STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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
F 000	INITIAL COMMENTS Complaint NJ #'s: 167424, 169844, 169906, 170986, 174139, 174186 and 179097 Survey Dates: 2/19/25 to 2/26/25 Census: 140 Sample size: 28 + 2 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.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		2/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint #NJ 169844 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident environment, equipment, and living areas in a safe, sanitary, and homelike manner. This deficient practice was evidenced on 3 of 3 resident units ([redacted]) and was evidenced by the following: 1.) On 2/20/25 at 9:58 AM, the surveyor, in the presence of [redacted] #1, observed the following in the pantry area on the [redacted]: -A water cooler had a build-up of white streaks and grime. -An ice cart that contained a plastic liner with	F 584	Corrective Action: Identified ice cart as well as the other 2 facility ice carts were pulled from the floor, emptied and discarded. New temporary carts were immediately purchased, and new permanent ones were ordered and since installed. In Service was done on 2/25/25 for the staff by the Dietary Director regarding the cleaning/sanitizing/refilling process for the bins. 10 New trash lids were purchased and installed around the facility. All water coolers and trash lids were cleaned or replaced. On 2/21, the Large Atrium windows on all 3 units [redacted], as well as the middle of the vaulted ceiling on [redacted] were deep cleaned by maintenance using a tall ladder. Lower doors/windows were scrubbed by	

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F 584	Continued From page 2 multiple rips and brown stains. -The black lid on a large gray trash can contained a build-up of white and brown substances. At that same time in the day room, the following was observed: -The black lid on a large gray trash can also contained a build-up of white and brown grime throughout. On 2/20/25 at 10:14 AM , the surveyor interviewed Housekeeper (HSK) #5, who stated that when she cleaned the pantry area, she sweeps, checks for paper towels and soap, cleans next to and behind the refrigerator, makes sure there was nothing on top of the counter, takes out the trash, sweeps and mops the floor. She did not include cleaning the water cooler or trash can lids. On 2/20/2025 at 10:20 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the water cooler should be kept "sparkling" and should be cleaned twice a shift. She further stated that the ice cart should be taken to the kitchen daily to be cleaned by the dietary staff. On 2/25/25 at 10:06 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the kitchen staff was responsible for cleaning the ice carts and they should be cleaned once per week. She further stated, "when they bring them to us, we clean them. Some units never brings them to us at all." 2.) On 2/20/25 at 10:30 AM, the surveyor conducted resident council with five (5) oriented residents (Resident #5, #14, #28, #44 and #64).	F 584	housekeeping. Black substance in resident 89s bathroom was removed as well as the washcloths. Film and cobwebs on and around resident 28's window were cleaned. Glass company was out to take measurements for the broken window in the 200 Atrium and we are expecting a service date of this week. On 2/22 and 2/23 the exterior of the facility was fully cleaned with cobwebs removed by a crew of a few of our employees. In Service was done by the Interim Housekeeping Director for HK staff on 2/25/25 regarding cleaning of kitchenettes pantries sinks garbages water coolers fridges garbage lids high dusting/cobwebs, window cleaning, bathroom cleaning, shower cleaning and shower chair cleaning. In Service done on 2/26/25 by Administrator with Interim HK Director regarding Exterior cleaning. 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 The following measures have been put into place to prevent the deficient practice from recurring: Cleaning schedule has been established where Nursing is responsible to bring the carts to the kitchen and Dietary cleans/sanitize and refills them each morning. Trash lids, water coolers, showers and atrium windows were specifically included on Housekeepers daily responsibilities. Maintenance was assigned the task of weekly cleaning of	

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F 584	Continued From page 3 Resident # 28 stated that the windows have not been washed and there were cobwebs in the windows. Resident #28 further stated that the housekeeping department was short staffed. Four (4) out of five (5) residents verbalized agreement that the windows were not clean, and there were cobwebs present on both the inside and the outside of the windows at the facility. On 2/21/25 at 10:46 AM, the surveyor observed the following on the [redacted]: -The large atrium windows with a large windowsill in the resident lounge had large cobwebs located in each corner. One large window had a large crack. The doors and windows that led to a courtyard had a film on the inside and black debris at the edge of the doors that met the flooring. -Resident #89's shower located the resident's bathroom had a black substance on the floor and a shower chair with washcloths hanging on the chair. On 2/21/25 at 10:49 AM, the surveyor observed the following on the [redacted]: -The window and doors located at the end of the hallway by Room [redacted] had large number of cobwebs on the outside of the window and the door. -The window located in Resident #28's room had a film on the window and a dark colored cobweb outside in the right corner of the window. -In the resident lounge, the large atrium window located above the doors had several large cobwebs in the corners. On 2/21/25 at 11:00 AM, the surveyor observed the following in the [redacted]: -Cobwebs in the corners of the large atrium	F 584	hard to reach areas that require a ladder. Exterior was put on a monthly cleaning program with Housekeeping responsible. The Housekeeping Director will conduct a weekly audit of Trash lids, water coolers, showers, upper and lower atrium windows and exterior. The Dietary Director will conduct a weekly audit on the cleanliness of the ice chests. Quality Assurance A quarterly review of the audits will be conducted and documented by the Food Service Director or designee and Director of Housekeeping 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 well as the Quality Assurance committee at their quarterly meeting for one year	

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F 584	Continued From page 4	F 584		

window
-A white substance with black dots on the ceiling in the middle of the vaulted ceiling.

On 2/21/25 at 11:03 AM, the surveyor interviewed Housekeeper (HSK) #1 on the [NJ Ex Order 26. 4B1] who stated she had been employed with the facility for about [NJ Ex Order 26. 4B1]. She stated her responsibilities included to clean both resident hallways, including the resident's rooms, the lounge, and offices. She further stated that every day the lounge was swept and mopped, the tables were wiped, and the inside windows were cleaned. HSK #1 stated dusting was done where needed, but she doesn't dust up high by the atrium windowsills.

On 2/21/25 at 11:10 AM, the surveyor interviewed HSK #2 on the [NJ Ex Order 26. 4B1] who stated she had been employed with the facility for [NJ Ex Order 26.4(b)(1)]. She stated she was responsible to clean both hallways including the resident rooms and the lounge. HSK #2 further stated that everyday she swept and mopped the lounge and wiped the tables and countertops before breakfast. She stated that she does not dust up high by the atrium windowsills.

On 2/21/25 at 11:26 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated he had been employed at the facility in the housekeeping department [NJ Ex Order 26. 4B1]. The [U.S. FOIA] stated that each unit was supposed to have two housekeepers each but at this time each unit only had one housekeeper. The [U.S. FOIA] further stated the housekeeping department had one [U.S. FOIA (b) (6)] and one [U.S. FOIA (b) (6)] on the 3-11 PM shift. The [U.S. FOIA] explained the [U.S. FOIA (b) (6)] would empty trash, mop the floors, and would clean a

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F 584	Continued From page 5	F 584		

resident's room on occasion if needed for an admission. The [U.S. FOIA] further stated that housekeeping was responsible for cleaning the units, the resident's rooms, the lounge, and inside and outside windows. The [U.S. FOIA] stated the outside windows have not been cleaned in over five years. He also stated that housekeeping was responsible for dusting the atrium windowsills in the unit lounges, but it has been over five years since they were cleaned because a ladder would be needed to clean the atrium windowsills. The [U.S. FOIA] stated that cobwebs should not be in the lounges where the residents eat and do activities. He explained that it was important that the facility be kept clean because the facility should be kept like it is their home.

On 2/21/25 at 12:25 PM, the surveyor was accompanied by the [U.S. FOIA (b) (6)] and toured the [NJ Ex Order 26. 4B1]. The [U.S. FOIA (b) (6)] stated that he completes environmental rounding of the building and looked for cleanliness and safety maintenance. At that time, residents were eating lunch in all three lounges. The [U.S. FOIA (b) (6)] confirmed the presence of the cobwebs in each unit lounge and the cobwebs outside the facility on the windows and doors. The [U.S. FOIA (b) (6)] stated, about the window located at the end of the [NJ Ex Order 26. 4B1] hallway, "it's a beautiful window you want to look out of it." The [U.S. FOIA (b) (6)] stated that he will have someone clean all the cobwebs in the windows that day and clean the outside of the building. The [U.S. FOIA (b) (6)] stated "it's hard to keep up with the outside of the building and we try to do what's needed."

On 2/21/25 at 12:25 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated he had been the [U.S. FOIA (b) (6)] for [NJ Ex Order 26. 4B1]. The [U.S. FOIA]

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F 584	Continued From page 6	F 584		

stated that the facility should be kept in good repair. He further stated that the housekeeping department was responsible for dusting the lounges,

A review of the facility's "Trashcan [sic.] Receptacle Management and Disinfection Procedures" policy, updated January 2025, included "Trash cans and surrounding areas must be disinfected at least once daily or more frequently if soiled or contaminated."

A review of the facility's "Ice Machines and Ice Storage Chests" policy, updated January 2025 included "To help prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow these precautions: clean and sanitize the chest and ice scoop daily; Regular cleaning of ice chests or coolers, especially before use and when contaminated or soiled."

A review of the facility's "Routine Cleaning and Disinfection" policy, undated, included that the facility is to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible ....Clean from top to bottom (bring dirt from high levels down to floor levels ....Horizontal surfaces with infrequent hand contact (window sill and hard surface flooring) in routine resident care area should be cleaned on a regular basis and when soiling and spills occur.... Area around the buildings shall be maintained in a safe and orderly manner.

NJAC 8:39-4.1 (a)11; 31.2(e)

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F 607	Continued From page 7	F 607		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to implement the facility's abuse policy to ensure reference checks were completed for 10 of 10 employee files	F 607	Corrective Action: All employees in the facility have had reference checks done, all previously undocumented reference checks have now been documented. In service Initiated	3/12/25

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F 607	Continued From page 8 reviewed. This deficient practice was evidenced by the following: On 2/25/25 at 11:00 AM, the surveyor reviewed the 10 randomly selected employee files, which revealed the following: 1. Registered Nurse (RN #1), with a hire date of [redacted], did not have a previous employee reference on file. 2. Licensed Practical Nurse (LPN #5), with a hire date of [redacted], did not have a previous employee reference on file. 3. Certified Nursing Assistant (CNA #5), with a hire date of [redacted], did not have a previous employee reference on file. 4. Housekeeper (HSK #8), with a hire date of [redacted], did not have a previous employee reference on file. 5. CNA #6, with a hire date of [redacted], did not have a previous employee reference on file. 6. LPN #6, with a hire date of [redacted], did not have a previous employee reference on file. 7. Dietary Aide (DA #4), with a hire date of [redacted], did not have a previous employee reference on file. 8. RN #2, with a hire date of [redacted], did not have a previous employee reference on file. 9. HSK #9, with a hire date of [redacted], did not	F 607	by the LNHA to the U.S. FOIA (b) (6) regarding the need for documenting a reference check on all facility hires, has been completed on 2/25/25. Identification of Residents at Risk: No residents have been identified as being affected by this deficient practice. All residents in the facility have the potential to be affected by this deficient practice. Systemic Change A new reference check form has been sent to all interviewers requiring it to be filled out prior to hiring any new candidates. Director of Human Resources will conduct a Monthly audit of all reference checks. Quality Assurance A quarterly review of the audit will be conducted and documented by the Director of Human Resources 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 well as the Quality Assurance committee at their quarterly meeting for one year	

