STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	**3419 HIGHWAY 9 FREEHOLD, NJ 07728**

(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 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		
F 000	INITIAL COMMENTS 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. Survey date: 03/01/23 Survey dates: 02/14, 02/15, 02/16, 02/17, 02/21, 02/22, 02/23, 02/24, 02/28 and 03/01/23 CENSUS: 93 SAMPLE SIZE: 22 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey. The following immediate jeopardy (IJ) situation was identified for F760: During a Standard Survey conducted 02/14/23 through 03/01/23, the survey team identified the following: F760 s/s J The facility failed to protect residents from the potential for significant medication errors by not	F 000		

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

Electronically Signed | 03/26/2023

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 000	Continued From page 1	F 000		

following the standards of practice for the administration of medication and also not following the facility policy for Medication Administration when 1 of 3 nurses (*U.S. FOIA (B)(6)* [redacted]) on 1 of 3 units (*NJ Ex Order 26. 4B* [redacted]) observed during a medication pass observation prepared and attempted to give *NJ Ex Order 26. 4B1* [redacted] medications to the wrong resident. The *U.S. FOIA* [redacted] did not follow the five rights of medication administration by identifying the correct resident with the correct medications. The 5 rights are the following: the right patient, the right drug, the right dose, the right route, and the right time. The surveyor intervened before the medications could be administered to Resident #49.

This posed a serious and immediate threat for all the residents on the *NJ Ex Order 26. 4B* [redacted] Unit.

The immediate jeopardy (IJ) began on 02/22/23 at 8:37 AM and continued until 02/23/22.

The *U.S. FOIA (B)(6)* [redacted] were notified of the IJ on 02/22/23 at 3:10 PM. The failure of LPN #1 to follow the six rights of medication administration in accordance with professional standards of nursing practice that must be used to reduce the risk of medication errors and harm (identifying a resident prior to administering medications) constituted an Immediate Jeopardy situation due to the potential for injury or death to the residents on the *NJ Ex Order 26. 4B* [redacted] unit.

An acceptable removal plan was received on 02/23/23 at 12:17 PM and verified by the survey team on 02/23/23 and throughout the remainder of the survey.

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F 641	Continued From page 2	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 2 residents reviewed for NJ Exec Order 26.4b (Resident #29). This deficient practice was evidenced by the following: On 02/15/23 at 12:14 PM, the surveyor observed Resident #29 in the main dining room NJ Ex Order 26. 4B1 U.S. FOIA (B)(6) , sitting in a reclining chair. A [redacted] (CNA #1) was sitting next to the resident and NJ Ex Order 26. 4B [redacted] the resident. CNA#1 stated that resident was a NJ Exec Order 26.4b1 and can NJ Exec Order 26.4b1 [redacted]. On 02/16/23 at 1:03 PM, the surveyor reviewed Resident #29's electronic medical record. The resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26. 4B1 [redacted]. Review of the Significant Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident had NJ Ex Order 26. 4B1 . The Section [redacted] (the section used to list NJ Exec Order 26.4b1	F 641	Full chart review, plan of care and MDS has been reviewed and updated for Resident #29 in reference to incorrect coding of NJ Ex Order 26. 4B1. A Modified MDS was transmitted to CMS to reflect accurate coding of NJ Ex Order 26. 4B1. An audit for all residents who required staff assistance with eating in Section G0110(H) of the MDS for the period from 1/1/2023 □ 3/30/2023, was completed. The facility recognizes that all residents have the potential to be affected by this deficiency. NSG/MDS department will be educated on the RAI definition of Activities of Daily Living (ADL) Assistance items in Section G0110. Nursing staff will be educated by the U.S. FOIA (B)(6) [redacted] on the accuracy of POC documentation. Additional supplemental information has been displayed at the nursing units to assist staff with the definitions and coding showing an ADL algorithm to capture the resident's appropriate level of ADL function. Prior to completion of any OBRA, Annual or Significant Change MDS, the MDS coordinator will verify accuracy of ADL	4/12/23

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F 641	Continued From page 3 NJ Exec Order that best describes the NJ Ex Order 26. 4B1 of the MDS reflected that Resident #29 NJ Ex Ord performance in NJ Ex Order 26. was coded as "NJ Ex Order 26. 4B1" with "NJ Ex Order 26. 4B1 ." Review of NJ Ex Ord task record from Electronic Health Record (EHR) completed by the CNA's dated NJ Exec Order 26.4b1 revealed the following: On NJ Exec Order 26.4b1 NJ Ex Order 26. was coded as NJ (total), and support provided coded as NJ . On NJ Exec Order 26.4b1 NJ Ex Order 26. was coded as NJ Ex Order 26. 4B1 . On NJ Exec Order 26.4b1 NJ Ex Order 26. was coded as NJ Ex Order 26. 4B1 . On NJ Exec Order 26.4b1 NJ Ex Order 26. was coded as NJ Ex Order 26. 4B1 . On NJ Exec Order 26.4b1 NJ Ex Order 26. was coded as NJ Ex Order 26. 4B1 . Review of the admission MDS, dated 8/31/22, documented under section NJ E that Resident #29 NJ Ex Ord performance in NJ Ex Order 26. was coded as "NJ Ex Order 26. 4B1" with "NJ Ex Order 26. 4B1 " Review of the quarterly MDS, dated 12/01/22, documented under section NJ E that Resident #29 NJ Ex Ord performance in NJ Ex Order 26. was coded as NJ Ex Order 26. 4B1" with "NJ Ex Order 26. 4B1 ."	F 641	coding with primary CNA and or nursing staff with an emphasis on the Eating ADL in Section G0110(H). MDS coordinator will complete the assessment. Residents chart/kardex will reflect residents who require assistance with eating. DON and MDS Coordinator will audit up to four charts weekly from the OBRA, Annual or Significant Change Assessments completed to ensure accuracy of ADL coding for two months, then biweekly x2 months, then monthly x2 months. Results of audits will be submitted to the quarterly Quality Assurance and Performance Improvement (QAPI) committee and Administrator for review and to determine further re-education or action is needed.	

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F 641	Continued From page 4	F 641		

On 02/21/23 at 12:07 PM, the surveyor interviewed the U.S. FOIA (B)(6). The U.S. FOIA stated that Resident #29 was under NJ Ex Order 26. 4B1 and that the resident was NJ Exec Order 2 to NJ Ex Orde himself/herself since being admitted to the the facility in NJ Ex Order 26. 4B1. The U.S. FOI added that the resident used a NJ Ex Order 2 NJ Exec Order 26.4b1, but the staff needed to hold the NJ Ex Order 2 NJ Exec because the resident was NJ Exec Order 26.4b1 and would NJ Exec Order 26.4b1 .

On 02/23/23 at 10:45 AM, the surveyor interviewed the U.S. FOIA (B)(6). The U.S. FOIA (B)(6) stated that Resident #29 was NJ Exec Order 2 to NJ Ex Orde hinself/herself and that staff did everything for the resident like NJ Ex Order 26. 4B1. The U.S. FOIA (B)(6) added that Resident #29 used a NJ Ex Order 2 NJ Exec O but that staff still NJ Exec Order 26.4b1 otherwise it will be all NJ Exec O residents' NJ Exec Order 26.4

On 02/24/23 at 10:36 AM, the surveyor interviewed the U.S. FOIA (B)(6) who stated that Resident #29 had an NJ Ex Order 26. 4B1 and since admission needed NJ Ex Order 26. 4B1 with all NJ Ex Order 26. 4B1 .

On 02/28/23 at 11:14 AM, the surveyor interviewed the U.S. FOIA (B)(6). The U.S. FOIA (B)(6) stated that the resident recently signed on NJ Ex Order 26. 4B1 and that the resident NJ Exec Order 26.4b1 in NJ Ex Order 26. 4B from staff.

