2613536 Based on interviews and review of facility documents on 4/8/26, it was determined that the facility failed to ensure staffing ratios were met for 11 of 21-day shifts reviewed. This deficient practice had the potential to affect all residents. Reference: New Jersey Department of Health (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: 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		S0560	Corrective Action The following corrective actions have been accomplished for the identified deficiency: Efforts to hire more facility staff to allow us to have adequate or more than adequate staff to serve our residents have been ramped up. In meantime the facility will utilize agencies to fill open slots in the schedule. Identification of At-Risk Resident All residents have the potential to be affected by the deficient practice of not meeting the NJ staffing requirement ratios. Systemic Change The following measures have been put into place to prevent the deficient practice from recurring: Advertisements/ job postings for CNAs have been posted on hiring platforms, social media websites as well as flyers posted. Incentives are offered to CNAs to work extra shifts such as gift cards, bonuses, and raffles. Many agencies are being utilized to fill in any open shifts. Bonuses are also being offered to agency staff to pick up shifts. Hiring and recruitment efforts now include referral bonuses, sign-on bonuses, weekend bonuses amongst other incentives to bring in good staff and		04/23/2026	

Office of Primary Care and Health Systems Management

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061706		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2026	
NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT SOUTHGATE				STREET ADDRESS, CITY, STATE, ZIP CODE 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
S0560	Continued from page 1 that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 1 week of staffing for complaint survey 22BD-H1 at Autumn Lake Southgate from 12/28/25 to 01/03/26, the facility was deficient in CNA staffing for 4 of 7-day shifts as follows: -12/28/25 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -01/01/26 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -01/02/26 had 15 CNAs for 134 residents on the day shift, required at least 17 CNAs. 01/03/26 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs For the 2 weeks of staffing prior to survey from 3/22/26-4/4/26, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: 3/22/26 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. -3/23/26 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. -3/25/26 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs 3/26/26 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. -3/27/26 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. -3/28/26 had 13 CNAs for 141 residents on the day shift, required at least 18 CNAs. -3/29/26 had 13 CNAs for 141 residents on the day shift, required at least 18 CNAs.			S0560	Continued from page 1 quickly. Quality Assurance The DON or designee will review staffing levels daily to ensure that we have adequate staffing x's 1 year. The administrator or designee will review the staffing schedule weekly to monitor the staffing ratio on all shifts weekly x 90 days. The administrator will report the findings of the audits to the QA committee on a quarterly basis x 4 quarters.		04/23/2026

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

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 04/29/2026	
NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT SOUTHGATE				STREET ADDRESS, CITY, STATE, ZIP CODE 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 An offsite/desk review of the facility's Plan of Correction was conducted on 4.29.26 in relation to the 4.8.26 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.			F0000			

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
---	--	-------	-----------

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061706		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/29/2026	
NAME OF PROVIDER OR SUPPLIER AUTUMN LAKE HEALTHCARE AT SOUTHGATE				STREET ADDRESS, CITY, STATE, ZIP CODE 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
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 4.29.26 in relation to the 4.8.26 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.			S0000			

Office of Primary Care and Health Systems Management

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