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F 607	Continued From page 9 have a previous employee reference on file. 10. Cook #3, with a hire date of [redacted], did not have a previous employee reference on file. On 2/25/25 at 11:59 AM, the surveyor interviewed the [redacted] who stated she completed the reference checks, but a lot of times she was not successful with reaching the references. The [redacted] stated she normally attempted three times if not successful. She then stated that most of the hires were re-hires, or they knew a current employee whom she obtained the reference from. The [redacted] stated that the references would be documented on the reference form or on the back page of the application. She stated if the employee was a re-hire, then she did not complete the reference check unless it was more than a year. The [redacted] stated most of the references were current employee references, and so they were a verbal conversation. She stated she was the only one that did the reference checks. At that time, the [redacted] confirmed the verbal references were not documented. She stated it was important to document to ensure it was done and to know if there were any issues in their prior jobs. The [redacted] stated that was "one of her weaknesses" not documenting after she talked to someone. The surveyor continued to interview the [redacted] who stated that RN #1, CNA #5, HSK #8, and HSK#9 were all [redacted]; LPN #5 and DA #4 had verbal references from current employees; CNA #6 and LPN #6 were agency staff they liked and became employees; and for RN #2 she did not call the references. The [redacted] then stated she utilized the Health Care Facility Inquiry Regarding Health Care Professional form as part of the reference	F 607		

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F 607	Continued From page 10 check for RN #2. She stated she was unsure where it was, but confirmed it was not in the folder; and Cook #3 she stated the reference check sheet was "accidentally shredded." On 2/25/25 at 12:31 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the U.S. FOIA (b) kept him in the loop regarding new hires and that the reference checks were done as needed. He then stated that the U.S. FOIA (b) oversaw the reference checks. When asked did employees that were NJ Ex Order 26.4(b), or hired from NJ Ex Order 26.4(b) need a reference check, the U.S. FOIA (b) (6) stated he would have to ask the U.S. FOIA (b) regarding if reference checks were needed. On 2/25/25 at 12:38 PM, the U.S. FOIA (b) (6) stated that for an agency staff who became their staff, they obtained the reference checks from the current staff. He stated he was not sure if those reference checks were a verbal conversation or documented. The U.S. FOIA (b) (6) stated for employees that were NJ Ex Order 26.4(b), then it was based on their prior history at the facility in a short period of time. The U.S. FOIA (b) (6) stated that it was important to ensure reference checks were done for the safety of the residents. On 2/25/25 at 12:42 PM, the U.S. FOIA (b) provided her job description and an applicant employment verification form. At that time, the U.S. FOIA (b) confirmed she did not have any documented evidence that the 10 employees reference checks were completed. On 2/25/25 at 2:00 PM, the U.S. FOIA (b) confirmed she did not complete an applicant employment verification form and provided blank forms for the 10 of 10 employees reviewed.	F 607		

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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, NJ 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
F 607	Continued From page 11 A review of the [redacted] job description, included "*NJ Ex Order 26. 4B1 [redacted]*" A review of the facility's "Abuse, Neglect and Exploitation" policy undated, included, "1. Screening: a. potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property ...reference checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants."	F 607		
F 656 SS=E	NJAC 8:39-9.3(b) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		3/19/25

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F 656	Continued From page 12 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint #: NJ167424, NJ169906, NJ170986 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to develop an individual comprehensive care plan (ICCP) to include *NJ Ex Order 26. 4B1* [redacted]. This deficient practice was identified in 3 of 28 residents (Resident #85, #108, and #391)	F 656	Corrective Action: On [redacted], comprehensive care plans reviewed on residents #85 & #108, and updated as indicated. Resident #391 is a *NJ Ex Order 26. 4B1* [redacted] On 2/25/25 an in-service was conducted with unit managers on updating comprehensive care plans on admission, re-admission, change in status, addition or removal of specialty equipment, new	

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F 656	Continued From page 13 reviewed and was evidenced by the following: 1.) On 2/25/25 at 10:14 AM, the surveyor reviewed the medical record for Resident #85. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, NJ Ex Order 26. 4B1 [redacted]. A review of the Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26 [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's NJ Ex Order 26. 4B1 [redacted]. Further review of the MDS in Section NJ [redacted] -NJ Ex Order 26. 4B1 [redacted]. A review of the physician's orders (PO) revealed the following: -A PO, dated NJ Ex Order 26.4[redacted], for NJ Ex Order 26. 4B1 [redacted] -A PO, dated NJ Ex Order 26.4[redacted], for NJ Ex Order 26. 4B1 [redacted]. -A PO, dated NJ Ex Order 26.4[redacted], NJ Ex Order 26. 4B1 [redacted]	F 656	orders, etc; in addition to initial, quarterly, sig change, and annual care plan reviews. On 2/25/25 an in-service was conducted with U.S. FOIA (b) (6) [redacted] on reviewing and updating nutritional care plans on all nutrition evaluations. An audit was conducted on all current residents comprehensive care plans to assure updated accurately; any needed updates were corrected immediately. Identification of Residents at Risk: All residents have the potential to be affected by this deficient practice. Residents can be identified on resident roster. Systemic Change: Admission checklist tool revised to prompt unit manager to review/ update comprehensive care plan. U.S. FOIA (b) (6) [redacted] educated to review care plan when completing MDS assessments, correct or coordinate with unit manager with any updates/ changes needed. A Nursing Care Plan Audit Tool implemented to be utilized by unit managers during all care plan reviews. Quality Assurance: The MDS Coordinator, or designee, will conduct an audit monthly, reviewing residents comprehensive care plans to assure accuracy. Any discrepancies will be corrected/ addressed immediately. These audits will be turned into the DON monthly, for one year. The results of the audits will be conducted and documented quarterly by	

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F 656	Continued From page 14 -A PO, dated [NJ Ex Order 26.4(b)], for [NJ Ex Order 26. 4B1] [redacted] -A PO, dated [NJ Ex Order 26.4(b)] for [NJ Ex Order 26. 4B1] [redacted] A review of the individualized comprehensive care plan (ICCP) did not include a focus area for the peg tube. On 2/25/25 at 11:11 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] [redacted] who stated that a baseline care plan was done upon admission and that the ICCP was placed sometime after. The [U.S. FOIA (b)] [redacted] stated that care plans should be reviewed upon admission or re-admission. The [U.S. FOIA (b)] [redacted] stated she was unable to state the importance of keeping the care plan up to date. On 2/25/25 at 11:43 AM, during tour of the [NJ Ex Ord] [redacted] dining room, Resident #85 was observed awake and alert, sitting in a wheelchair. At that time, the surveyor interviewed Resident #85 who stated they did not have any concerns with the [NJ Ex Order 26. 4B1] [redacted]. On 2/25/25 at 12:25 PM, the surveyor interviewed the [U.S. FOIA (b) (6)], who stated that the care plan should be updated to reflect care for the [NJ Ex Order 26. 4B1] [redacted], however, the timing depended on if the MDS was due. The [U.S. FOIA (b) (6)] also stated that the [U.S. FOIA (b)] [redacted] was responsible for the ICCP. 2.) On 2/19/25 at 10:05 AM, during the initial tour, the surveyor observed Resident #108 lying in bed. At that time, [U.S. FOIA (b) (6)] [redacted] entered the room to administer the resident's medications and asked the resident if he/she had [NJ Ex Order] [redacted] The resident	F 656	the DON, or designee. Results of the quarterly audit will be reported to the LNHA and QAA committee for one year.	

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F 656	Continued From page 15 complained of NJ Ex Order 26. 4B1 . When U.S. FOIA (b) (6) left the room to get the resident NJ Ex Ord medication, the resident stated NJ Ex O pain was not being managed properly. The resident explained that he/she had NJ Ex Ord in his/her NJ Ex Order as well. On 2/21/25 at 9:35 AM, the surveyor reviewed the medical record for Resident #108. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, NJ Ex Order 26. 4B1 . A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b)(1) included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated the resident's NJ Ex Order 26. 4B1 . Further review of the MDS revealed the resident frequently had NJ Ex Order 26. 4B1 . A review of the Medical Visit evaluation, dated NJ Ex Order 26.4(, revealed the resident had recently NJ Ex Ord . Further review of the evaluation included a recommendation from the U.S. FOIA (b) (6) for a NJ Ex Ord management appointment. A review of the Order Summary Report, dated as of NJ Ex Order 26.4(, included the following physician's order (PO):	F 656		

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F 656	Continued From page 16 -A PO, dated [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26. 4B1] [redacted]. A review of the [NJ Ex Order 26.4(b)(1)] Medication Administration Record revealed the above order for [NJ Ex Order 26. 4B1] [redacted] out of 10 on the [NJ Ex Ord] scale. A review of the individual comprehensive care plan (ICCP) did not include a care plan related to the resident's [NJ Ex Order] On 2/25/25 at 10:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the Unit Managers (UM) were responsible for creating resident care plans "[NJ Ex Order 26. 4B1]" so that staff know the needs of the resident, the resident's history, and how to accommodate the resident. The LPN further stated that interventions for a resident with [NJ Ex Ord] included adjusting [NJ Ex Ord] medications, making sure [NJ Ex Ord] was not affecting activities of daily living, assessing [NJ Ex Ord] level, and notifying the physician of any issues with [NJ Ex Ord] management. The LPN added that pain should be included on the care plan for a resident with [NJ Ex Order] On 2/25/25 at 10:52 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated care plans were created collaboratively by the nursing, social services, activities, and dietary departments within 24 hours of the initial care conference which takes place within the first two weeks of the resident's admission. The LPN/UM added that if there was a change in the resident's condition, the care plan would be updated within 48 hours. The LPN/UM	F 656		

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F 656	Continued From page 17 further stated that interventions for a resident with pain included monitoring [NJ Ex Ord] levels, attempting non-pharmacological interventions, providing [NJ Ex Ord] medication as ordered, and notifying the physician of inadequate [NJ Ex Ord] management. The LPN/UM also stated that [NJ Ex Ord] should be included on the care plan for a resident with [NJ Ex Order] On 2/25/25 at 1:54 PM, the surveyor interviewed the *U.S. FOIA (b) (6)* , in the presence of the survey team, the *U.S. FOIA (b) (6)* [redacted] stated that the comprehensive care plans were created within 21 days of the resident's admission and updated quarterly and as needed. When asked about Resident #108, the [U.S. FOIA (b)] stated the resident should have had a care plan related to pain. 3.) On 2/20/25 at 10:01 AM, the surveyor reviewed the closed medical record for Resident #391. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, [NJ Ex Order 26. 4] [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Ex Order 26.4(b)], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's *NJ Ex Order 26. 4B1* . Further review of the MDS revealed the resident received *NJ Ex Order 26. 4B1* .	F 656		

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F 656	Continued From page 18	F 656		

A review of the [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] [NJ Ex Order] Treatment Administration Records revealed the resident was receiving [NJ Ex Order 26. 4B1] .

A review of the individual comprehensive care plan (ICCP) did not include a care plan related to the resident's [NJ Ex Order 26. 4B1].

On 2/25/25 at 10:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the Unit Managers (UM) were responsible for creating resident care plans "[NJ Ex Order 26. 4B1]" so that staff know the needs of the resident, the resident's history, and how to accommodate the resident. The LPN further stated that interventions for a resident with [NJ Ex Order 26.4] included ensuring the resident was [NJ Ex Order 26.4(b)(1)] as ordered, ensuring the [NJ Ex Order 26.4] equipment was functioning properly, and checking the resident's [NJ Ex Order 26. 4B1] every shift and as needed. The [U.S. FOIA] added that [NJ Ex Order 26.4] use should be included on the care plan for a resident who [NJ Ex Order 26.4(b)(1)].