On 02/28/23 at 11:21 AM, the surveyor interviewed the U.S. FOIA (B)(6) on the process of assessing the NJ Ex Orde activity. The U.S. FOIA (B stated she would check the NJ Ex Orde

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F 641	Continued From page 5 status by using the seven day lookback period, reading the progress notes, and interviewing the [redacted]. The surveyor reviewed Resident #29 [redacted] MDS with the [redacted] and questioned the resident's [redacted] of [redacted] being coded as "[redacted]" with "[redacted]." The [redacted] stated that "[redacted]" indicated "[redacted]" and that she incorrectly coded Resident #29's [redacted] as "[redacted]" At that time, she provided the Center for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual with an edition date of October 2019. According to the manual, "Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well)." NJAC 8:39-11.1, 11.2(e)(1)	F 641		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		4/12/23

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F 732	Continued From page 6 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of	F 732	The U.S. FOIA (B)(6) who is	

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F 732	Continued From page 7 pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour staffing information was updated and accurately displayed daily. This deficient practice was evidenced by the following: On 02/21/23 at 12:09 PM, the surveyor observed the facility's "Wedgwood Gardens Care Center NJ Dept of Health & Senior Services Resident Care Staffing Report" dated 02/20/23, in a clear plastic sleeve at the front receptionist desk. On 02/22/23 at 8:45 AM, and 02/23/23 at 8:50 AM, upon entry into the building, the surveyor observed the facility's "Wedgwood Gardens Care Center NJ Dept of Health & Senior Services Resident Care Staffing Report" dated 02/20/23, in a clear plastic sleeve at the front receptionist desk. During an interview with the surveyor on 02/23/23 at 1:15 PM, the [redacted] stated she reports the staffing every morning online to the state, she then prints it out and should put it in the clear plastic sleeve at the front receptionist desk. The [redacted] then confirmed that the displayed staffing was for [redacted]. She stated, "I got busy. It should have been changed every day." During an interview with the surveyor on 02/23/23 at 1:40 PM, the [redacted] stated that staffing was posted daily at the front receptionist desk. At that time, the surveyor made the [redacted] aware of the above observations. The [redacted] acknowledged that staffing should have been updated and displayed daily. During a meeting with the survey team, [redacted]	F 732	responsible for posting Nurse Staffing Information was immediately re-educated by the [redacted] on the requirements for maintaining and posting accurate and timely staffing information as per regulation. Review of the facility policy and procedure related to Nurse Staffing posting updated. The facility recognizes that all residents, employees and visitors have the protentional of being affected by the deficient practice. The Staffing Coordinator will ensure that the staffing information is visibly accessible in facility. The Staffing Coordinator will be responsible for providing the nurse Staffing information and data to the Director of Nursing and Administrator at the time of posting. The Staffing Coordinator job description has been updated to specifically reflect the daily posting requirements. Audits will be conducted by the Assistant Administrator or the designee of Nurse Staffing Information posting, including weekend coverage. Audits will be conducted daily for 30 days. Results of audits will be submitted to the QA and QAPI committee and the Administrator to ensure compliance and reassessed on a quarterly basis.	

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F 732	Continued From page 8 U.S. FOIA (B)(6) on 02/24/23 at 12:23 PM, the surveyor made the U.S. FOIA (B)(6) aware that the staffing was not updated and displayed daily. NJAC 8:39-41.2(a)	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		4/12/23

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F 755	Continued From page 9 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain accurate accountability and reconcililation for controlled medications. This deficient practice was identified for 1 of 3 medication carts ([redacted] Unit) inspected and was evidenced by the following: On 02/22/23 at 9:24 AM, the surveyor, in the presence of the *U.S. FOIA (B)(6)* [redacted], inspected the [redacted] Unit medication cart. On 02/22/23 at 9:30 AM, the surveyor, in the presence of the [redacted], observed the [redacted] medication located in the secured and locked [redacted] box. When the [redacted] medication inventory was compared to the declining inventory sheet, the surveyor identified that the [redacted] medication inventory for Resident #86's *NJ Ex Order 26. 4B1* [redacted], did not match the declining inventory sheet. The blister pack of *NJ Ex Order 26. 4B1* tablets contained [redacted] tablets and the declining inventory sheet indicated there should be [redacted] tablets remaining. The [redacted] stated that she gave Resident #86 one *NJ Ex Order 26. 4B1* at 8:00 AM today and stated that she should have signed for the medication on the declining inventory sheet within one hour of giving the medication. On 02/22/23 at 9:36 AM, the surveyor, in the presence of the [redacted], continued to compare the [redacted] medication inventory to the declining inventory sheets on the [redacted] Unit medication cart.	F 755	The [redacted] signed out the medication that had been previously given and all counts were reconciled and correct. Nursing staff have been educated by the *U.S. FOIA (B)(6)* [redacted] on the importance of accurate accounting of narcotic medications and documentation of medication administration. [redacted] was immediately re-educated on February 22, 2023 by the *U.S. FOIA (B)(6)* on timely documentation of administered narcotic on Declining Inventory Sheet and nursing medication administration pass was completed on February 22, 2023. All other narcotic declining inventory sheets were audited as to accuracy and for any miscounts due to late entry/ signature.There were no additional findings related to this citation. The facilities audit indicated that no residents were affected by the deficient practice. Nursing staff have been re-educated on the importance of accurate accounting of narcotic medications and documentation at time of administration of medication on both EMAR and Declining Inventory Sheet. The Director of Nursing/ Designee will be responsible for ensuring that nurses accurately count and document narcotic medications. All nurses have received competency	

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F 755	Continued From page 10 The surveyor identified that the narcotic medication inventory for Resident #20's [redacted] did not match the declining inventory sheets. The blister pack of [redacted] tablets contained [redacted] tablets and the declining inventory sheet indicated that there should be 10 tablets remaining. The [redacted] stated that she gave Resident #20 one [redacted] tablet at 8:06 AM this morning. The [redacted] stated, "[redacted]" to sign the declining inventory sheets for both medications. Reviews of the Medication Administration Records revealed that Resident #86 received a [redacted] tablet on 02/22/23 at 7:30 AM and that Resident #20 received a [redacted] tablet on [redacted] at 9:00 AM. On 02/22/23 at 12:25 PM, the surveyor interviewed the [redacted]. The [redacted] stated that she expected the [redacted] to sign the declining inventory sheet immediately when a medication is removed from the [redacted] blister pack. The [redacted] stated that the importance of signing for a [redacted] in the declining inventory sheet immediately was to keep the [redacted] count accurate. On 02/24/23 at 9:51 AM, the surveyor interviewed the [redacted] stated that the declining inventory sheet should have been signed as soon as the [redacted] was removed from the blister pack. A review of the facility provided policy, "Declining	F 755	training on proper documentation of narcotic declining sheet by the DIrector of Nursing and RN Staff Educator, on going comptencies will be conducted monthly for 2 months. The Director of Nursing/Designee will complete random audits of 5 percent of narcotic count sheets to ensure that medication counts match the medication on hand correctly and are documented when given, weekly for 4 weeks, monthly x 3 months for review and recommendations. The results will be reported to the QAPI Committee, pharmacy consultant and Administrator monthly for 6 months.	

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(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 755	Continued From page 11 Inventory" with a revised date of January 2023, included under the Procedure section that for "Schedule II Controlled Substances: Separate individual narcotic records are maintained on all Schedule II drugs in the form of a declining inventory. This form includes: ... date and time of administration and the signature of the person administering the drug." The policy also included that for "Schedule III-V Controlled Substances: Counted per facility policy and in accordance with state regulations." NJAC 8:39- 29.2(d)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation performed on 02/22/23, the surveyors observed three nurses administer medications to four residents. There were 31 opportunities, and six errors were observed, which calculated to a medication administration error rate of 19.35 %. This deficient practice was identified for one of four residents, (Resident #49), that were administered medications by one of three nurses. The deficient practice was evidenced by the	F 759	Nurse #1 was immediately removed from the floor. The facility recognized that all residents had the potential of being affected by the deficient practice. Audit completed of LPN #1□s medication administration for accuracy. No other residents were affected. No additional findings related to this defcient practice. Nurses were re-educated on medication administration accuracy and medication administration competencies with	4/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

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F 759	Continued From page 12 following: On 02/22/23 at 8:06 AM, the surveyor observed LPN #1 during medication pass on the [NJ Ex Order 26. 4B] Unit. Resident #74, who was positioned by the bed [NJ Exec Order 26.4b1], did not have an identification (ID) band but was able to identify themself. LPN #1 then asked another nurse to identify Resident #74 by the resident's name. The surveyor observed LPN #1 open the Medication Administration Record (MAR) to prepare six (6) medications for Resident #74 which included the following: [NJ Ex Order 26. 4B1] [redacted]. The surveyor observed LPN #1 bring a [NJ Ex Order 26. 4B1] [redacted] tablets into the resident's room. At 8:14 AM, LPN #1 administered the [NJ Ex Order 26. 4B1] medication, handed medication cup #1 to the resident and instructed Resident #74 to chew the [NJ Ex Order 26.] tablet. LPN #1 used the [NJ Ex Order 26. 4B1] to check the [NJ Ex Order 26. 4B1] of the resident which read [NJ Ex Order 26. 4B1] [redacted]. At this time, LPN #1 accidentally threw medication cup #2 into the garbage can while cleaning the resident's overbed table. The surveyor observed	F 759	emphasis on the 5 rights; the right patient, the right drug, the right time, the right dose, and the right route. All nursing staff provided with re -education by the [U.S. FOIA (B)(6)] on coping skills during stressful situations during medication administration, and when to ask for assistance. Resident identification process upgraded to include new arm band with residents photo and verification of the 5 rights. Director of Nursing or designee will audit Medication pass weekly x 4 weeks, than monthly x3 months. Should adverse findings arrise they be immediately addressed by the Director of Nursing or designee for continued re-education. Findings of the audits will be reported to the QA,QAPI Committee and the Administrator monthly for 6 months.	

