

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Salem County		STREET ADDRESS, CITY, STATE, ZIP CODE 438 Salem-Woodstown Road Salem, NJ 08079	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Salem County		STREET ADDRESS, CITY, STATE, ZIP CODE 438 Salem-Woodstown Road Salem, NJ 08079	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Intake ID: 2636901Based on interviews, review of closed medical records and other facility documentation, it was determined that the facility failed to perform an initial full body skin assessment and implement timely interventions for a resident upon admission to the facility in accordance with the facility Skin Assessment Policy to prevent altered skin integrity.This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for pressure injury prevention and was evidenced by the following:On 10/23/25 at 10:28 AM, the surveyor reviewed the closed electronic medical record for Resident #1.A review of the admission Record, an admission summary, revealed the resident was admitted to the facility with diagnosis that included but were not limited to; aphasia (loss of ability to understand or express speech), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side, other abnormalities of gait (manner of walking) and mobility, type 2 (two) diabetes (the body does not use or produce insulin effectively to regulate blood sugar levels) without complications, and major depressive disorder, recurrent, unspecified.A review of the comprehensive Minimum Data Set (MDS), an assessment tool, revealed that the resident was discharged from the facility prior to the completion of the admission Assessment and the assessment was unable to be viewed.A review of the Admit/Readmit Screening Tool dated 9/23/25, revealed that the resident was oriented to person and situation only and was not oriented to place or time. Further review of the Admit/Readmit Screening Tool revealed that the resident required one-person physical assistance for transfers. Further review of the Admit/Readmit Screening Tool revealed that the resident's skin integrity was described as normal, warm, dry, with normal turgor (elasticity), and indicated that the resident's skin was intact.A review of the Baseline Care Plan dated 9/23/25, revealed that the resident required one-person physical assistance for personal hygiene, toilet use, dressing, bathing, and bed mobility, and used mobility devices which included a walker and wheelchair. A Further review of the Base Line Care Plan revealed that the resident was alert and was always incontinent of urine and was frequently incontinent of bowel. A Further review of the Base Line Care Plan revealed that the resident did not have any current skin integrity issues and had no history of skin integrity issues.A review of the resident's Order Summary Report revealed a physician's order dated 9/24/25, for Zinc Oxide External Cream 10% (Zinc Oxide (topical)) Apply to b/l (bilaterally, both sides) buttocks topically every shift for wound care.A review of the Treatment Administration Record (TAR) revealed an entry dated 9/24/25 at 5:00 PM, for a Skin Evaluation Weekly; Document under weekly skin evaluation in the evening every Wed (Wednesday) document using the following codes: 0-No Skin impairments, 1-Previous skin impairment present, 2-Newly identified skin impairment . Further review of the entry revealed that the entry was signed out as administered with a code of 1 (one), which indicated the resident had a previous skin impairment present.A Further review of the TAR revealed an order dated 9/24/25 at 10:21 AM, for Zinc Oxide External Cream 10% (Zinc Oxide (Topical)) Apply to b/l buttocks topically every shift for wound care that was administered during the evening shift on 9/24/25.The surveyor reviewed the resident's Progress Notes (PN) which failed to indicate that the facility had previously identified that the resident had a previous skin impairment present upon admission to the facility.On 10/23/25 at 11:44 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #1 who stated that if she noted that a resident's skin was red, she would put Zinc Oxide on it and tell the nurse.On 10/23/25 at 11:44 AM, the surveyor interviewed the License Practical Nurse (LPN) #1 who stated that if any skin issues were identified she would complete an incident report, document the findings in the electronic medical record (EMR), and get an order for a wound treatment. The LPN #1 stated that if a previous skin impairment were identified on the skin assessment then an incident report should have been initiated. The LPN #1 reviewed the resident's closed EMR and confirmed that the resident's skin assessment was coded to indicate that a previous skin impairment was present and that a risk management, or incident report was not completed on behalf of the resident.On 10/24/25 at 12:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated that nursing was required to document what type of skin impairment was identified. The DON stated that she did not believe that an incident report was initiated for Resident #1 and whether the resident had a previous skin impairment. On 10/24/25 at 1:01 PM, in a later interview with the DON she presented the surveyor with a Body Check Form dated 9/24/25 at 10 AM, which indicated that the resident had edema to b/l Lower extremities and had excoriation (a superficial wound on the skin) to b/l buttocks. When the surveyor asked why the Body Check Form documentation completed on 9/24/25 differed from the Admit/Readmit Screening that was completed</p>		