On 2/25/25 at 10:52 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated care plans were created collaboratively by the nursing, social services, activities, and dietary departments within 24 hours of the initial care conference which takes place within the first two weeks of the resident's admission. The LPN/UM added that if there was a change in the resident's condition, the care plan would be updated within 48 hours. The LPN/UM further stated that interventions for a resident with [NJ Ex Order 26.4] included monitoring [NJ Ex Order 26. 4B1], ensuring [NJ Ex Order 26.4(b)(1)] were not empty, and

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F 656	Continued From page 19 following the physician's order for NJ Ex Order 26.4(b)(1). The LPN/UM also stated that NJ Ex Order 26.4(b)(1) should be included on the care plan for a resident who NJ Ex Order 26.4(b)(1). On 2/25/25 at 1:54 PM, the surveyor interviewed the U.S. FOIA (b) (6), in the presence of the survey team, the U.S. FOIA (b) (6) stated that the comprehensive care plans were created within 21 days of the resident's admission and updated quarterly and as needed. When asked about Resident #391, the U.S. FOIA (b) stated the resident should have had a care plan related to NJ Ex Order 26.4(b)(1). A review of the facility's "Comprehensive Care Plans" policy, updated 10/17/23, included the following: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.	F 656		
F 686 SS=D	NJAC 8:39-11.2 (e)(f) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		3/20/25

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F 686	Continued From page 20 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for NJ Ex Order 26. 4B1 [redacted] for a resident at risk for developing NJ Ex Order 26. 4B1. This deficient practice was identified for 1 of 1 resident (Resident #7) reviewed for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b and was evidenced by the following: On 2/20/25 at 12:37 PM, the surveyor observed Resident #7 resting in bed. The resident was awake and stated that he/she was not NJ Ex Order 26. 4B1 [redacted] at that time and would like to NJ Ex Order them. The resident's NJ Ex Or were noted to be resting on two green pillows. There were no NJ Ex Order 26. 4B1 observed in the resident's room. The surveyor reviewed the medical record for Resident #7. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to,	F 686	Corrective Action: On 2/20/25, U.S. FOIA (6) & CNA #8 applied NJ Ex Order 26. 4B1 on Resident #8 immediately after notification from surveyor. On 2/20/25, an in-service was conducted, by U.S. FOIA (6), with LPN #7 & CNA #8 on following a physician□s order for all preventative devices, including NJ Ex Order 26. 4B1. Identification of Residents at Risk: Any resident with a Physician□s Order for a preventative device, including heel boots, has the potential to be affected. These residents can be identified by a review of the Physician Order Sheets. Systemic Change: On 2/21/25, in-service conducted, by DON, with all nurses on accurately following a physician□s order for all preventive devices, including heel boots. Facility wide audit conducted, by U.S. FOIA (b) (6), on all physician□s	

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F 686	Continued From page 21 NJ Ex Order 26. 4B1 [redacted].	F 686	orders for preventative devices, including heel boots, and assuring the devices are present/ in place as ordered. An audit tool developed identifying each resident with physician□s orders for preventative devices. Quality Assurance: An audit will be conducted and documented monthly by unit managers, or designee, on all physician orders for preventative devices are in place as ordered. Any discrepancies will be corrected and addressed immediately. Audits will be turned into the DON monthly for one year. The results of the preventative device audits will be reviewed by the DON, or designee, monthly and the findings will be reported to the LNHA and QAA committee quarterly for one year. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's cognition was [redacted]. Further review of the MDS revealed the resident was at risk [redacted].

A review of the resident's individual comprehensive care plan (ICCP) included a focus area that the resident was at risk for [redacted]. Interventions included: [redacted].

A review of the Order Summary Report (OSR), dated [redacted], included a physician's order for [redacted] when in bed as tolerated every shift for prevention.

On 2/20/25 at 12:44 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #7) who stated Resident #7 wears [redacted] and the caretaker would [redacted] and [redacted]. She also stated that the resident did not refuse them and was always offered them. LPN #7 further stated that the [redacted] were used to prevent [redacted].

On 2/20/25 at 12:48 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) #8 who stated, the resident had "[redacted]" on, and "[redacted]" She further stated that Resident #7 did not decline treatment. She further stated the [redacted] would be notified if the resident

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AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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
F 686	Continued From page 22 declined any treatment. The surveyor, accompanied by the CNA #8, returned to the resident's room and CNA #8 stated "[redacted] " and pointed to [redacted] On 2/20/25 at 1:05 PM, the surveyor asked the [redacted] to show the surveyor a [redacted]. The [redacted] presented a [redacted] of [redacted] and stated, "[redacted]." At that time, the surveyor accompanied the [redacted] and the [redacted] into the resident's room. The [redacted] and [redacted] both applied the [redacted]. The resident accepted the heel boots and stated, "[redacted]." On 2/21/25 at 1:38 PM, the surveyor conducted a follow-up interview with the [redacted], who stated that if there was an order in place for [redacted], it should be followed. A review of the facility's "Physician Orders" policy, updated April 2024, included "All nurses will follow physician orders and recommendations."	F 686		
F 695 SS=D	NJAC 8:39-27.1(e) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		3/19/25

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F 695	Continued From page 23 This REQUIREMENT is not met as evidenced by: Complaint #: NJ167424 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow a physician's order for a resident who required NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 3 residents (Resident #31) reviewed for NJ Ex Order 26. 4B1 and was evidenced by the following: On 2/19/25 at 9:57 AM, during the initial tour of the facility, the surveyor observed Resident #31 resting in bed with their eyes closed and receiving NJ Ex Order 26. 4B1 On 2/20/25 at 9:02 AM, the surveyor observed Resident #31 resting in bed with their eyes closed. At that time, the surveyor observed the resident wearing a NJ Ex Ord which was connected to an empty NJ Ex Order 26. 4B1 on the back of the resident's wheelchair. At 9:06 AM, the surveyor interviewed Certified Nurse Aide (CNA) #4 who stated that she was assigned to care for Resident #31. She stated that the resident had not yet gotten out of bed that morning. At 9:10 AM, the surveyor returned to the resident's room accompanied by Licensed Practical Nurse (LPN) #3, who confirmed that the NJ Ex Ord that the resident was using was connected to an empty NJ Ex Order 26. 4B1 . LPN #3 connected the NJ Ex Order 26. 4B1	F 695	Corrective Action: On 2/19/25, LPN #3 connected Resident #31□s NJ Ex Order 26. 4B1 , immediately after notification from surveyor. Resident #31 was NJ Ex Order 26.4(b)(1), no signs or symptoms of NJ Ex Order 26. 4B1. LPN #3 removed the empty NJ Ex Order 26. from room. On 2/19/25, facility wide in-service conducted, by U.S. FOIA (b) (6) , with all staff on monitoring NJ Ex Order 26. levels throughout the shift, report to nursing if tank is running low or out. A facility wide audit was conducted, by nurse supervisor, on all residents with Physician□s Order for NJ Ex Order 26. 4B1 on accurate setting and delivery; no discrepancies identified. Identification of Residents at Risk: Any resident with a physician□s order for oxygen has the potential to be affected. These residents can be identified by reviewing the physician□s orders. Systemic Change: In-service conducted with nursing staff on 2/19/25, by U.S. FOIA (b), to monitor oxygen settings and delivery throughout the shift, assure to match physician□s order. Empty (or close to empty) E tanks need to be removed from a residents room, and placed in an appropriate location. Quality Assurance:	

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F 695	Continued From page 24 NJ Ex Order 26. 4B1 and replaced the NJ Ex Order 26. 4B1 . At 9:28 AM, the surveyor conducted a follow-up interview with LPN #3 who stated that the resident required checks to ensure that the resident was NJ Ex Order 26.4(b)(1) NJ Ex Order 26. 4B. He further stated that upon entering the room, normally he would check to ensure that everything was connected properly and the NJ Ex Order 26. 4B1 in it. LPN #3 stated that it was important for Resident #31 to get NJ Ex Order 26. 4B to maintain safe NJ Ex Order 26. 4B1. At 9:38 AM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #1 who stated, Resident #31's NJ Ex Order 26. 4B should be administered continuously as per the physician's order. She stated that everyone was responsible for ensuring that the resident was receiving NJ Ex Order 26. 4B. She then stated that the NJ Ex Order 26. 4B1 did not last too long, therefore, every person that went in the resident's room should be checking to ensure there was NJ Ex Order 26. 4B1. On 2/20/25 at 11:00 AM, the surveyor reviewed the medical record for Resident #31. A review of the Admission Record, an admission summary, revealed Resident #31 had diagnoses which included NJ Ex Order 26. 4B1 . A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26.4(b)(1), included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26. 4B1 out of 15, which indicated the resident's NJ Ex Order 26. 4B1	F 695	Evening Nursing Supervisor, or designee, will conduct an audit on all residents with physician□s order for oxygen, to assure correct delivery and setting. Any discrepancies will be corrected / addressed immediately. The results of these audits will be turned into the DON monthly for 1 year. Nightshift Nursing Supervisor, or designee, will conduct an audit monthly on monitoring E tanks in facility, assuring empty (or close to empty) are not accessible to residents. Any discrepancies will be addressed immediately. The results of these audits will be turned into the DON monthly for one year. The results of the oxygen audits will be reviewed by the DON, or designee, monthly and the findings will be reported to the LNHA and QAA committee quarterly for one year. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F 695	Continued From page 25 NJ Ex Order 26. 4B1 . Further review of the MDS revealed the resident experienced NJ Ex Order 26. 4B1 . A review of the Order Summary Report (OSR) revealed a physician's order (PO), dated NJ Ex Order 26. 4B at 11:00 PM, for NJ Ex Order 26. 4B1 . A review of the resident's individualized comprehensive care plan (ICCP) revealed a focus area of NJ Ex Order 26. 4B1 . On 2/21/25 at 1:30 PM, the surveyor interviewed the U.S. FOIA (b) (6) , who stated that Resident #31's NJ Ex Order 26. 4B should be administered continuously as per the physician's order. She stated that the staff should be aware that it was in place and the resident was receiving it. She further stated that the resident was NJ Ex Order 26. 4B1 and should have a NJ Ex Order 26. 4B1 readily available. A review of the facility's "Physician Orders" policy, updated April 2024, included "All nurses will follow physician orders and recommendations."	F 695		
F 697 SS=E	NJAC 8:39-27.1(a) Pain Management CFR(s): 483.25(k)	F 697		3/19/25

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F 697	Continued From page 26 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Complaint #: NJ169906 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to follow-up on a healthcare provider's recommendation for a [NJ Ex Ord] management appointment in a timely manner for 1 of 2 residents (Resident #108) reviewed for [NJ Ex Ord] management. This deficient practice was evidenced by the following: On 2/19/25 at 10:05 AM, during the initial tour, the surveyor observed Resident #108 lying in bed. At that time, the nurse entered the room to administer the resident's medications and asked the resident if he/she had [NJ Ex Order] The resident complained of [NJ Ex Ord] out of 10 [NJ Ex Ord] to his/her [NJ Ex Order 2] When the [U.S. FOIA (b) (6)] left the room to get the resident pain medication, the resident stated [NJ Ex O] [NJ Ex Ord] was not being managed properly. The resident explained that he/she had [NJ Ex Ord] in his/her back from *NJ Ex Order 26. 4B1* and that he/she had *NJ Ex Order 26. 4B1* as well. The resident further stated that he/she had been asking to see [NJ Ex Order 26.] , but that '*NJ Ex Order 26. 4B1* " about it. On 2/21/25 at 9:35 AM, the surveyor reviewed the medical record for Resident #108.	F 697	Corrective Action: On 2/25/25, Resident #108 comprehensive care plan reviewed and updated as indicated, by unit manager. On 2/25/25, Resident #108 was seen and evaluated by consulting [NJ Ex Order 26.4(b)(1)] specific to [NJ Ex Ord] management. On 2/26//25, Resident #108 verbalized satisfaction with *U.S. FOIA (b) (6)* , and no longer wants to pursue out-patient [NJ Ex Ord] management consult. [U.S. FO] notified, consult request cancelled. An audit was conducted on all residents, by *U.S. FOIA (b) (6)* , to assure any appointment/ consult request have been scheduled within a timely manner. No additional concerns noted. Identification of Residents at Risk: All residents have the potential to be affected by this deficient practice, these residents can be identified on the resident roster. Systemic Change: Unit managers & unit clerks were in-serviced, by DON on 2/25/25, on appointments needing to be addressed in a timely manor. The importance of documenting all attempts to schedule, re-schedule, and/ or any barriers to scheduling appointment. Any barriers with scheduling appointment needs to be	