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	315504	A. BUILDING _____ B. WING _____	03/03/2023

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F 759	Continued From page 13	F 759		

LPN#1 retrieve the medication out of the garbage and exit the room to dispose of them.

On 02/22/23 at 8:37 AM, the surveyor observed LPN #1 prepared six medications for Resident #74. LPN #1 prepared *NJ Ex Order 26. 4B1* [redacted]. LPN #1 went inside the resident's room but there were no residents inside the room. LPN #1 then checked the bathroom and there was one resident (Resident #49) inside. LPN #1 waited outside the bathroom for the resident to exit the bathroom. After [redacted] the resident in the [redacted] a [redacted] wheeled Resident #49 from the bathroom to the resident's bedside which was located near the door.

The surveyor observed LPN #1 place the medication cups on the overbed table, take the *NJ Ex Order 26. 4B1* and turned to Resident #49. The surveyor further observed that LPN #1 did not identify the resident by asking their name, by reading the resident's ID band, nor by asking another staff to identify the resident. LPN #1 proceeded to pull Resident #49's [redacted] up to [redacted] the *NJ Ex Order 26. 4B1* [redacted], which was ordered and prepared for Resident #74. The surveyor immediately stopped LPN #1 and asked her if this was the correct resident. The surveyor then observed LPN #1 check Resident #49's ID band and LPN #1 stated, "[redacted]."

Review of Admission Record face sheet for Resident #49 indicated that the resident was admitted to the facility with diagnoses which

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	315504	A. BUILDING _____ B. WING _____	03/03/2023

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F 759	Continued From page 14 included but were not limited to: NJ Ex Order 26. 4B1 [redacted].	F 759		

Review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) sheet for Resident #49 revealed the following orders to be administered by 9 AM:

a.) *NJ Ex Order 26. 4B1* [redacted] tablet by mouth two times a day related to *NJ Ex Order 26. 4B1* [redacted] dated 01/15/2022
b.) *NJ Ex Order 26. 4B1* [redacted] tablet by mouth two times a day related to *NJ Ex Order 26. 4B1* [redacted] dated 01/18/2022
c.) *NJ Ex Order 26. 4B1* [redacted] tablet by mouth two times a day for NJ Ex Order 26. 4B1 dated NJ Exec Order 26.4b1,
d.) *NJ Ex Order 26. 4B1* [redacted] tablet by mouth one time a day related to *NJ Ex Order 26. 4B1* [redacted] dated NJ Exec Order 26.4b1.
e.) *NJ Ex Order 26. 4B1* [redacted] by mouth one time a day related to *NJ Ex Order 26. 4B1* dated NJ Exec Order 26.4b1,
f.) *NJ Ex Order 26. 4B1* [redacted] tablet by mouth one time a day for *NJ Ex Order 26. 4B1* [redacted] dated NJ Exec Order 26.4b1
g.) *NJ Ex Order 26. 4B1* [redacted] topically one time a day for NJ Ex Ord and remove per schedule dated NJ Exec Order 26.4b1

There was no evidence from the corresponding OSR sheets for NJ Exec Order 26.4 NJ Ex Order that Resident #49 was receiving any of the same morning

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 759	Continued From page 15 medications. Reviewed of the Annual Minimum Data Set (MDS) dated NJ Exec Order 26.4b1 for Resident #49, which reflected the resident had a BIMS score of NJ out of 15 indicating that the resident had NJ Ex Order 26. 4B1 . Reviewed of Resident #49's Care Plan, with a initiated date NJ Exec Order 26.4b1, had a focus area which revealed, "*NJ Ex Order 26. 4B1* ." On 02/22/23 at 10:39 AM, the surveyor, in the presence of the survey team, discussed the medication pass concerns with the U.S. FOIA (B)(6) , and LPN #1. LPN #1 stated that the correct process to administer medications was to identify the resident by checking the ID band, if the resident did not have an ID band, then you could get a U.S. FOIA (or another staff member to identify the resident. LPN #1 added that she could also look at the resident's picture on the electronic health record. LPN #1 stated that you should, "triple check" for the rights of medication administration including right resident, right drug, right dosage, and right route. LPN #1 further stated that during the medication pass observation that some of Resident #74's medications fell into the garbage and that once she poured the medications again that she had become "*NJ Ex Order 26. 4B1* ." LPN #1 added that Resident #74 was originally in the room but had been taken out the room to go to NJ Ex Order 26. 4B. LPN #1 stated that she believed that Resident #49 was the resident that she was originally working with and that her "*NJ Ex Order 26. 4B1*"	F 759		

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F 759	Continued From page 16	F 759		

to assisting Resident #49 because now this was the only resident in the room. LPN #1 continued that she was about to give the resident an [redacted], but she stopped because the surveyor interrupted her. LPN #1 confirmed that she did not check Resident #49's ID band as she should have.

On 02/22/23 at 10:59 AM, in the presence of survey team, the [redacted] stated the process to identify a resident when administering medication to was to check the resident's ID band, get a nurse to identify the resident, or if the resident was [redacted] have the resident identify themselves. The [redacted] stated that safety was the most important thing in medication administration and that, "you could kill them if you give the wrong medication". The [redacted] continued that she identified Resident #74 during the medication pass observation for LPN #1 and that Resident #49 was in the room the entire time.

On 02/22/23 at 11:06 AM, the [redacted] stated, in the presence of the survey team, that nurses administering medications were expected to identify the proper resident, to check the picture in the electronic health record and the resident's name band. The [redacted] stated that the importance of giving the right medication to the right resident was to, "do no harm" and to not cause adverse effects. The [redacted] stated that LPN #1 should have identified the correct resident before attempting to give medications.

On 02/24/23 at 12:18 PM, in a meeting with the [redacted], and survey team, the surveyor reviewed that the medication error rate was 19%. No further information was provided.

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F 759	Continued From page 17 A review of the facility's policy dated as reviewed/revised on 01/2023 for "Medication Administration-Policy" that was provided by the DON revealed under "Step 1 Identify Resident" Step 5 Identify the resident by name and identification system (bracelet, photograph, in PCC, or with other staff member)."	F 759		
F 760 SS=J	NJAC 8:39-29.2 (d) Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined the facility failed to: a.) protect residents from the potential for significant medication errors by not following the standards of practice for the administration of medication, and b.) implement the facility policy for Medication Administration when 1 of 3 nurses ([redacted]) on 1 of 3 units ([redacted]) observed during a medication pass observation prepared and attempted to give high-risk medications to the wrong resident. On 02/22/23, the surveyor observed the [redacted] (LPN #1) attempt to administer six specific medications for [redacted]	F 760	Nurse #1 was immediately [redacted]. All nurses completed a competency in medication administration with emphasis on the 5 rights; the right patient, the right drug, the right time, the right dose, and the right route and are able to able to verbalize and demonstrate the 5 rights of medication administration. The facility recognized that all residents had the potential of being affected by the deficient practice. No other residents identified to be affected by this deficient practice. Initiated on 2/22/23 and ongoing, Review	4/12/23

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	315504	A. BUILDING _____ B. WING _____	03/03/2023

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F 760	Continued From page 18 NJ Ex Order 26. 4B1 . LPN #1 did not follow the five rights of medication administration by identifying the correct resident with the correct medications. The five rights include the following: the right resident, the right drug, the right dose, the right route, and the right time. The surveyor intervened before the medications could be administered to Resident #49. Interviews with LPN #1 revealed it was her NJ Ex Order 26. 4B1 at the facility. She was oriented to the facility's medication administration system and completed a medication pass competency on 01/31/23 at the facility prior to an assignment on the NJ Ex Order 26. 4B Unit medication cart. This incident posed a serious and immediate threat to all the residents on NJ Ex Order 26. 4B Unit. The immediate jeopardy (IJ) began on 02/22/23 at 8:37 AM and continued until 02/23/23. The U.S. FOIA (B)(6) were notified of the IJ on 02/22/23 at 3:10 PM. The failure of LPN #1 to follow the five rights of medication administration in accordance with professional standards of nursing practice that must be used to reduce the risk of medication errors and harm (identifying a resident prior to administering medications) constituted an Immediate Jeopardy situation. The failure to identify a resident prior to administering medications was likely to cause serious injury, harm, impairment, or death to the residents on the NJ Ex Order 26. 4B unit due to the risk associated with a resident receiving the wrong high-risk medications not prescribed to them by their physician or receiving a medication that may be associated with a medication allergy. An acceptable removal plan was received on 02/23/23 at 12:17 PM and verified by the survey	F 760	and updated medication administration policy & procedure, specifically to address proper identification of Resident. Initiated on 2/22/23 and ongoing re-education by the U.S. FOIA (B)(6) for all Nursing staff on emphasis on proper identification of resident prior to a medication administration; resident picture, ID band, if one of the 2 is not able to be identified a second staff member will be needed for identification prior to medication administration. Initiated on 2/22/23 and ongoing full audit was completed of resident□s as to proper identifiers in the medical chart and arm bands. All residents not found to have arm bands were replaced by 2/23/23 7am. Initiated 2/22/23 and ongoing, training on the 5 points of resident identification for medication error with emphasis made on; right patient, right medication, right dose, right time and right route, by the U.S. FOIA Initiated on 2/22/23 and ongoing, EHR audit of resident identifiers including pictures. Initiated on 2/22/23 and ongoing, medication passes will be performed for accuracy on identification of resident during medication administration, by the U.S. FOIA (B)(6) . Initiated on 2/22/23 and ongoing, 17 nurses will receive education over 3 shifts	

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	315504	A. BUILDING _____ B. WING _____	03/03/2023

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F 760	Continued From page 19 team on 02/23/23 and throughout the remainder of the survey. This deficient practice was evidenced by the following: On 02/22/23 at 8:06 AM, the surveyor observed LPN #1 during medication pass on the NJ Ex Order 26. 4B Unit. Resident #74, who was positioned by the bed near the window, did not have an identification (ID) band but was able to identify themself. LPN #1 then asked another U.S. FOIA (B) to identify Resident #74 by the resident's name. The surveyor observed LPN #1 open the Medication Administration Record (MAR) to prepare six (6) medications for Resident #74, which included the following: NJ Ex Order 26. 4B1 [redacted]. The surveyor observed LPN #1 bring a NJ Ex Order 26. 4B1 [redacted] device used to perform a NJ Ex Order 2 [redacted] solution bottle, medication cup #1 containing the NJ Ex Order 26. [redacted] and medication cup #2 containing NJ Ex Order 26. 4B1 [redacted] tablets into the resident's room. At 8:14 AM, LPN #1 administered the NJ Ex Order 26. 4B1 medication, handed medication cup #1 to Resident #74, and instructed Resident #74 to chew the NJ Ex Order 26. [redacted] tablet. LPN #1 used the NJ Ex Order 26. 4B1 to check the resident's NJ Ex Order 26. 4B1	F 760	on the above by 8:00am on 2/23/23, other scheduled nurses not already in-serviced will be in-serviced prior to their next assignment. By the U.S. FOIA (B)(6) [redacted] Initiated on 2/23/23 and ongoing, family of resident #49 notified of the near miss medication error. Resident #49 audited for resident identifiers, arm band and photo in PCC. Initiated on 2/22/23, U.S. FOIA NJ Ex Order 26. 4B1 [redacted] from the facility immediately following the incident. By the U.S. FOIA (B)(6) [redacted] Resident identification process upgraded to include new arm band with residents photo and verification of the 5 rights; the right patient, the right drug, the right time, the right dose, and the right route. Director of Nursing or designee will perform nurse competency on 2 nurses per shift for 30 days or until all nurses have been able to demonstrate proper identification of resident, the 5 rights of safe medication administration, medication administration accuracy, use of new identification ID bands with scanner for additional identifiers such as; name, room number, medical record number and photo and nurse coping skills. Audits will be submitted to the QA, QAPI Committee and the Administrator monthly X 3 months then quarterly thereafter.	

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F 760	Continued From page 20	F 760		

level, which read NJ Ex Order 26. 4B1 [redacted]. At this time, LPN #1 accidentally threw medication cup #2 into the garbage can while cleaning the resident's overbed table. The surveyor observed LPN #1 retrieve the medication from the garbage and exit the room to dispose of it.

On 02/22/23 at 8:37 AM, the surveyor observed LPN #1 prepare six medications for Resident #74. LPN #1 prepared NJ Ex Order 26. 4B1 [redacted]. LPN #1 went inside the resident's room, but there were no residents inside the room. LPN #1 then checked the NJ Exec Order 26.4b1 and there was one resident (Resident #49) inside. LPN #1 waited outside the bathroom for the resident to exit. After NJ Exec Order 26.4b1 the resident in the NJ Exec Order 26.4b1 a U.S. FOIA (B)(6) wheeled Resident #49 from the bathroom to the resident's bedside, which was located near the door.

The surveyor observed LPN #1 place the medication cups on the overbed table, take the NJ Ex Order 26. 4B1, and [redacted] to Resident #49. The surveyor further observed that LPN #1 did not identify the resident by asking for their name, by reading the resident's ID band, or by requesting another staff to identify the resident. LPN #1 proceeded to pull Resident #49's [redacted] up to expose the NJ Ex Order 26. 4B1 [redacted], which was ordered and prepared for Resident #74. The surveyor immediately stopped LPN #1 and asked her if this was the correct resident. The surveyor then observed LPN #1 check Resident #49's ID band, and LPN #1 stated, "[redacted]."

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	315504	A. BUILDING _____ B. WING _____	03/03/2023

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F 760	Continued From page 21 On 02/22/23 at 10:39 AM, the surveyor, in the presence of the survey team, discussed the medication pass concerns with the U.S. FOIA (B)(6) [redacted], and LPN #1. LPN #1 stated that the correct medication administration process was identifying the resident by checking the ID band. If the resident did not have an ID band, then you could get a U.S. FOIA [redacted] or another staff member to identify the resident. LPN #1 added that she could also look at the resident's picture on the electronic health record. LPN #1 stated that you should "triple check" for the rights of medication administration, including the right resident, the right drug, the right dosage, and the right route. LPN #1 further stated that during the medication pass observation, some of Resident #74's medications fell into the garbage and that once she poured the medications again that she became "NJ Exec Order 26.4b1 [redacted]." LPN #1 added that Resident #74 was originally in the room but had been taken out of the room to go to NJ Ex Order 26. 4B [redacted]. LPN #1 stated that she believed that Resident #49 was the resident she was originally working with and that her "NJ Ex Order 26. 4B1 [redacted]" to assisting Resident #49 because now, this was the only resident in the room. LPN #1 continued that she was about to give the resident an NJ Ex Order 26. 4 [redacted], but she stopped because the surveyor interrupted her. LPN #1 confirmed that she did not check Resident #49's ID band as she should have. Review of Resident #74's Admission Record (AR) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26. 4B1 [redacted]	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

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WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

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F 760	Continued From page 22	F 760		

NJ Ex Order 26. 4B1 .

Review of Resident #74"s NJ Exec Order 26.4b1 Order Summary Report (OSR) sheet revealed the following physician's orders:

1.) *NJ Ex Order 26. 4B1* tablet by mouth one time daily for *NJ Ex Order 26. 4B1* dated NJ Exec Order 26.4b1,
2.) *NJ Ex Order 26. 4B1* tablet by mouth every 12 hours for *NJ Ex Order 26. 4B1* dated NJ Exec Order 26.4b1
3.) *NJ Ex Order 26. 4B1* tablet by mouth every 12 hours for *NJ Ex Orde* dated NJ Exec Order 26.4b1,
4.) *NJ Ex Order 26. 4B1* tablet by mouth two times a day dated NJ Exec Order 26.4b1,
5.) *NJ Ex Order 26. 4B1* capsule by mouth two times a day dated NJ Exec Order 26.4b1,
6.) *NJ Ex Order 26. 4B1* time a day for supplement give *NJ Ex Order 2* dated NJ Exec Order 26.4b1,
7.) *NJ Ex Order 26. 4B1* in both eyes two times a day dated NJ Exec Order 26.4b1, and
8.) *NJ Ex Order 26. 4B1* before meals and at bedtime dated NJ Exec Order 26.4b1, with the following NJ Exec Order 2 instructions:
0NJ Exec Order 26.4b1 and to call MD [medical doctor] if NJ Exec Order 26.4b1] is NJ Exec Order NJ Ex or NJ Exec Order 26.4b1.