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F 697	Continued From page 27 A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted]. Further review of the MDS revealed the resident frequently had [redacted]. A review of the individual comprehensive care plan (ICCP) did not include a care plan related to the resident's [redacted] A review of the Order Summary Report, dated as of [redacted], included the following physician's order (PO): -A PO, dated [redacted], for [redacted]. A review of the [redacted] Medication Administration Record revealed the above order for [redacted] for a [redacted] level ranging from [redacted] to [redacted] out of 10. A review of the Medical Visit evaluation, dated [redacted], revealed the resident had recently [redacted]. Further review of	F 697	documented with MD/NP notification. Quality Assurance: An Audit will be conducted and documented monthly by unit managers, or designee, on appointments being scheduled/ addressed in timely fashion. Any discrepancies or concerns will be addressed immediately. Audits will be turned in to DON monthly for one year. The results of the appointment audits will be reviewed by the DON, or designee, monthly and the findings will be reported to the LNHA and QAA committee quarterly for one year. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F 697	Continued From page 28 the evaluation included a recommendation from the U.S. FOIA (b) (6) for a NJ Ex Ord management appointment. A review of the Appointment/Outing Note, dated NJ Ex Order 26.4(b)(, included, "NJ Ex Order 26. 4B1 ." A review of the Medical Visit evaluation, dated NJ Ex Order 26.4(b)(, revealed the U.S. FO again recommended a NJ Ex Ord management appointment related to the resident's NJ Ex Order 26.4(b)(1). Further review of the Appointment/Outing Notes revealed the next note regarding the NJ Ex Ord management appointment was on NJ Ex Order 26. 4B1, which was written by Unit Clerk (UC) #1 and included the following: "NJ Ex Order 26. 4B1 ." A review of the census tab in the resident's electronic medical record (EMR) revealed the resident's room was switched from the NJ Ex Order 26. 4B1 . Further review of the Appointment/Outing Notes revealed the next note regarding the NJ Ex Ord management appointment was on NJ Ex Order 26. 4B1, which was written by UC #2 and included that she spoke with the U.S. FO who gave the okay to send the resident to a NJ Ex Ord management appointment. The note further indicated that she called a U.S. FOIA (the same one UC #1 called on NJ Ex Order 26. 4B1) and that they did not take the resident's insurance. The note also included that UC #2 asked the U.S. FOIA (b) (6) to call the resident's insurance company to see where the resident could go for NJ Ex Ord management.	F 697		

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There were no further Appointment/Outgoing Notes related to the resident's NJ Ex Ord management appointment after NJ Ex Order 26. 4B1 .

On 2/25/25 at 10:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that when a recommendation was made for a resident to be scheduled for an appointment, the UC was notified to set up the appointment and transportation. The LPN further stated that it was the U.S. FOIA (b) (6) responsibility to ensure that resident appointments were being scheduled as recommended. The LPN added that it was important to ensure resident appointments were scheduled 'NJ Ex Order 26. 4B1 " and that the resident, 'NJ Ex Order 26. 4B1 ."

On 2/25/25 at 10:52 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated when an appointment was recommended, the U.S. FOIA (b) (would notify the UC to set up the appointment and transportation. The LPN/UM further stated that it was the U.S. FOIA (b) responsibility to ensure appointments were being made as recommended. The LPN/UM added that it was important for resident appointments to be scheduled because, 'NJ Ex Order 26. 4B1 ." When asked about Resident #108, the LPN/UM stated the UC was handling his/her NJ Ex Ord management appointment and was trying to find one that takes his/her NJ Ex Order 26. 4B1 . The LPN/UM was unsure when the process for finding a NJ Ex Order 26.4(b)(1) had started.

On 2/25/25 at 11:02 AM, the surveyor interviewed the UC for the NJ Ex Order 26. 4B1 (UC #2) who stated she

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F 697	Continued From page 30	F 697		

was made aware of appointment recommendations through the Appointment/Outings Notes in the residents' EMR. The UC stated that appointments should be scheduled "[NJ Ex Order 26. 4B1]" to ensure "[NJ Ex Order 26. 4B1] [redacted]." When asked about Resident #108, the UC stated she had to find a [U.S. FOIA] [redacted] that took the resident's [NJ Ex Order 26. 4B1]. The UC added that she received a prescription from the [U.S. FOI] on [NJ Ex Order 26.4(b)], for the resident to consult [NJ Ex Ord] management related to [NJ Ex Order 26.4(b)(1)] and that she was given a list of [U.S. FOIA] [redacted] that took the resident's [NJ Ex Order 26. 4B1]. The UC was unable to recall when she received the list or who gave the list to her. The UC removed the list from the bottom of her drawer designated for scheduling appointments, and the [NJ Ex Order 26.4(b)] prescription for [NJ Ex Ord] [redacted] was paperclipped to the list. The surveyor reviewed the list with the UC and observed there were 16 [NJ Ex Order 26. 4B1] [redacted] highlighted. The UC explained that the highlighted offices took the resident's [NJ Ex Order 26.4(b)(1)] When asked which offices the UC had already attempted to call, the UC stated she had not yet tried to schedule the resident for any of the highlighted offices.

On 2/25/25 at 11:18 AM, the surveyor interviewed the UC for the [NJ Ex Order 26. 4B1] (UC #1) who stated appointment recommendations were communicated to her verbally or through the Appointment/Outings Notes in the EMR. The UC stated that appointments should be scheduled within 24-72 hours of receiving the recommendation and that she documented when she called the doctors' offices in the Appointment/Outing Notes. The UC stated it was important to schedule recommended

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F 697	Continued From page 31 appointments to '*NJ Ex Order 26. 4B1*," and that '*NJ Ex Order 26. 4B1*" When asked about Resident #108, the UC could not recall any specifics related to his/her NJ Ex Orde management appointment. On 2/25/25 at 11:21 AM, the surveyor interviewed the U.S. FO who stated she was managing Resident #108's NJ Ex Orde at the facility. She further stated that the facility was having difficulty finding a U.S. FOIA office that would take the resident's NJ Ex Order 26. 4B1 and that the issue had been "NJ Ex Order 26. 4B1." At that time, the surveyor informed the U.S. FO that UC #2 had a list of *NJ Ex Order 26. 4B1* that accepted the resident's NJ Ex Order 26. 4B1, and the U.S. FO verified that Resident #108 should still be scheduled to see a *NJ Ex Order 26. 4B1*. On 2/25/25 at 12:06 PM, the surveyor interviewed the *U.S. FOIA (b) (6)*. The surveyor asked the U.S. FO about the Appointment/Outings Note, dated NJ Ex Order 26.4B1, which indicated UC #2 had asked the U.S. FO to call the resident's NJ Ex Order 26. 4B1 to find a *U.S. FOIA (b) (6)* that will accept the resident's NJ Ex Order 26. 4B1. The U.S. FO stated that the note was not accurate and that he never called the resident's NJ Ex Order 26. 4B1. On 2/25/25 at 1:54 PM, the surveyor interviewed the *U.S. FOIA (b) (6)*, in the presence of the survey team, the *U.S. FOIA (b) (6)*. The surveyor informed the *U.S. FOIA (b) (6)* recommended Resident #108 see a U.S. FOIA on NJ Ex Order 26. 4B1, and that the first documented attempt to schedule the appointment was on *NJ Ex Order 26. 4B1*. The surveyor also informed the U.S. FOIA (b) that UC #2 had since received a list of U.S. FOIA	F 697		

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F 697	Continued From page 32 U.S. FOIA (b) (6) to call, but had not yet made any attempts to contact their offices. The U.S. FOIA (b) confirmed that whoever obtained the recommendation from the U.S. FOI should have notified the U.S. FOI to schedule the appointment in a reasonable amount of time, "within three to four days." A review of the facility's Medical Follow-Up Appointments" policy, updated 1/2025, included, "Medical follow-up appointments will be scheduled as per the recommendations made by the attending physician or other healthcare provider during initial assessments, hospital discharges, or routine evaluations." Further review of the policy revealed, "A consulting physician/practitioner may include, but not limited to a resident's ... specialists."	F 697		
F 804 SS=D	NJAC 8:39-27.1(a) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to ensure a palatable temperature of	F 804	Corrective Action: Food temperatures were addressed and corrected at the time of discovery and	2/27/25

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

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F 804	Continued From page 33 food for 1 of 1 lunch meals observed on 1 of 3 nursing units ([redacted]). This deficient practice was evidenced by the following: On 2/20/25 at 10:35 AM, the surveyor conducted a Resident Council Meeting with five residents (Resident #5, #14, #28, #44, and #64). Four out of five residents stated that if meals were served in the resident's room the meals were cold, that only the dining room received warms meals, and that the eggs were always cold. Resident #28 stated that the meals were delivered on open racks that did not keep the food warm and that the last unit served, [redacted], was served cold food. On 2/21/25 at 11:34 AM, the surveyors observed Cook #1 testing the temperatures of the food on the steam table. The temperatures were as follows: Pureed baked fish (tilapia) 173 F (degrees Fahrenheit) Pureed rice 144.9 F Mashed potatoes 143.4 F Green beans 199 F Pureed green beans 192 F Yellow rice 202 F Baked fish (tilapia) 168 F. Upon interview, Cook #1 stated that the desired temperature of the food on the steam table was 150 F, however Cook #1 stated that the preferred temperature was 180 F. The [redacted] who was present, stated that food items should be held above 135 F on the steam table.	F 804	going forward . An In service was performed by the Regional Dietary Director with the dietary cooks on 2/21/25 regarding the need for ensuring that the temperatures are being taken, documented, and in the correct range.. Identification of At-Risk Resident No Residents have been identified as affected by the deficient practice. All residents in the facility that receive food from the kitchen have the potential to be affected by these deficient practices. Systemic Change: Ongoing education will be provided by the Regional Dietary team regarding proper food temperatures. Moving forward, all puree food will be served on heated plates. The Dietary Director will conduct a weekly audit to ensure hot foods are served at 135 degrees Fahrenheit or greater. Quality Assurance: A quarterly review of the audits will be conducted and documented by the Food Service 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 well as the Quality Assurance committee at their quarterly meeting for one year	

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F 804	Continued From page 34 On 2/21/25 at 11:57 AM, the surveyors requested to have a regular meal tray and a pureed tray prepared and placed on the food truck for [NJ Ex Order 26. 4B] [redacted] as a test tray. The surveyor requested that the [U.S. FOIA (b) (6] [redacted] record temperatures of the food in the presence of the surveyors on the nursing unit using a calibrated (procedure used to confirm accuracy) thermometer. On 2/21/25 at 12:15 PM, the surveyors observed the lunch meal service for the [NJ Ex Order 26. 4B1] [redacted] A tray line prep in the kitchen, in the presence of Cook #1, Dietary Aides (DA) #2, DA #4, DA #5, and DA #6. Dinner plates were observed being picked up by hand by Cook #1 who portioned food from the steam table onto the plates. The plates were covered with a plastic insulated dome and were placed on the trays. The completed trays were placed on an uncovered food truck at the end of the line. At 12:24 PM, the surveyor and the [U.S. FOIA (b) (6] [redacted] accompanied DA #6 and the [NJ Ex Ord] [redacted] A food cart to the unit. At 12:26 PM, DA#6 arrived on [NJ Ex Order 26. 4B1] [redacted] and the nursing staff proceeded to deliver meal trays to the residents in the dining room. At 12:30 PM, the [U.S. FOIA (b) (6] [redacted] confirmed the last tray was delivered on [NJ Ex Order 26. 4B1] [redacted] and the surveyors observed the [U.S. FOIA (b) (6] [redacted] obtain the temperatures using a calibrated thermometer of the lunch meal trays. The temperatures were as follows: Pureed baked fish 125 F Pureed green beans 127.2 F Pureed rice 129 F Pureed pears 61 F	F 804		