Review of Resident #74's NJ Exec Order 26.4b1 Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a brief interview for mental status (BIMS) score of NJ Ex out of 15, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 760	Continued From page 23	F 760		

indicated that the resident was NJ Ex Order 26. 4B1.

Review of Resident #74's interdisciplinary care plan (IDCP), dated NJ Exec Order 26.4b1, revealed under a focus area of at NJ Ex Order 26. 4B1 .

Review of Resident #49's AR indicated that the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26. 4B1

Review of Resident #49"s NJ Exec Order 26.4 NJ Ex Order OSR revealed the following orders to be administered at 9 AM:

1.) NJ Ex Order 26. 4B1 tablet by mouth two times a day dated NJ Exec Order 26.4b1,
2.) NJ Ex Order 26. 4B1 tablet by mouth two times a day dated NJ Exec Order 26.4b1,
3.) NJ Ex Order 26. 4B1 tablet by mouth two times a day dated NJ Exec Order 26.4b1,
4.) NJ Ex Order 26. 4B1 tablet by mouth once a day dated NJ Exec Order 26.4b1,
5.) NJ Ex Order 26. 4B1 by mouth one time a day dated NJ Exec Order 26.4b1
6.) NJ Ex Order 26. 4B1 tablet by mouth once a day dated NJ Exec Order 26.4b1
7.) NJ Ex Order 26. 4B1 applied to NJ Ex Order 26. 4B1 topically once a day dated NJ Exec Order 26.4b1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 760	Continued From page 24 There was no evidence from the corresponding OSR sheets for [NJ Exec Order 26.4] [NJ Ex Order] that Resident #49 was receiving any of the same morning medications as Resident #74. Review of Resident #49's [NJ Exec Order 26.4b] Annual MDS reflected that the resident had a BIMS score of [NJ] out of 15, indicating that the resident had [NJ Ex Order 26. 4B1]. Review of Resident #49's IDCP, initiated date [NJ Ex Order 26. 4B1], revealed a focus area of "[NJ Ex Order 26. 4B1]." On 02/22/23 at 10:59 AM, in the presence of the survey team, the [U.S. FOIA (B)(6)] stated the process to identify a resident when administering medication to was to check the resident's ID band, get a nurse to identify the resident, or if the resident was [NJ Exec Order 26.4b1] have the resident identify themselves. The [U.S. FOIA (B)(6)] stated that safety was the most important thing in medication administration and that "you could kill them if you give the wrong medication." The [U.S. FOIA (B)(6)] continued that she identified Resident #74 during the medication pass observation for LPN #1 and that Resident #49 was in the room the entire time. On 02/22/23 at 11:06 AM, the [U.S. FOIA (B)] stated, in the presence of the survey team, that nurses administering medications were expected to identify the proper resident, check the picture in the electronic health record, and the resident's name band. The [U.S. FOIA (B)] stated that giving the right medication to the right resident was to "do no harm" and not cause adverse effects. The [U.S. FOIA (B)] stated that LPN #1 should have identified the	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 760	Continued From page 25 correct resident before attempting to give medications. Review of the facility's policy titled "Medication Administration-Policy," dated as reviewed/revised on 01/2023, provided by the [redacted] revealed under "Step 1 Identity Resident" " Step 5 Identify the resident by name and identification system (bracelet, photograph in PointClickCare (PCC), or with another staff member)." Review of the facility's policy titled "Insulin Administration" dated 01/2023, provided by the DON, revealed under "Procedure for administering insulin using an insulin pen 1. Performs the six rights and 3 point medication check."	F 760		
F 880 SS=F	N.J.A.C. 8:39-11.2 (b) 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,	F 880		4/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880	Continued From page 26	F 880		

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 §483.70(e) 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880	Continued From page 27 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, and review of pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate infection control practices for proper hand hygiene during meal observation in 1 of 1 resident dining rooms (Main Dining Room), b.) ensure staff wore appropriate proper personal protective equipment (PPE) for a resident on *NJ Ex Order 26. 4B1* , and c.) provide proper hand hygiene and proper infection control practices for 1 of 3 nurses observed during medication adminsitration. This deficient practice was identified on 1 of 3 nursing units (*NJ Ex Order 26. 4B*). This was cited at a level F as the deficient practice was cited at the last standard survey of 01/20/21. The deficient practice was evidenced by the following: 1. On 02/14/23 at 12:24 PM, the surveyor observed staff serve lunch to residents in the Main Dining Room.	F 880	DPOC The Facility will conducted a thorough Root Cause Analysis (RCA) as related to Infection Prevention. All policy and procedures for Infection Prevention with emphasis on Hand hygiene during meal service have been reviewed and updated and will be disseminated to all staff. Staff education and competencies are ongoing for Employees on hand hygiene during meal service. Adequate and sufficient availability of hand hygiene supplies to be made conveniently available to all staff. All nursing staff competencies were performed by the *U.S. FOIA (B)(6)* for proper hand hygiene procedures to include hand hygiene demonstration with emphasis on the proper washing time. All Infection Prevention policy and procedure with emphasis on Enhanced Barrier Precautions as to appropriateness	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880	Continued From page 28 On 02/14/23 at 12:25 PM, the surveyor observed the U.S. FOIA (B)(6) (CNA #1) deliver Resident #16's lunch tray. CNA #1 used the resident's utensils to NJ Ex Order 26. 4 resident's meat and put a straw in the resident's juice. The surveyor observed that CNA #1 did not perform hand hygiene after she finished assisting Resident #16 and before she began assisting the next resident. On 02/14/23 at 12:28 PM, the surveyor observed CNA #1 carry a lunch tray, place it down on the table, and set up the meal for Resident #68. CNA #1 used the resident's utensils to NJ Ex Order 26. 4B1 on the tray, cut open a banana, put creamer in the resident's coffee, and fed 2 forkfuls of food to the resident. The surveyor observed that CNA #1 did not perform hand hygiene after she finished assisting Resident #68 and before she began assisting the next resident. On 02/14/23 at 12:30 PM, the surveyor observed CNA #1 carry a lunch tray and place it down on the table in front of Resident #32. CNA #1 moved a NJ Exec Order 26.4b1 that was sitting on the table near the resident, unlocked the NJ Exec Order 2 of Resident #32's wheelchair, touched the handles of the resident's wheelchair to NJ Exec Order 26.4b1 the resident and get them closer to the table. The surveyor observed that CNA #1 moved a surgical face mask that was on the table away from Resident #32 then proceeded to set up the resident's meal including uncovering their food items and using the resident's utensils to cut their food without peforming hand hygiene. The surveyor observed that CNA #1 did not perform hand hygiene after she finished NJ Exec Order 26.4b1 Resident #32 and before she began NJ Exec Order 26.4b1 the next resident. On 02/14/23 at 12:32 PM, the surveyor observed	F 880	of donning and doffing of PPE□s will be updated and reeducating of all staff of proper use and technique for PPE□s. Nursing,IP and Administrative staff will perform daily rounds and utilize audit tools to monitor adherence to infection Prevention standards specifically related to Infection Prevention hand hygiene during meal service and PPE donning and doffing compliance for enhanced barrier precautions. Administrative and Infection Prevention staff will report to the QAPI committee on a monthly basis to review compliance and adherence to standards related to Infection Control and prevention and the plan of correction. Training specifics; 1- CDC: Implementation and use of Enhanced Barrier Precautions in Nursing Homes 2- CDC FAQ: Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of MDROs 3- CDC: Donning and Doffing of PPE 4- CDC: Keeping Hands Clean 5- CDC: Fight Germs; Wash your Hands	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880	Continued From page 29 CNA #1 carry a lunch tray, place it down on the table, and set up the meal for Resident #30. CNA #1 uncovered the resident's plates and used the resident's utensils to chop up their food. The surveyor observed that CNA #1 did not perform hand hygiene after [redacted] Resident #30. On 02/14/23 at 12:34 PM, the surveyor stopped CNA #1 from serving any additional residents and interviewed CNA #1 at this time. The surveyor stated that she observed her touch several resident's lunch trays, utensils, food items, and personal items without performing hand hygiene in between residents. CNA #1 stated that her practice was to wash her hands before she started to serve resident's their lunches and to wash them again once she finished serving lunch to all the residents. On 02/22/23 at 12:32 PM, the surveyor interviewed the [redacted] stated that it was not acceptable to go from resident to resident and touch their trays and personal items without performing hand hygiene in between residents. On 02/24/23 at 9:51 AM, the surveyor interviewed the [redacted] stated that hand hygiene should be done between residents when serving residents and touching their items and trays. 2. On 02/14/23 at 12:03 PM, the surveyor observed Resident #57 lying in bed wearing a hospital gown and interviewed the resident at that time. Resident #57 stated that he/she had a [redacted] near their [redacted] and that was why he/she was at the facility	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880		F 880		

Continued From page 30
for NJ Ex Order 26. 4B1.

On 02/14/23 at 12:07 PM, the surveyor reviewed the hybrid electronic and paper medical record for Resident #57.

The Admission Record revealed that Resident #57 was admitted to the facility with diagnoses which included but were not limited to:
NJ Ex Order 26. 4B1

The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1, revealed that Resident #57 had a Brief Interview of Mental Status Score of NJ Ex out of 15 which indicated that the resident was NJ Ex Order 26. 4B1. The MDS also indicated that the resident had a NJ Ex Order 26. 4B1.

The Order Summary Report indicated that the resident had a NJ Exec Order 26.4b1 active order for 'NJ Ex Order 26. 4B1.

The NJ Exec Order 26.4b1 care plan for Resident #57 revealed a focus of "NJ Ex Order 26. 4B1: Resident #57 has an NJ Ex Order 26. 4B1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880	Continued From page 31	F 880		

NJ Ex Order 26. 4B1 [redacted]

On 02/16/23 at 11:06 AM, the surveyor entered Resident #57's room with the *U.S. FOIA (B)(6)* [redacted] and CNA #2. The surveyor observed a sign posted on the resident's cabinet which indicated, "*NJ Ex Order 26.* [redacted]", "*NJ Ex Order 26. 4B1* [redacted]", "*NJ Ex Order 26. 4B1* [redacted]."

On 02/16/23 at 11:07 AM, the surveyor observed the *U.S. FO* [redacted] perform *NJ Ex Order 26. 4B1* [redacted] for Resident #57 with the assistance of CNA #2. The surveyor observed that both the *U.S. FO* [redacted] and CNA #2 wore N-95 respirator face masks and donned (put on) gloves. The surveyor observed that the *U.S. FO* [redacted] and CNA #2 *NJ Exec Order 2* [redacted] the resident, then the *U.S. FO* [redacted] removed the resident's *NJ Ex Order 26. 4B1* [redacted] and applied a *NJ Exec Order 26.4B1* [redacted] to the resident's *NJ Ex Order 26.* [redacted]. The *U.S. FO* [redacted] stated that she needed to medicate Resident #57 before proceeding with *NJ Ex Order 26.* [redacted] care and left the resident's room. CNA #2 stated that she would do the resident's morning care at this time because she was already in the room. The surveyor observed the *U.S. FOIA (* [redacted] gather supplies, then removed the resident's *NJ Ex Order 26. 4B1* [redacted], and changed the resident's linens.

On 02/16/23 at 11:28 AM, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880	Continued From page 32	F 880		

interviewed the [U.S. FOI]. The [U.S. FOI] stated that Resident #57 was on [U.S. FOIA] because of *NJ Ex Order 26. 4B1*. The [U.S. FOI] stated that she performed [NJ Ex Order 26.4] care for the resident and that she should have worn a gown in addition to the mask and gloves while caring for the resident because they were on [NJ Ex Orde]. The [U.S. FOI] stated that the importance of wearing the appropriate PPE was to protect both herself and the resident.

On 02/16/23 at 11:36 AM, the surveyor interviewed CNA #2. CNA #2 stated that she changed Resident #57's hospital gown, [NJ Ex Order 26. 4B1] the resident, and changed the resident's bed sheets. CNA #2 stated that she was, "[NJ Ex Order 26. 4B1]" if Resident #57 was on [NJ Ex Orde] or not. The surveyor stated that Resident #57 had an order for *NJ Ex Order 26. 4B1*. CNA #2 stated that she should have worn a gown while assisting with [NJ Ex Order 26.] care and when *NJ Ex Order 26. 4B1* the resident.

On 02/17/23 at 11:16 AM, the surveyor interviewed the *U.S. FOIA (B)(6)* stated that when staff did, "hands on care", including [NJ Ex Order 26.] care, [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1 for Resident #57 that they should wear a face mask, gloves, and a gown. The *U.S. FOIA (B)(6)* stated that the *NJ Ex Order 26. 4B1* could potentially leak and that wearing a gown as well as gloves protected both the staff member and the resident.

On 02/24/23 at 9:51 AM, the surveyor reviewed the above observations with the *U.S. FOIA (B)(6)* stated that because the resident was ordered to have *NJ Ex Order 26. 4B1* that a gown should have been worn by the [U.S. FOI]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880	Continued From page 33 and CNA #2 .	F 880		

3. On 02/22/23 at 7:50 AM, during morning medication administration pass, the surveyor observed LPN #1 knock on the resident's door, check the resident's identification band, then proceed to the bathroom to wash her hands. LPN #1 turned on the water faucet, applied soap to both hands, rubbed both hands together under running water for total of 11 seconds, dried both hands with a paper towel and then took another paper towel to turn off the faucet.

On 02/22/23 at 8:06 AM, the surveyor observed LPN #1 go into the bathroom to perform handwashing. LPN #1 turned on the faucet, pumped soap from the dispenser then washed her hands under running water then again pumped additional soap from the dispenser and lathered her hands for a total of 9 seconds. She then rinsed her hands with water, took a paper towel to dry both hands then used another paper towel to turn off the faucet.

On 02/22/23 at 8:14 AM, the surveyor observed LPN #1 donned (applied) gloves, administered NJ Ex Order 26. 4B1 to a resident's eyes. She then accidentally threw the rest of resident's oral medication into the garbage can. LPN #1 took the garbage can from the floor and placed it on top of the resident's blanket on the bed to retrieve the medications from inside the garbage can.

On 02/23/23 at 10:37 AM, the surveyor interviewed LPN #2 on the proper procedure for handwashing. LPN #2 stated that she would turn

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 880	Continued From page 34	F 880		

the faucet on to get water, check the temperature so that it is not too hot or too cold, apply soap, lather her hands for 20 seconds, rinse her hands, use a paper towel to dry both hands, then another paper towel to turn off the faucet.

On 02/23/23 at 10:45 AM, the surveyor interviewed LPN #3 about the proper procedure for handwashing. LPN #3 stated that she would first turn on the water and make sure it was warm, apply soap, wash hands for 20 seconds, then rinse hands, get a paper towel to dry her hands and then another paper towel to turn the faucet off.

The facility policy titled "Hand Washing and Hand Hygiene," with an updated date of January 2023, revealed that the proper hand washing method was to, "scrub the hands for at least 20 seconds." The facility policy also revealed that a hand washing/ hand hygiene indication was, "Before preparing or serving food."