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F 804	Continued From page 35 Milk 40 F Regular baked fish 150 F Regular rice 141 F Regular green beans 147 F Regular pears 62 F At that time, the [redacted] stated that the puree foods were not meeting the desired temperatures of 135 F for hot foods, and that the cold items should be 41 F or below. The [redacted] also stated that if the temperature fell out of range it may cause bacterial growth in the food and that food items were in the temperature danger zones. Review of the undated facility's, "Record of Food Temperatures" policy included: "...Policy Explanation and Compliance Guidelines: 1. Food temperatures will be checked on all items prepared in the dietary department. 2. Hot foods will be held at 135 degrees Fahrenheit greater....4. Potentially hazardous cold food temperatures will be kept at 41 degrees Fahrenheit...8. If food temperature falls into an unsafe range, immediately follow procedures for previously cooked food...11. No food will be served that does not meet the food code standard temperatures.	F 804		
F 812 SS=F	NJAC 8:39-17.4(a)(2) 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,	F 812		2/27/25

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F 812	Continued From page 36 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: Based on observations, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 2/19/25 from 9:26 AM to 10:55 AM, the surveyor observed the following in the presence of Cook #1: 1. The U.S. FOIA (b) (6) was observed exiting the walk-in refrigerator with a tray of food items and proceeded to give the tray to Dietary Aide (DA) #3. When interviewed, DA #3 stated that he was instructed to throw eight containers of the pudding in the trash. Cook #1 who was present, then proceeded to reach into the trash can and retrieved a single container which she identified as butterscotch pudding, and she stated that it was not labeled or dated. The surveyor interviewed DA #1, who was also present, stated	F 812	Corrective Action: All undated or expired items were immediately discarded. All identified open items were discarded. All dietary staff have been in serviced on 02/21/25. All dietary staff have been in serviced on 2/19/25 on proper hand washing. All exposed food were removed All dietary staff have been in serviced 2/26/25. All dietary staff have been in serviced 2/25/25 regarding maintaining and documenting Fridge/Freezer temperature logs and Meal Temp logs. Cooling process education, compliance and logs □ All staff has been in serviced 2/19/25. Dirty/greasy items, can opener, cooking equipment, tilt skillet, deep fryer and drying racks have been cleaned, Cleaning schedule has been updated to include all items referenced. Personal items have been removed from the dietary area, Chemicals have been removed from prep area/steamer, Plunger	

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F 812	Continued From page 37 that it was important to label and date food items to ensure that they were not out of date. 2. The surveyor observed Cook #1 wash her hands for nine seconds out of the stream of running water prior to resuming the tour of the kitchen. 3. In the walk-in freezer, on the second shelf from the top of a four-tiered wired rack, there were ten pounds of frozen meatballs that were opened and exposed to air. Cook #1 stated that it should have been fully covered. 4. When the surveyor asked where the temperature logs were for the walk-in refrigerator and walk-in freezer Cook #1 stated that they were in the office. The surveyor reviewed the temperature logs and noted that there were no temperatures recorded on 2/19/25. Cook #1 stated that they should have been done, but she worked short staffed today. 5. In the walk-in refrigerator, on the third shelf from the top of a four-tiered wired rack, there were three six-inch pans which each had two ten-pound logs of meatloaf wrapped in parchment paper in them that were surrounded by a thick coating of a white and brown substance. Cook #1 stated that she started to cook them yesterday but she left the facility around 3:00 PM, before they were finished cooking. Cook #1 stated that there were no temperature logs to demonstrate the cooling process that was used. Cook #1 then proceeded to remove a tray of meatloaf from the walk-in refrigerator and used a calibrated thermometer to obtain the temperature of the meatloaf which was 48.6 F (Fahrenheit).	F 812	has been removed to its proper closet, All Dietary staff have been in serviced 2/25/25 on the proper storage location. Missing Thermometers have been replaced, staff in serviced 2/25/25 on the importance and placement of the thermometers. Cutting boards have been removed and replaced, Dented can removed, Signs hung in area, All dietary staff has been in serviced 2/25/25 on cross contamination regarding keeping clean with clean and dirty with dirty, as well as confirming that items that have been cleaned are fully clean before using them. Dish machine was repaired on the day of the concern, no further issues. A new high temp machine which had already been on order, was received and installed since that time. All Dietary staff have been in serviced 2/19/25 regarding proper dish machine temps, proper logging, as well as who to alert for improper temperatures. Dirty Ceiling tiles have been replaced. All Dietary staff have been in serviced 2/22/25 regarding proper hair coverings which cover the entire head. Personal items have been removed from all 3 unit refrigerators, items that were missing labels or dates have been discarded, refrigerators have been cleaned and staff have been in-serviced 2/25/25 Drying Racks have been replaced with new one. Identification of At-Risk Resident No Residents have been identified as affected by this deficient practice. All residents in the facility have the potential to be affected by these deficient practices.	

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F 812	Continued From page 38 Cook #1 stated that items in the refrigerator should be held at a temperature of 41 F or less. Cook #1 stated that the meatloaf should have been taken out of their juices, drained and placed in separate pans for the cool down process. Cook #1 further stated that meatloaf was on the menu for lunch today and it was safe to serve. At 10:25 AM, the U.S. FOIA (b) (6) described the cooling process for meatloaf. The U.S. FOIA (b) (6) stated that the meatloaf should have been cooled within two hours to get the temperature from 135 F to 70 F, and then from 70 F to 41 F within four hours, but not greater than six hours to cool. The U.S. FOIA (b) (6) stated that the meatloaf should be 41 F and it was unacceptable for the meatloaf to be 48 F at this time. The U.S. FOIA (b) (6) stated and there was a potential for bacterial growth if the meatloaf was not properly cooled as it was a potentially hazardous food. The U.S. FOIA (b) (6) stated that the meatloaf would have to be discarded and replaced with another meal. 6. In the galley of the kitchen, the surveyor observed DA #1 use a table mounted can opener to open a seven pound can of vanilla pudding. Cook #1 pulled the can opener out of the sheathe when requested by the surveyor, which revealed that the tip of the can opener had a thick, dried, black substance on it. Cook #1 stated that the can opener should be cleaned after every use. 7. In the galley of the kitchen, there was a pink coat, a travel mug, and a 24 ounce coffee cup in the food preparation area. Cook #1 stated that the coat and drinks should not be in the galley of the kitchen.	F 812	Systemic Change Cleaning schedule has been updated to include all items referenced. The Dietary Director will conduct a weekly audit of the following items: All food labeled and dated with no expired food, All staff washing hands according to facility policy, No food exposed in the freezer or refrigerator, All refrigeration logs completed, Cooling logs completed for all items cooling, Can opener Tilt skillet, kitchen floor, deep fryer clean, No personals in the kitchen, Thermometers in all freezers and refrigerator, Cleaning supplies stored in janitors closet, Plunger stored in janitors closet, All chemicals not in original containers are labeled, Dish machine temps are accurate and filled in check for accuracy Monitor sanitizer PPM log and test buckets, All cutting boards no groves and in good condition, No dented cans in storage room, Four tier carts drying rack clean No cross contamination between clean and dirty, Dish machine functioning at the correct temperature for wash and rinse. Dish machine log completed. All ceiling tiles clean., staff wear hairnets and beard guards correctly fully covering all hair, Food temperature logs completed. Nourishment rooms- All food labeled and dated with no expired items. Refrigerators and freezers cleaned, have a thermometer, and temperature log completed. Quality Assurance A quarterly review of the audits will be conducted and documented by the Food	

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F 812	Continued From page 39 8. There was a thick layer of dried food particles on the side of the tilt skillet next to the deep fryer and both a thick, black shiny substance and food particles were noted on the floor beneath and around the deep fryer. Cook #1 stated that there were was only an AM Cook and a PM Cook here to clean. Cook #1 stated that the floor was cleaned every night, but grease dripped onto the floor from the deep fryer. 9. In the galley of the kitchen, in the reach-in refrigerator, there was a package of hot dogs in a hotel pan that was opened to the air and was not labeled or dated. There was a hotel pan with grape jelly in it that was not labeled or dated. There was no thermometer inside of the refrigerator. Cook #1 stated that everything should be labeled and dated. Cook #1 further stated that there should have been a thermometer inside of the refrigerator. 10. In the galley of the kitchen, there was a double steamer which had cleaning solutions, and cleaning supplies stored in both the upper and lower units. Cook #1 stated that the steamer did not work, but they should not store stuff in there. 11. In the galley of the kitchen, there was a plunger under the prep area beside a drain on the floor. Cook #1 stated that the plunger was kept there because the drain gets clogged sometimes. 12. In the galley of the kitchen, on the third shelf from the top of a rolling rack, there was a cutting board with cuts in it, and a personal drinking cup was on top of it. Cook #1 stated that they should not use the cutting board.	F 812	Service 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 well as the Quality Assurance committee at their quarterly meeting for one year	

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F 812	Continued From page 40 13. In the galley of the kitchen, Cook #1 placed a plastic cutting board on the prep area with multiple cuts in it beside the meatloaf pan. Cook #1 stated that "this is what we have until we get new ones." Cook #1 then placed parchment paper over the cutting board surface. 14. In the dry storage area, on the canned goods rack, there was a six pound container of creamed corn that was dented at both the top and the bottom of the can. Cook #1 stated that it should not have been in the rack. 15. On the second shelf from the top of a four-tiered wired rack, there was an opened bag of acine de pepe pasta that was opened to the air. Cook #1 removed it from the storage area. 16. On the lower shelf, second shelf, and third shelf of a four-tiered drying rack, a reddish-brown substance was noted on the racks where cookware had been placed in direct contact of the substance to dry. 17. A three-tiered rolling cart was noted in front of the drying rack and there were serving trays noted on top of the cart which was soiled with dried food particles. DA #1 was interviewed, and she stated that the serving trays were cleaned in the dish washer and were then placed on the rolling cart which was dirty. DA #1 stated that the trays could become contaminated. 18. On the third shelf from the top of a four-tiered drying rack, there was a white hot beverage carafe that had a dried brown substance around the outer edge. DA #1 then proceeded to wipe the brown stain off with her finger and she stated that	F 812		

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F 812	Continued From page 41 the staining came off. DA #1 then proceeded to place the hot beverage carafe in the dish machine. 19. In the dish machine area, the surveyor reviewed the dish machine log which instructed that the minimum wash and rinse temperature was 140 F and should the temperature drop below, inform the manager. The log also indicated that the test strip for chemical sanitizer should register 50-100 parts per million (PPM). The wash temperature was recorded as 143 F, and the rinse temperature was recorded as 130 F, and the chemical sanitizer level was recorded as 100 PPM. The surveyor interviewed DA #2 in the presence of the [redacted]. DA #2 agreed to demonstrate the dish machine usage. A laminated data strip affixed to the dish machine indicated: low temp wash 140 F, rinse 140 F. DA #2 stated that both the wash and rinse cycle values should be 140 F. DA #2 ran a tray of dishes through the dish machine and the gauges for both the wash and rinse cycles did not move and were fixed in place at 146 F for the wash cycle and 130 F for the rinse cycle. DA #2 stated that the gauges moved sometimes during use. DA #2 ran a second tray through the dish machine and the [redacted] stated that she did not see the dish machine gauges move and stated that she planned to shut down the dish machine. The [redacted] stated that the dishes were not properly sanitized if the the gauges were not functional. 20. In the paper storage area, two ceiling tiles were observed to have black circular stains surrounded by outer brown stains. An insect was observed flying around the black stain.	F 812		

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F 812	Continued From page 42 On 2/19/25 at 11:15 AM, the surveyor interviewed Cook #2 in the presence of the survey team. Cook #2 stated that he worked yesterday from 10 AM to 6:30 PM. Cook #2 stated that Cook #1 prepared the meatloaf between 2:00 PM and 2:30 PM, and he removed it from the oven around 3:30 PM. Cook #2 stated that he opened the oven door and allowed the meatloaf to cool for five to ten minutes. Then he put it on the speed rack (an open rolling rack) on the side of the oven and let it cool for 20 to 30 minutes before he placed it on the middle rack of a covered rolling rack and then placed it in the middle of the walk-in refrigerator. Cook #2 further stated that he did not normally document the cooling of the meat during the cooling process. Cook #2 further stated that the only temperatures that he obtained were for the tray line during meal service. Cook #2 stated that if meat were not properly cooled before it were placed in the refrigerator, bacteria could result. Cook #2 stated that the temperature of the meatloaf after being in the refrigerator over night should have been 41 F. Cook #2 stated that the importance of keeping a food temperature log for cooling meat was to ensure that residents did not get sick. On 2/19/25 at 11:44 AM, in a later interview with the [redacted], she stated that Cook #1 should have washed her hands vigorously for twenty seconds out of the stream of running water or cross contamination could result. On 2/21/25 from 11:26 AM to 12:24 PM, the surveyor observed the following in the presence of the [redacted]:	F 812		

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F 812	Continued From page 43 1. During the tray line lunch meal service, Dietary Aide (DA) #5 wore a hair net that did not fully cover her hair and left a large part of the back of her head exposed. 2. During the tray line lunch meal service, DA #2 and DA #5 were observed returning from the dining room with trays and lids and placed them back on the tray line. When interviewed, DA #2 confirmed that both the trays and lids were previously used to serve residents in the dining room and were then brought back to the kitchen to be reused. DA #5 stated that lids should not be reused once taken out to the dining room because of the potential for germs. 3. The surveyor requested to see the temperature log book and noted that during the month of February 2025, meal temperatures were not obtained from the meal service tray line as follows: -On 2/3/25, A Daily Food Temperature Log was not found. -On 2/6/25, the dinner meal section of the form was not completed. -On 2/9/25, the dinner meal section of the form was not completed. -On 2/10/25, the dinner meal section of the form was not completed. -On 2/12/25, both the breakfast and lunch meal sections of the form were not completed. -On 2/13/25, a Daily Food Temperature Log was not found. -On 2/14/25, both the breakfast and lunch meal sections of the form were not completed. -On 2/18/25, both the breakfast and lunch meal sections of the form were not completed. -On 2/18/25, both the breakfast and lunch meal sections of the form were not completed.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 44 -On 2/19/25, both the breakfast and lunch meal sections of the form were not completed. The [U.S. FOIA (b) (6)] stated that temperatures were supposed to be checked at every meal. On 2/21/25 at 1:08 PM, the surveyor observed the [NJ Ex Order 26. 4B1] in the presence of Registered Nurse/Unit Manager (RN/UM) #1. 1. There was a lunch bag in the refrigerator that RN/UM #1 stated belonged to a staff nurse. 2. There was a prepackaged frozen lasagna in the freezer that was not labeled and dated. When interviewed, RN/UM #1 referred to signage on the refrigerator door which indicated, "Please label and date all food items and beverages with the following: name, room number, date and discard after three days. Any items not having the above information is to be discarded on the 11-7 shift." On 2/21/25 at 1:24 PM, the surveyor observed the [NJ Ex Order 26. 4B1] in the presence of Licensed Practical Nurse/Unit Manager (LPN/UM) #1. 1. A lunch bag was noted within the refrigerator. LPN/UM #1 stated that it should not have been in the refrigerator if did not belong to a resident. 2. There was a dried brown liquid on top shelf of the interior door of the refrigerator. 3. There was pink matter on the bottom of the freezer. LPN/UM #1 stated that Housekeeping was responsible to clean it. On 2/21/25 at 1:37 PM, the surveyor observed the [NJ Ex Order 26. 4B1] Refrigerator in the presence of	F 812		

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F 812	Continued From page 45 Licensed Practical Nurse (LPN) #4. 1. A lunch bag as noted within the refrigerator. LPN #4 reviewed the contents which included containers of food that were not labeled and dated. LPN #4 stated that the food was brought in today. LPN #4 further stated that you would not know if the contents were safe to eat if it were not labeled and dated. On 2/25/25 at 9:43 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that there should be no personal items in the unit nourishment room refrigerators because it was a resident refrigerator and the staff had been told about that before. The U.S. FOIA stated that the kitchen staff did not adhere to a cleaning schedule. The U.S. FOIA stated, "Cleaning was done by word of mouth" when delegated and when we have enough staff. The U.S. FOIA further stated that staffing has been a real challenge. A review of the facility's undated "Nutrition and Dining Services" policy, included: Cooling food...Never cool large amounts of hot food in a cooler. Transfer cooked product to a container (s) with a depth no greater than two inches. Label and date the container(s). Leave container uncovered or loosely covered during the cooling process. Take temperature of product. Document temperature on cooling log. The food must be cooled from 135 * to 70* within 2 (two) hours and cooled from 70*F to 41*F within 4 (four) more hours...Record action taken to achieve proper temperature on cooling log. When temperature reaches 41*F, cover tightly and store in refrigerator or freezer...Danger Zone 41*F and	F 812		

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F 812	Continued From page 46 135*F. A review of the facility's undated "Record of Food Temperatures" policy, included: It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature (s) before trays are assembled. Potentially Hazardous Food (PHF)...means food that requires time/temperature control for safety to limit the growth of pathogens such as bacterial or viral organisms capable of causing disease. Food temperatures will be checked on all items prepared in the dietary department. ...Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit. A review of the facility's "Sanitization" policy, reviewed and updated January 2025, included: The food service area shall be maintained in a clean and sanitary manner. All kitchens, kitchen areas and dining areas shall be kept clean... ...Once cutting boards has scars from knife usage they must be replaced. Dishwashing machines must be operated using the following specifications: Low-temperature Dishwasher (Chemical Sanitization) Wash temperature (120*F) Final rinse with 50 parts per million (PPM) hypochlorite (chlorine) for at least 10 seconds... ...The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas.... A review of the facility's "Hair Restraint (Net) Policy" updated January 2025, included: .....Hair restraints must cover all head hair	F 812		

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F 812	Continued From page 47	F 812		

completely. This includes securing bangs and other loose strands that might escape from primary restraints.
...Hair restraints (Net) help maintain standards of hygiene and safety in food handling, crucial for patient health and compliance with health regulations.

A review of the facility's "Dented Can Policy for Dietary Services" policy, updated April 2024, included: ...Dented cans that are deemed unsafe must be disposed of in accordance with the facility's waste management policies...

A review of the facility's "Unit Refrigerators" policy, updated April 2024, included:
...Housekeeping staff should clean the refrigerator daily and as needed. Nursing staff should discard any foods that are out of compliance and clean up spills as needed, or refer to housekeeping staff...No staff food personal food to be in refrigerator...

A review of the facility's "Hand Hygiene" policy accessed 2023, included:
All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility...Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers...

A review of the facility's "Dating and Labeling Policy" updated January 2025, included: It is the policy of this facility for the kitchen to assure food safety by maintaining proper dates and labels to all ready to eat food products...

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F 812	Continued From page 48 NJAC 8:39-17.2(g), 19.4	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		3/18/25

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F 880	Continued From page 49 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to minimize the spread of infection to residents during incontinence care rounds. This deficient practice was identified on 1 of 3 nursing units ([redacted]) and was evidenced by	F 880	Corrective Action: On 2/25/25 the Infection Preventionist conducted a 1:1 training with CNA #7 on proper hand hygiene techniques. CNA # 7 was able to verbalize and perform and accurate return demonstration of proper handwashing and proper use of hand sanitizer.	

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F 880	Continued From page 50 the following: On 2/21/25 at 9:09 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #7 who stated that she was assigned to eight residents and had four residents who still awaited *NJ Ex Order 26. 4B1*. On 2/21/25 at 9:11 AM, the surveyor accompanied CNA #7 into Resident #17's room with the resident's permission. Resident #17 stated that he/she was *NJ Ex Order 26. 4B1* [redacted]. CNA #7 donned (put on) gloves. CNA #7 then proceeded to [redacted] the resident's [redacted] and adjusted the resident's linens to demonstrate the resident's *NJ Ex Order 26. 4B1*. The resident's *NJ Ex Order 26. 4B1* [redacted]. When finished, CNA #7 then proceeded to doff (remove) her gloves and washed her hands out of the stream of running water for 10 seconds before rinsing her hands and drying them on a paper towel. On 2/21/25 at 9:19 AM, the surveyor accompanied CNA #7 to Resident #35's room. There was a sign posted on the outside of the door which indicated that the resident was on *NJ Ex Order 26. 4B1* [redacted] and CNA #7 stated that a gown and gloves were required to be worn when direct care was provided to the resident. CNA #7 then proceeded to donn a gown and gloves before she entered the room. CNA #7 stated that Resident #35 had *NJ Ex Order 26. 4B1* [redacted] and he/she did not respond verbally when CNA #7 requested to check his/her [redacted]. CNA #7	F 880	Identification of Residents at Risk: All residents have the potential to be affected by the spread of infection; residents can be identified on the resident roster. No residents have been identified as being affected by this deficient practice. Systemic Change: On 2/25/25 the Infection Preventionist conducted facility wide education/ training on proper handwashing techniques. Quality Assurance: An audit will be conducted and documented monthly by Infection Preventionist, or designee, to evaluate that proper handwashing practices are being implemented throughout the facility. Individual staff members will be addressed as needed based upon results of audit. Audits will be submitted to DON monthly for one year. The results of the handwashing audits will be reviewed by the DON, or designee, monthly and the findings will be reported to the LNHA and QAA committee quarterly for one year. The QAA committee will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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F 880	Continued From page 51	F 880		

NJ Ex Order 26.4(b)(1) the resident's *NJ Ex Order 26. 4B1* and then proceeded to fasten the residents [redacted]. When finished, CNA #7 doffed both her gown and gloves and used ABHR (alcohol based hand rub) to clean her hands afterward.

On 2/21/25 at 9:26 AM, the surveyor accompanied CNA #7 to Resident #1's room. There was a sign posted on the outside of the door which indicated that the resident was on [redacted]. CNA #7 then proceeded to donn a gown and gloves before she entered the room. CNA #7 stated that Resident #1 had *NJ Ex Order 26. 4B1* [redacted]. Resident #1 did not respond verbally when CNA #7 requested to check his/her [redacted]. The resident's *NJ Ex Order 26. 4B1* [redacted]. When finished, CNA #7 doffed both her gown and gloves. CNA #7 then proceeded to wash her hands out of the stream of running water for nine seconds before rinsing her hands and drying them on a paper towel. When interviewed at that time, CNA #7 stated that she was supposed to wash her hands for 20 to 30 seconds out of the stream of running water and she sang happy birthday once to ensure that she had washed her hands long enough.

On 2/21/25 at 10:07 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that the process for hand washing was to scrub your hands for at least 20 seconds. LPN/UM #1 further stated that if hand washing was not performed for a full 20 seconds it was an infection control issue and could spread germs around.

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F 880	Continued From page 52 On 2/25/25 at 11:00 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that staff should sing at least two rounds of the happy birthday song to ensure they washed their hands for the required 20 to 30 seconds. The [redacted] stated that if hands were washed for less than 20 seconds, you were not killing any bacteria. The [redacted] further stated that it could be a potential "[redacted]" if hands were only washed for nine seconds during NJ Ex Order 26. 4B1. On 2/25/25 at 2:27 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that it was her expectation that staff followed the protocol to wash their hands for a minimum of 20 seconds otherwise their hands were not clean. A review of the facility's "Hand Hygiene" policy, accessed April 2023, included: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors... Hand hygiene technique when using soap and water: ...Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers...	F 880		
F 908 SS=E	NJAC 8:39-19.4 Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 908		2/27/25

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F 908	Continued From page 53 Based on observation, interview, and review of facility documents, it was determined that the facility failed to maintain dryer machines in a safe operating condition for 2 of 4 dryer machines observed. This deficient practice was evidenced by the following: On 2/21/25 at 12:20 PM, the surveyor, accompanied by the [redacted], toured the facility's laundry room. The [redacted] explained that the laundry staff clean the dyer lint traps every two hours and sign off the completion in a logbook. The [redacted] retrieved the dyer lint trap cleaning log binder, opened the binder to review it, and stated the laundry staff had not completed the logs per the facility's policy. When asked when the logs were last completed, the [redacted] opened the binder and turned to the last page that was filled out which contained the dates for "8/20" and "8/21." The dates did not indicate the year it was completed. At that time, the surveyor requested to see the lint traps for the four dryer machines which revealed two out of the four dryer machines had a moderate amount of lint accumulation in the lint traps. The [redacted] then stated, "there should not be that much lint in the trap if it was cleaned two hours ago." The [redacted] further stated the staff should be following the facility's policy for dryer lint trap cleaning to prevent fires. At that time, the [redacted] removed a policy that was hanging up on the wall of the laundry room. A review of the policy titled, "Laundry Drain and Dryer Lint Trap Cleaning," effective 1/28/11, included, "Lint traps are to be cleaned of debris	F 908	Corrective Action: All lint traps were fully cleaned, and in absence of our Director of Housekeeping being able to respond as to a location of an updated Log book, we made new copies of the log book and in-serviced the staff on 02/24/25 regarding 2 hour cleaning and entries. Signs were place by each machine reminding the staff to empty the traps and fill out the logs. Identification of At-Risk Resident No residents have been identified as affected by the deficient practice. All residents have the potential to be affected by this deficient practice. Systemic Change The following measures have been put into place to prevent the deficient practice from recurring: Director of Housekeeping□s Daily rounds list has been updated to reflect auditing the lint traps as well as the Lint Trap Logs. Director of Housekeeping or designee will for one year conduct a weekly audit of the lint traps and the lint logs. Quality Assurance A quarterly review of the audit will be conducted and documented by the Director of Housekeeping 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 well as the Quality Assurance committee at their quarterly meeting for one year	

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F 908	Continued From page 54 every (2) two hours," and, "Document cleaning in the laundry activity log book (Lint Trap Cleaning Tracking Form)." On 2/25/25 at 12:38 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated he expected the laundry staff to clean the lint traps every two hours to prevent fires. At that time, the surveyor informed the U.S. FOIA (b) (6) of the two dryer machine lint traps observed and the U.S. FOIA (b) (6) stated he was concerned about the lack of documentation related to the lint trap cleaning. A review of the facility's "Lint Cleaning Policy for Dryers in Long-Term Care Facilities," updated, 1/2025, included the following: 1. Daily Maintenance: -Staff must inspect and clean lint traps in all dryers every two hours. This helps to prevent lint buildup, which can pose a fire risk and reduce the efficiency of the dryer. 4. Record Keeping: -Maintain a log of all cleaning and maintenance activities. This log should include dates of lint trap cleaning, inspections, and any maintenance work performed on the dryers. NJAC 8:39-31.2(e) NJAC 8:39-31.7(e)	F 908		

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

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 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	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ167424 and NJ179097 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 4 of 4 weeks of complaint staffing and 2 of 2 weeks of staffing prior to the recertification survey dated 2/26/25. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S560 Corrective Action Efforts to hire more facility staff have been ramped up. Between in house staff and agency we are staffing to or above the staffing levels that are needed. An In Service was conducted with the staffing coordinator on 2/26/25 specific to Mandatory Staffing Ratios we must adhere to. Identification of At-Risk Resident No Residents were identified as affected by this deficient practice. All residents	2/27/25

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

Electronically Signed | 03/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061706	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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) COMPLETE DATE
S 560	Continued From page 1 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 at 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 (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: 1. For the week of 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing on 2 of 7 day shifts as follows: -09/10/23 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. -09/16/23 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs. 2. For the 3 weeks of Complaint staffing from 10/06/2024 to 10/26/2024, the facility was deficient in CNA staffing on 4 of 21 day shifts as	S 560	have the potential to be affected by the deficient practice of not meeting the NJ staffing requirement ratios. Systemic Change Additional agencies have been contracted to attain the appropriate staff ratios for the facility census. Advertisements/ job postings for CNAs have been posted on hiring platforms and social media websites Incentives such as overtime and bonuses are offered to CNAs and Agency to work extra shifts. Hiring and recruitment efforts now include referral bonuses, sign-on bonuses, weekend differentials amongst other incentives to bring in good staff and quickly. Tap Check payout system implemented for staff to receive instant pay as incentive to employing more staff. Overtime is made available to all current employees. Quality Assurance The DON or designee will review staffing levels daily to ensure that we have adequate staffing. Findings will be reported to the Administrator. A quarterly review of the audits will be conducted and documented by the Administrator 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 Quality Assurance committee at their quarterly meeting for one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061706	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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) COMPLETE DATE
S 560	Continued From page 2 follows: -10/06/24 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -10/12/24 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -10/13/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. -10/20/24 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs. 3. For the 2 weeks prior to survey from 02/02/2025 to 02/15/2025, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -02/02/25 had 10 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/15/25 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. On 2/25/25 at 11:54 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated her role was to schedule the Nurses and the Certified Nursing Assistant (CNA) staff. The SC stated the staffing for the weekend were the "struggle points." She stated that the facility offered in-house bonuses and increased the agency's rates. The SC stated that she has seen an improvement with the staffing lately. The SC stated the CNAs staffing ratios were 1:8 for the day shift (7:00 AM to 3:00 PM); 1:10 for the evening shift (3:00 PM to 11:00 PM); and 1:14 for the night shift (11:00 PM to 7:00 AM). On 2/25/25 at 12:27 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM-3:00 PM shift, one CNA	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061706	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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) COMPLETE DATE
S 560	Continued From page 3 for ten residents on the 3:00 PM-11:00 PM shift, and one CNA for fourteen residents on the 11:00 PM-7:00 AM shift. He stated he felt they were meeting the staffing ratios most of the time. The LNHA stated that the facility did schedule accordingly and even overstaff, but due to callouts it could be difficult especially on the weekends. He then stated the SC moved into the Director of Nursing (DON)'s office to have continuity and to be on the same page to ensure they had enough staff. A review of the facility's "Staffing" policy, undated, included, "the facility will provide sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents ...Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care."	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:	S1680		2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061706	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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) COMPLETE DATE
S1680	Continued From page 4 Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061706	A. BUILDING: _____ B. WING _____	C 02/26/2025

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

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S1680	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on review of the Nursing Staffing Reports for the two weeks prior to survey from 2/2/2025 to 2/15/2025, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days. The required staffing hours and actual staffing hours are as follows: The facility was deficient in Registered Nurse (RN) staffing hours as follows: For the week of 02/02/25 Required Staffing Hours: 400 -02/02/24 had 336 actual staffing hours, for a difference of -64 hours. On 2/25/25 at 11:54 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated her role was to schedule the Nurses and the Certified Nursing Assistant (CNA) staff. The SC stated the staffing for the weekend were the "struggle points." On 2/25/25 at 12:27 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated the facility did schedule accordingly and even overstaff but due to callouts it can be difficult especially on the weekends. A review of the facility's "Staffing" policy, undated,	S1680	Corrective Action: In Service was done with staffing coordinator on 2/26/25 specific to required RN hours necessary to provide care for all residents. Identification of At-Risk Resident No Residents have been identified as affected by the deficient practice. All residents in the facility have the potential to be affected by this deficient practice. Systemic Change Director of Nursing will on a weekly basis, educate and oversee that the RN hours meet or exceed the requirements put forth in 8:39-25.2(b)(1)&(2). Quality Assurance The Director of Nursing or Designee will audit staffing numbers vs acuities on a monthly basis for one year to ensure we are staffed with proper RN numbers. Results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061706	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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) COMPLETE DATE
S1680	Continued From page 6 included, "the facility will provide sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents ...Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care."	S1680		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315237 Y1	A. Building B. Wing Y2	4/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0607	Correction	ID Prefix F0656	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	02/27/2025	LSC	03/12/2025	LSC	03/19/2025
ID Prefix F0686	Correction	ID Prefix F0695	Correction	ID Prefix F0697	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(k)	Completed
LSC	03/20/2025	LSC	03/19/2025	LSC	03/19/2025
ID Prefix F0804	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	02/27/2025	LSC	02/27/2025	LSC	03/18/2025
ID Prefix F0908	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(d)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/27/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/26/2025	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315237	A. Building B. Wing	4/3/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 02/27/2025	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 03/19/2025	ID Prefix F0697 Reg. # 483.25(k) LSC	Correction Completed 03/19/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/26/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061706	A. Building B. Wing	4/3/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/27/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 02/27/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/26/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061706 Y1	A. Building B. Wing Y2	4/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/27/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/26/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING **02** B. WING _____	**02/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD** **CARNEYS POINT, NJ 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
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 015 SS=D	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. (D) Sewage and waste disposal.	E 015		2/27/25

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

Electronically Signed | 03/19/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING **02** B. WING _____	**02/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD** **CARNEYS POINT, NJ 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
E 015	Continued From page 1 *[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 observation, interview, and review of facility documents, it was determined that the facility failed to ensure that a three day emergency food supply menu and all required emergency food items were maintained in stock in accordance with the facility policy. This deficient practice was evidenced by the following: On 2/19/25 at 9:55 AM, during the entrance conference the U.S. FOIA (b) (6) stated that the facility census was 140. On 2/21/25 at 12:45 PM, in the presence of the	E 015	Corrective Action: The 3 day supply has been replenished. 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 Food Service Director will conduct a weekly audit of the the 3 day supply closet to ensure that there is enough emergency water and food for residents staff and vendors, and make sure that the menu is	

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	315237	A. BUILDING **02** B. WING _____	**02/26/2025**

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

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E 015	Continued From page 2 U.S. FOIA (b) (6) the surveyor observed the three day emergency food supply. When the surveyor asked to see the three day emergency food supply menu plan the U.S. FOIA (b) (6) stated that she was unable to find one within the storage unit. The surveyor observed the following food items: six #10 cans (ten pounds) of chile concarne, two cases of beef stew (#10 cans), two cases of three bean salad (#10) cans, two cases of creamed corn, one case of regular corn, one case of canned pineapples, one case of canned pears, one case of fruit cocktail, one case of oatmeal, one case of oatmeal, one case of vanilla, lemon, banana, and tapioca pudding, four boxes which each contained ninety-six individual bowls of dried cereal, seven cases of juice, and thirty pounds of dried milk. There were ten cases of water that had six gallons of water in each unit. The U.S. FOIA (b) (6) stated that the facility was required to have enough water in stock to supply one gallon of water per resident per day for three days. On 2/25/25 at 9:43 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that she stocked the three day emergency food supply yesterday. The U.S. FOIA (b) (6) stated that the three day menu should have been maintained in the three day emergency food suplly storage area. The U.S. FOIA (b) (6) stated that she put one case of carrots (six ten pound cans), one case of beets, two cases of tuna fish (eight pound cans) and potato chips in there. The U.S. FOIA (b) (6) stated that there should have been enough food to serve 140 residents, plus staff and vendors for three days. The U.S. FOIA (b) (6) stated that there was probably not enough food in there to do that, but there is now. The U.S. FOIA (b) (6) further stated that the facility needed to keep the three day emergency food supply stocked in case of a disaster and we can not get any food delivered.	E 015	posted there. Quality Assurance A quarterly review of the audits will be conducted and documented by the Food Service 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 well as the Quality Assurance committee at their quarterly meeting for one year	

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E 015	Continued From page 3 On 2/25/25 at 1:59 PM, in the presence of the survey team the surveyor informed the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted] of the surveyors findings related to the emergency three day food supply and the corresponding menu plan. A review of the facility's "Emergency Food Supply" policy, reviewed April 2024, included: It is the policy of this facility to establish procedures to ensure that food is available for residents, staff, and volunteers in case of emergency... ...The amount of food needed is estimated based on the facility assessment, and considers assessment, and considers census, total staff, and average number of volunteers/visitors... NJAC 8:39-31.6(n)	E 015		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/24/2025, 02/25/2025 and 02/26/2025 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.	K 000		

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K 000	Continued From page 4 It is composed of Type V (111) fully sprinklered building. 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 140 of 152.	K 000		
K 293 SS=F	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 REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 02/24/2025 in the presence of the facility's [redacted], it was determined that the facility failed to 1) ensure illuminated ext signs were Illuminated and 2) provide two (2) illuminated exit signs to clearly identify the exit access paths to reach an exit discharge door in accordance with NFPA Life Safety Code 101 2012 - 7.10.1.5.1, 7.10.5.2.1 and 19.2. These deficient practices had the potential to affect all 140 Residents and were evidenced by the following: On 02/24/2025 during the survey entrance at approximately 8:53 AM, a request was made to the [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke	K 293	Corrective Action: The Broken Dining Room Exit sign was replaced. 2 Exit signs were installed in the courtyard by a licensed electrician. [redacted] In Serviced 3/26/25 on the need for and importance of properly working Exit Signs. Identification of Residents at Risk: No Residents were identified as affected by this deficient practice. The residents who use the dining room or courtyard were at risk by not having a properly lit exit sign. These residents can be identified by reviewing the resident roster. Systemic Change:	3/17/25

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K 293	Continued From page 5 compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with one (1) enclosed center courtyard that Residents, Visitors and Staff could use. Observations on 02/24/2025 revealed the following: 1. At approximately 10:50 AM, one (1) of two (2) illuminated exit sign was not illuminated inside the Main Dining room. 2. At approximately 11:45 AM, the facility failed the have two illuminated exit signs to clearly identify the exit access route to reach an exit in the enclosed outside courtyard. In an interview at the tome of observations, the U.S. FOIA (b) confirmed the findings. The *U.S. FOIA (b) (6)* were informed of the deficient practice during the Life Safety Code survey exit on 02/26/2025 at approximately 12:50 PM.	K 293	Maintenance Director or designee will conduct a monthly audit of Facility Exit signs to ensure they are in working order. Quality Assurance: A quarterly review of the audit will be conducted and documented by the Maintenance Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. The results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	
K 321 SS=F	NJAC 8:39-31.1 (c), 31.2(e) 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 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	K 321		2/27/25

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K 321	Continued From page 6 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 REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation and interview on 02/24/2025 and 02/25/2025 in the presence of facility U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that 1 of 7 fire-rated doors inspected to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 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 all 140 residents and was evidenced by the following: An observation on 02/25/2025 at approximately 11:51 AM revealed when the corridor door leading	K 321	Corrective Action: The broken door to admissions has been repaired by the Director of Maintenance. Identification of Residents at Risk: No Residents were identified as affected by this deficient practice. All residents in the facility have the potential to be affected by the door that does not close properly. Systemic Change: Maintenance Director or designee will conduct a weekly audit of Facility Doors to ensure they are in working order and self closing.	

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K 321	Continued From page 7 into the Admissions Department/ Medical Records storage room when tested, the door did not self-close into its frame leaving a 1-1/2 inch opening between the door and door frame. Observations inside the room revealed the following combustible products: - 8 cardboard boxes (18-inches by 12-inches by 10-inches) filled with combustible copy machine paper. - 60 cardboard boxes (18-inches by 12-inches by 10-inches) filled with combustible medical records. - Multiple medical records stored on top of filing cabinets. A review of an evacuation diagram posted on the wall in the corridor revealed to pass the Admissions Department/Medical Records room is the primary and/or secondary egress route to reach an exit. In an interview at the time, the [U.S. FOIA (b)] confirmed the findings. The [U.S. FOIA (b) (6)] were informed of the deficient practice during the Life Safety Code survey exit on 02/26/2025 at approximately 12:50 PM.	K 321	Quality Assurance: A quarterly review of the audit will be conducted and documented by the Maintenance Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. The results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	
K 341 SS=F	NJAC 8:39-31.2 (e) Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in	K 341		3/31/25

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K 341	Continued From page 8 accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 02/24/2025 in the presence of the U.S. FOIA (b) (6) , it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. This deficient practice had the potential to affect all residents and was evidenced by the following: On 02/24/2025 during the survey entrance at approximately 8:53 AM, a request was made to the U.S. FOIA (b) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with one (1) enclosed (surrounded by the building) center	K 341	Corrective Action: Audio/Visual Alarm was installed 3/31/25 by our vendor in the courtyard, which is tied into the facility fire alarm system. U.S. FOIA (b) (6) has completed an in-service on 2/26/25 regarding the importance of having audio/visual fire alarm in the courtyard. Identification of Residents at Risk: No Residents were identified as affected by this deficient practice. All residents had the potential to be affected by the deficient practice. Systemic Change: Maintenance Director or designee will conduct a monthly audit to ensure that the audio/visual alarm is properly functioning. Quality Assurance: A quarterly review of the audit will be conducted and documented by the	

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K 341	Continued From page 9 courtyard that Residents, Visitors and Staff could use. Observations on 02/24/2025 revealed the following: 1. At approximately 11:45 AM, the surveyor observed in the enclosed outside courtyard, that the facility failed the have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system. In an interview at the time the surveyor asked the [redacted] if there was an audio and visual alarm in the courtyard that was tied into the buildings fire alarm system. The [redacted] said they did not, but you can hear it. In an interview, the [redacted] confirmed the finding at the time of observations. The [redacted] were informed of the deficient practice during the Life Safety Code survey exit on 02/26/2025 at approximately 12:50 PM. NJAC 8:39-31.2(e) NFPA 72	K 341	Maintenance Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. The results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	
K 353 SS=F	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	K 353		2/27/25

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K 353	Continued From page 10 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review on 02/24/2025, 02/25/2025 and 02/26/2025 in the presence of the facility's U.S. FOIA (b) (6), it was determined that the facility failed to comply with the quarterly inspection and testing requirements for fire sprinkler systems in accordance with NFPA 25. This deficient practice had the potential to affect all 140 residents and was evidenced by the following: On 02/24/2025 (day one of survey) during the survey entrance at approximately 8:53 AM, a request was made to the U.S. FOIA (b) (6) to provide all mandatory inspections from the last Re-Certification survey of 01/17/2023 through to 02/23/2025. A record review at approximately 12:10 PM revealed the facility's Quarterly (every 3 months) Fire Sprinkler System inspections for the previous 25 months identified the system had eight (8) quarterly inspections on the following dates: U.S. FOIA (b) (6)): - 03/14/2023 Quarterly Inspection (QI),	K 353	Corrective Action: U.S. FOIA (b) (6) was immediately in serviced on 2/26/25 on the need for quarterly sprinkler inspections equaling 4 times per year. 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: Maintenance Director or designee will conduct a monthly audit of the charts to ensure we are in compliance with, and have timely scheduled our upcoming quarterly sprinkler inspection. Quality Assurance: A quarterly review of the audit will be conducted and documented by the Maintenance Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. The results of the review will be	

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K 353	Continued From page 11 06/20/2023 QI, 09/27/2023 Annual Inspection and 12/08/2023. - 04/16/2024 QI, 07/30/2024 Annual Inspection and 11/11/2024 QI. - 01/10/2025 QI. In an interview on 02/25/2025 at approximately 12:53 PM, a request was made to the [redacted] if the facility could provide any additional quarterly Fire Sprinkler inspections. In an interview on 02/26/2025, the [redacted] told the surveyor he called the [redacted] and they told him the sprinkler inspection was late. The facility failed to conducted 4 quarterly (every three months) sprinkler inspections for the year 2024 as required per NFPA 25. The [redacted] confirmed the findings at the times of review. The [redacted] were informed of the deficient practice during the Life Safety Code survey exit on 02/26/2025 at approximately 12:50 PM. NJAC 8:39-31.2(e) NFPA 25	K 353	reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for 3 years.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.	K 372		2/28/25

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

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K 372	Continued From page 12 Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/24/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to maintain the integrity of smoke barrier partitions for two (2) of seven (7) smoke barrier walls in accordance with NFPA 101:2012 Edition, Section 19.3.6.2.3, 8.5.6,8.5.6.2, 8.5.6.3. This deficient practice had the potential to affect 70 of the 140 residents and was evidenced by the following: On 02/24/2025 during the survey entrance at approximately 8:53 AM, a request was made to the U.S. FOIA (b) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with eight (8) smoke compartments. Observations on 02/24/2025 revealed the following: 1) At approximately 10:05 AM, the surveyor observed above the ceiling tiles by the double corridor smoke doors next to Resident Salon, one (1) approximately 1-inch in diameter hole with 3 wires running through the smoke barrier wall.	K 372	Corrective Action: The holes above the ceiling tiles by the double corridor smoke doors next to Resident Salon and above the ceiling tiles by the double corridor smoke doors next to Resident room #316 have been sealed using [redacted] Fire Barrier sealant. 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: Maintenance Director or designee will conduct a monthly audit of the fire barriers in the facility to ensure no new breach has been made. Quality Assurance: A quarterly review of the audit will be conducted and documented by the Maintenance Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. The results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING **02** B. WING _____	**02/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	**449 S PENNSVILLE-AUBURN ROAD** **CARNEYS POINT, NJ 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
K 372	Continued From page 13 2) At approximately 11:22 AM, the surveyor observed above the ceiling tiles by the double corridor smoke doors next to Resident room #316, two (2) approximately 1-inch in diameter holes with 1 wire running through one hole in the smoke barrier wall. These unsealed penetrations indicated these walls were not 1/2 hour fire rated and sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartmenst. The [U.S. FOIA (b)] confirmed the findings at the time of observations. The [U.S. FOIA (b) (6)] were informed of the deficiency during the Life Safety Code survey exit on 02/26/2025 at approximately 12:50 PM.	K 372		
K 918 SS=F	N.J.A.C 8:39-31.2(e) Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING 02 B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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
K 918	Continued From page 14 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/24/2025 in the presence of the facility U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice had the potential to affect all 140 residents and was evidenced by the following: In an interview on 02/24/2025 during the survey entrance at approximately 8:53 AM, the U.S. FOIA (b) stated they had one (1) 500 KW (Kilowatt) Diesel Emergency Generator.	K 918	Corrective Action: Quote was obtained from our Generator company to install a remote emergency stop button for the generator. Deposit was given. Work has been completed Thursday 3/20. Identification of At-Risk Resident All residents in the facility have the potential to be affected by these deficient practices. No resident was identified as being affected by this deficient practice. Systemic Change: Maintenance Director or designee will conduct a monthly test to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315237	A. BUILDING 02 B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 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
K 918	Continued From page 15 An observation at approximately 10:15 AM outside of the building where the 500 KW Emergency Generator is located, revealed the Emergency Generator had the Emergency Stop button located on the metal housing of the generator. The surveyor observed no evidence of a remote Emergency Stop button for the 500 KW Diesel Emergency Generator. In an interview at the time, the [redacted] stated they did not have an emergency stop button that was remote from the generator. The [redacted] confirmed the finding at the time of observation. The [redacted] were informed of the deficient practice during the Life Safety Code survey exit on 02/26/2025 at approximately 12:50 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	new emergency stop button is functional. Quality Assurance: A quarterly review of the audit will be conducted and documented by the Maintenance Director or designee for one year. Any concerns/recommendations will be made at that time and addressed as needed. The results of the review will be reported to the Administrator as well as the Quality Assurance committee at their quarterly meeting for one year.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315237 Y1	A. Building B. Wing Y2	4/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0015 Reg. # 483.73(b)(1) LSC	Correction Completed 02/27/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/26/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315237 Y1	A. Building 02 - SOUTHGATE B. Wing Y2	4/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT SOUTHGATE	449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	03/17/2025	LSC K0321	02/27/2025	LSC K0341	03/31/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	02/27/2025	LSC K0372	02/28/2025	LSC K0918	03/20/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/26/2025	☐ YES ☐ NO