The facility policy titled, "Enhanced Barrier Precautions," with an updated date of 01/2023, revealed that "Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO during specific high-contact resident care activities."
"High-contact resident care activities include: dressing, bathing/ showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	**3419 HIGHWAY 9 FREEHOLD, NJ 07728**

(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 880	Continued From page 35 NJAC 8:39-19.4 (a)(m)(n)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13004	A. BUILDING: _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 10 of 14 day shifts reviewed and b) ensure all staff complied with applicable state rules and regulations with regard to the New Jersey Department of Health (NJDOH) Vaccination Mandate for COVID-19, as 40 of 93 staff members were identified as deficient for COVID-19 vaccination booster status. This deficient practice was evidenced by the following:	S 560	The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls made by the shift supervisor to fill the shift. Facility has documented evidence to reflect facility□s Recruitment and Retention Efforts in its relentless attempts to comply with the staffing ratios. No residents have been adversely affected. All residents have the potential to be affected by this situation. Facility□s Recruitment and Retention Strategies and Efforts to comply with the	4/20/23

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

Electronically Signed | 03/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13004	A. BUILDING: _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 1.) Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified 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 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer 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 direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested staffing for the weeks of 01/29/2023 to 02/04/2023 and 02/05/2023 to 02/11/2023. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -01/29/23 had 10 CNAs for 103 residents on the day shift, required 13 CNAs. -01/30/23 had 12 CNAs for 101 residents on the day shift, required 13 CNAs.	S 560	State□s Staffing Ratios have been in progress, which include but are not limited to the following: Offer Sign on bonuses to attract staff, Recruitment bonus to encourage referrals from current staff, Offering daily and weekend bonuses to attract overtime or PRN staff shifts, Aggressively running ads in various social media, Currently have contracts with multiple staffing agencies Director of Nursing or designee will provide monthly audits to the Administrator or designee regarding all efforts made to try to comply with the State□s Staffing Ratios. Audits will be submitted to the QAPI Committee monthly X 3 months then quarterly thereafter. Assistant Administrator will submit monthly audits to the Administrator to document the status of all recruitment efforts. This will be reported monthly to the QAPI Committee X 3 months then quarterly thereafter. The facility actively provides education and encourages all employees on the importance and the requirements of the COVID-19 booster as stated in the Executive Directive 294. The facility recognizes that all residents, employees and visitors have the potential of being affected by the deficient practice. All staff that have not received the booster dose of the COVID-19 vaccine will be provided with education by the Infection Preventionist, Medical Director and	

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	13004	A. BUILDING: _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

(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 -01/31/23 had 11 CNAs for 101 residents on the day shift, required 13 CNAs. -02/02/23 had 11 CNAs for 94 residents on the day shift, required 12 CNAs. -02/04/23 had 9 CNAs for 94 residents on the day shift, required 12 CNAs. -02/05/23 had 8 CNAs for 94 residents on the day shift, required 12 CNAs. -02/06/23 had 11 CNAs for 95 residents on the day shift, required 12 CNAs. -02/09/23 had 11 CNAs for 95 residents on the day shift, required 12 CNAs. -02/10/23 had 11 CNAs for 94 residents on the day shift, required 12 CNAs. -02/11/23 had 8 CNAs for 93 residents on the day shift, required 12 CNAs. During an interview with the surveyor on 02/23/23 at 1:15 PM, the Staffing Coordinator/Receptionist (SC/R) stated she was aware of the state CNAs staffing ratios and that the facility was usually meeting them. During an interview with the surveyor on 02/23/23 at 1:40 PM, the Director of Nursing (DON) stated she was aware of the state CNAs staffing ratios and "I do believe we are meeting them based on our census." She further stated that staffing was a group effort with the SC/R, the Assistant Administrator (AA) and herself. The DON stated they meet on Tuesdays, Wednesdays, and Fridays to address staffing needs. During a meeting with the survey team and the DON on 02/24/23 at 12:23 PM, the AA stated she was aware of the state CNAs staffing ratios. She then stated, "We are always working on it. The 7AM to 3PM shift was usually the struggle, but they were meeting them 90% of the time."	S 560	Infectious Disease Physician. COVID-19 booster vaccination clinics will be offered monthly. The facilities COVID-19 vaccination policy and procedure have been updated to reflect the best practices for encouraging, tracking and documenting the education. IP will monitor and update all required logs for tracking staff vaccinations as proof of vaccinations is provided from the employee and as receive additional vaccinations or medical exempt forms are provided in real time. Findings will be reported to the QA, QAPI Committee and the Administrator until all staff are up to date with provided proof of vaccination status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13004	A. BUILDING: _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 A review of facility's policy, "Staffing" with a revised date of January 2023, revealed Policy Statement: Our facility provides adequate staffing to meet needed care and services for our resident population; Policy Interpretation and Implementation: 2. Our facility will staff according to the NJ DOH staffing ratios. 2.) Reference: New Jersey Executive Directive 294, dated 4/13/22: All covered workers must provide adequate proof that they have received their first booster dose by April 11, 2022, or within 3 weeks of becoming eligible for their first booster dose, whichever is later. On 02/14/23 at 11:47 AM, the surveyor conducted an Entrance Conference with the Administraor, AA, and the DON. The surveyor requested the vaccination status of the facility's employees. During an interview with the surveyor on 02/16/23 at 9:51 AM, the AA stated that not all staff members received booster vaccines for COVID-19, because there was resistance from staff to receive them, and that she could not force the employees to receive the booster. During an interview with the surveyor on 02/23/23 at 12:41 PM, the Registered Nurse/ Infection Preventionist acknowledged that several staff members did not have at least one COVID booster vaccine. On 02/24/23 at 8:46 AM, the surveyor reviewed the Employee COVID-19 Vaccination Matrix provided by the facility. This matrix revealed that 40 staff members did not receive COVID-19 booster vaccinations by 04/11/22 or within three weeks of being eligible.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13004	A. BUILDING: _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 4 During a follow-up interview with the surveyor on 02/24/23 at 9:51 AM, the AA stated that the COVID-19 Vaccination Matrix was updated and accurate. No further information was provided as to why there were 40 staff members at the facility that did not receive the COVID-19 booster as required. A review of the facility policy, "COVID-19 Vaccine" with a review date of October 2022 indicated that staff will be educated on the importance of the available COVID-19 booster shots via COVID vaccination clinics and information from the CDC and the local health department. The facility policy failed to reveal that staff were required to receive the COVID-19 booster.	S 560		

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
315504 Y1	A. Building B. Wing Y2	4/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

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 F0641	Correction	ID Prefix F0732	Correction	ID Prefix F0755	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	04/12/2023	LSC	04/12/2023	LSC	04/12/2023
ID Prefix F0759	Correction	ID Prefix F0760	Correction	ID Prefix F0880	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(f)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/12/2023	LSC	04/12/2023	LSC	04/12/2023
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?
3/3/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13004 Y1	A. Building B. Wing Y2	4/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/20/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/3/2023	☐ 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
	315504	A. BUILDING **01** B. WING _____	**03/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	**3419 HIGHWAY 9** **FREEHOLD, NJ 07728**

(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 000	INITIAL COMMENTS The nursing home building construction was stated to be 2008 with no current major renovations or noted additions. It is a two story building Type I (222) fire resistant construction and is fully sprinklered. The exterior 100 KW diesel generator does approximately 90% of the building. The facility is divided into 9 smoke-zones. There are 3-wings: Rose, Iris and Garden. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 151 certified beds. At the time of the survey the census was 90. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 291	Emergency Lighting	K 291		4/12/23

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

Electronically Signed | 03/24/2023

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
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K 291 SS=E	Continued From page 1 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/03/23, in the presence of the U.S. FOIA (B)(6) [redacted], it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified on 1 of 1 transfer switches and was evidenced by the following: At 10:07 AM, the surveyor, in the presence of the U.S. FOIA (B)(6), observed 1-transfer switch in the Rose unit electrical room. The room was not equipped with battery back-up emergency lighting. The U.S. FOIA (B)(6) both confirmed the findings at the time of the observations. The U.S. FOIA (B)(6) was informed of the findings at the Life Safety Code exit on 03/03/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	There was no harm to the residents due to the deficient practice. Emergency battery operated lighting in the area of the generator power panel is scheduled for installation, in the facilities electrical room and will provide a 1 ¿ hour lighting duration in the event of power loss. The Maintenance Director or designee will conduct checks of the emergency lighting during the scheduled Preventative Maintanence generator load test to ensure it is functioning properly. Testing will occur weekly for the first 4 weeks with a target of 100% compliance. If target is met, random checks will occur once every two weeks, for the following two months with results presented to the QA and QAPI Committee and Administrator for review monthly for 3 months to ensure desired outcomes are met and sustained.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		4/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 2 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/03/23, in the presence of the U.S. FOIA (B)(6) [redacted], it was determined that the facility failed to perform and document on the tag attached to the fire extinguisher, a monthly visual examination for 5 of 19 fire extinguishers observed. This deficient practice was evidenced by the following: 1). The corridor extinguisher outside the kitchen tag: blank 2). The extinguisher outside resident room 202 tag: missing february inspection 3). The extinguisher by the receptionist desk tag: blank 4). The extinguisher outside resident room 127 tag: missing february inspection 5). The extinguisher in the Rose unit closet observed on the floor in a cardboard box tag: blank The U.S. FOIA (B)(6) confirmed the findings during the observations. The U.S. FOIA (B)(6) was informed of the findings at the Life Safety Code exit conference on 03/03/2023.	K 355	The Maintenance staff immediately reinspected all fire extinguishers in the facility and marked each tag as inspected. Maintenance staff were in-serviced that all fire extinguisher must be inspected and the inspection tags must be signed each month. Preventive Maintenance & Scheduling will be followed reflecting the monthly and annual testing of the fire extinguishers. The Maintenance and Environmental Director will monitor all testing and report the findings to the QA and QAPI Committee and Administrator for a period of six (6) months for compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 355	Continued From page 3 NJAC 8:39-31.2(e) NFPA 10, Standard for Portable Fire Extinguishers.19.3.5.12, NFPA 10	K 355		
K 522 SS=F	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 03/02/23, in the presence of the U.S. FOIA (B)(6) [redacted], it was determined that the facility failed to ensure that 4 of 4 boilers were provided with certificates of inspection. The deficient practice was evidenced by the following: At 10:30 AM, the surveyor observed the facility boiler documentation, dated 01/09/23, from the State of New Jersey Bureau of Boiler and Pressure Vessel Compliance. The document indicated "Notice of Violation(s) and order of the Commissioner to Abate Violation(s)" Violation Date: 01/09/2023 Comply by: 02/08/2023	K 522	The 4 boilers failed inspection on January 3, 2023. A 60 day extension was requested on February 3, 2023. Boilers scheduled for repair Boilers are inspected daily, logs are maintained to check the function of the of the boilers. Logs monitored by the Administrator weekly.	4/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING **01** B. WING _____	**03/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	**3419 HIGHWAY 9** **FREEHOLD, NJ 07728**

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K 522	Continued From page 4 Violation # NJ 130019-08H: The mechanical and/or strutural integrity of the boiler piping system in question NJ 130020-08H: The mechanical and/or strutural integrity of the boiler piping system in question NJ 130158-09U: Pressure Vessel Piping System Violation NJ 130990-09U: Pressure Vessel Piping System Violation The U.S. FO provided a document from the facility to the State of New Jersey Bureau of Boiler and Pressure Vessel Compliance indicating a request for an extension of 60 days to abate the above violations. No further documents were provided. An interview was conducted with the U.S. FOIA (B)(6) while reviewing documentation. The U.S. FOIA (B)(6) stated they asked for a 60 day extension and provided no further documentation for review. The U.S. FOIA (B)(6) was informed of the findings at the Life Safety Code exit conference on 03/03/23.	K 522		
K 712 SS=F	NJAC 8:39-31.2(e) Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded	K 712		4/12/23

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K 712	Continued From page 5 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 03/02/23, in the presence of the U.S. FOIA (B)(6) [redacted], it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced by the following: Based on document review and interview on 03/02/23, with the U.S. FOIA (B)(6), the facility fire drill reports revealed method for the simulation of emergency fire conditions were not varied and specific to location on 12 of 12 fire drills: Date Type of alarm transmission: Pull, Smoke or Page - 02/04/23 Smoke, Garden unit - 01/29/23 Smoke, Electrical fire, Page - 12/28/22 Smoke, Admissions - 11/20/22 Smoke, Electrical fire, 2nd floor office? - 10/12/22 Electrical fire, 2nd floor Admissions office, Page - 09/15/22 Smoke, Laundry - 08/05/22 Smoke, Lobby area, Covid Restrictions? - 07/23/22 Smoke, Lobby, Page - 06/12/22 Electrical fire, Dietary - 05/27/22 Heavy Smoke, Laundry - 04/25/22 Smoke, Electrical fire, Page - 03/29/22 Smoke, Physical Therapy, Page	K 712	The contracted company was made aware of the deficient practice and of the requirements for the simulation of the fire drills by the Assistant Administrator and the contract was ended on March 8, 2023. No residents were affected by this violation. A new company has been contracted as of March 3, 2023. Monthly audits for drill simulation will be conducted to monitor for compliance by the Environmental Service Director for 6months. The results of these reviews will be presented to the QA & QAPI committee and Administrator to ensure compliance and to determine if further action is deemed necessary for 3 months.	

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K 712	Continued From page 6 An interview was conducted with the U.S. FOIA (B)(6), after documentation review, where they stated and confirmed the findings that currently fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions were not varied and specific to areas documented on the form. Ten of Twelve fire drills were smoke related, but did not indicate what was causing the (Simulated) smoke/fire condition. The U.S. FOIA (B)(6) was informed of the finding at the Life Safety Code exit conference on 03/03/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are	K 914		4/12/23

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K 914	Continued From page 7 maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 03/03/23, in the presence of the facility's U.S. FOIA (B)(6) [redacted] it was determined that the facility failed to functionally test electrical receptacles in residents' rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 65 of 76 resident rooms and observed by the following: From approximately 9:30 AM to 1:30 PM, the surveyor, U.S. FOIA (B)(6) observed that the resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. An undated document provided by the U.S. FO [redacted] from the electric vendor, indicated the facility had 11 hospital grade outlets in (NJ Ex C [redacted] unit) resident rooms : NJ Ex Orde 26 [redacted]. The last electrical inspection dated 08/25/22, "Electrical Certification" indicated an electrical inspection of equipment and devices were performed at the above referenced building and were found to be in safe working order. The inspection did not specify what rooms had hospital grade and non-hospital outlets and did not indicate specific functionally test of electrical receptacles in residents' rooms annually for grounding, polarity, and blade tension in	K 914	No Resident was directly affected by the deficient practice, all receptacles were inspected throughout the facility on August 25, 2022. The annual electrical inspection will provide a detailed report of the grounding, polarity and blade tension and will be reviewed by the U.S. FOIA (B)(6) for compliance annually. The U.S. FOIA (B)(6) has been sent the full regulation as to what needs to be completed in the reports. The results of these reviews will be presented to the QA & QAPI committee meeting to ensure compliance and to determine if further action is deemed necessary for 3 months.	

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K 914	Continued From page 8 accordance with NFPA 99. The U.S. FOIA (B)(6) indicated they were not aware of any non-hospital grade outlet testing procedures that had to be preformed annually. The U.S. FOIA (B)(6) was informed of the findings at the Life Safety Code exit conference on 03/03/23. NJAC 8:39-31.2(e) NFPA 99	K 914		
K 918 SS=F	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 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	K 918		4/12/23

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K 918	Continued From page 9 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 03/02/23, in the presence of the U.S. FOIA (B)(6) [redacted] it was determined that the facility failed to: a.) ensure a remote manual stop station on 1 of 1 of generator and 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 was evidenced on 1 of 1 generator. b.) The facility failed to ensure the generator was exercised under load for 30 minutes, 12 times a year in 20-40 day intervals. The deficient practice could affect all residents and was evidenced on 12 of 12 monthly load test's for 2022 on the provided log and by the following: A). At 10:05 AM, the surveyor, U.S. FOIA (B)(6), observed the exterior 100 kw (kilowatt) Kohler generator. There was a remote manual stop station inside the cabinet, but there was no remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover. An interview was conducted during the time of the observation with the U.S. FOIA (B)(6), who both	K 918	There was no harm to the residents due to the deficient practice. The facility recognizes that all Residents, employees and visitors have the potential of being affected by the deficient practice (a) The remote generator switch installation has been installed on March 24, 2023. (b) The U.S. FOIA (B)(6) was re-educated on the importance of filling out the generator load test log to its entirety to be in compliance with the regulation. Generator logs will be audited on a monthly basis x6 months by the Environmental Director. The results of these reviews will be presented to the QA & QAPI committee and the Administrator to ensure compliance and to determine if further action is deemed necessary for 3 months.	

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K 918	Continued From page 10 confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover. B). At 10:30 AM, the surveyor observed the monthly emergency generator tour log report provided by the U.S. FOIA (B)(6). The report indicated the following months: January, February, March, April, May, June, July, August, September, October, November, and December 2022, that the run times were not being logged to indicate how long the generator was being tested monthly. The entire year the run time on was filled out as zero on the report provided. The U.S. FOI indicated he was not sure why this happened and stated the reports were filled out by another Maintenance staff member who was no longer working at the facility. The U.S. FOIA (B)(6) was informed of the finding's at the Life Safety Code exit conference on 03/03/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315504 Y1	A. Building 01 - WEDGEWOOD GARDENS CARE CENTER B. Wing Y2	4/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

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		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0291	04/12/2023	LSC	K0355	04/12/2023	LSC	K0522	04/12/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0712	04/12/2023	LSC	K0914	04/12/2023	LSC	K0918	04/12/2023
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	
3/3/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO