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 _____	C 03/19/2025

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 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Complaint #'s: NJ165593, NJ165671, NJ174138, NJ176421and NJ181604. Survey Dates: 03/10/25-03/13/25 Survey Census: 92 Sample Size: 26 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys,	F 577		4/30/25

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

Electronically Signed | 04/10/2025

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

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F 577	Continued From page 1 certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of the monthly resident council meeting minutes, interview, and facility policy review, the facility failed to ensure the State survey inspection results were readily accessible to residents and/or family members and posted in areas of the facility that are prominent and accessible to the public. This failure had the potential to affect all 92 residents residing in the facility. This had the potential to cause residents and visitors to be uninformed of survey, certification, and complaint investigation findings. Findings include: Review of the facility's policy titled, "Resident Rights," revised 02/18/25, indicated, "The resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and . . . The facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. Have reports with respect to any surveys, certifications, and complaint investigations made reports the	F 577	All Residents have been informed of the location and posting of the facility survey results. This has been accomplished by resident council meeting, resident rights bingo and the facility admission agreement and facility postings. All resident had the potential to be affected. This has been accomplished by discussing in resident council, our monthly resident's rights bingo, the facility admission agreement, new resident welcome packet and facility postings. The Assistant Administrator, or designee will ensure the Survey results are present and up to date during daily rounds x1 month. Residents will be survived on a quarterly basis for adherence. QI monitoring system will be implemented and reported to the QA and QAPI committee.	

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F 577	Continued From page 2	F 577		

facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available to any individual to review . . . and post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public . . ."

Review of the past three months of the Resident Council Meeting Minutes, dated 11/21/24, 01/23/25, and 02/19/25, revealed no documentation that the State survey inspection results were discussed with residents or where the information was posted for residents to review.

During a Resident Council Meeting held on 03/10/25 at 3:03 PM, with the resident council president Resident (R) 15, when asked if the resident knew where the State survey inspection results were posted, R15 stated, "No, they do not cover that information with us. I'm not sure where the survey results would be."

During an observation on 03/11/25 at 10:36 AM, of the entire Garden Unit, including the entrance way, nursing station, and hallway, there was no evidence of the State survey results posted anywhere.

During an observation on 03/11/25 at 10:38 AM, of the front entrance of the facility, including the sitting area, front reception area, activity dining room, family room, and library, there was no evidence of the State survey results posted anywhere.

During an observation on 03/11/25 at 10:41 AM, of the Iris Unit, including the entrance way, nursing station, and hallway, there was no

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F 577	Continued From page 3 evidence of the State survey results posted anywhere. During an observation on 03/11/25 at 10:50 AM, of the Rose Unit, including the entrance way, nursing station, and hallway, there was no evidence of the State survey results posted anywhere. During an interview on 03/12/25 at 3:29 PM, the U.S. FOIA (b) (6)) was asked where the State survey inspection results were posted. The U.S. FOIA (b) stated, "It's at the front desk." During an observation and interview on 03/12/25 at 3:32 PM, observation was made of the front entrance with the U.S. FOIA (b), and there was no evidence of the State survey inspection results. At this time, the U.S. FOIA (b) stated to the front receptionist, who was seated behind a large, enclosed plexiglass area at the front entrance where the "Survey Book" was. The U.S. FOIA (b) (6) stated, "It's here," indicating the State survey inspections results were located behind the U.S. FOIA (b)(6) desk that was enclosed with a large area of plexiglass, on the left side of the reception desk next to the computer. At this time, the U.S. FOIA (b) stated to the U.S. FOIA (b)(6), "They should be here [pointing to the front top of the reception desk area] where they are visible." At this time, the U.S. FOIA (b) was asked if she considered the area where the survey inspection results were found behind the reception desk by the computer to be in a prominent location for residents and/or visitors/family members to read. The U.S. FOIA (b) stated, "No." During an interview on 03/12/25 at 3:45 PM, regarding the State inspection survey results, the	F 577		

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F 577	Continued From page 4 Receptionist (REC1) stated, "I've been here since [redacted]. I work Monday through Friday, and ever since I've been here, that survey binder has always been right here right next to me. Behind this desk and next to my computer where I sit." During an interview on 03/13/25 at 8:52 AM, regarding the State inspection survey results, the [redacted] stated that he was present at the 02/19/25 Resident Council meeting. He was asked if the information about where the State survey inspection results were posted was discussed with the residents. He stated, "No, but we will be doing that in March at our next meeting."	F 577		
F 583 SS=D	NJAC 8:39-9.4(b) Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583		4/30/25

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F 583	Continued From page 5 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure the privacy of health information for one of two residents (Resident (R) 71) that tested NJ Ex Order 26.4(b)(1) out of a total sample of 26. This failure had the potential to affect the NJ Ex Order 26.4(b)(1) of any of the current 92 residents should they contract a communicable illness. Findings include: Observation of the facility front doors on 03/11/25 at 8:40 AM revealed a sign posted that read, 'NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) Room #[Room Number withheld]." Review of R71's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R71 was admitted to the facility on U.S. FOIA (b)(6) with diagnoses that included NJ Exec Order 26.4b1	F 583	A review of all resident charts for indications of Personal Privacy/ Confidentiality of Records. The policy and procedure in the areas of potential release of private information for communicable disease with emphasis on what can be communicated has been updated. All residents confidential medical information had the potential to be affected by the deficient practice. To ensure that no other residents were affected by the deficient practice the Director of Nursing conducted an audit to ensure no others were affected and they were not. A review of the facilities policy and procedure of Personal Privacy/ Confidentiality of Records was updated. All staff were in-serviced on Personal Privacy/ Confidentiality of Records to	

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F 583	Continued From page 6 NJ Exec Order 26.4b1 . Review of R71's "Results" tab of the EMR revealed a laboratory result, dated NJ Ex Order 26.4(b)(1, that recorded R71 had tested NJ Exec Order 26.4b1 Review of R6 (R71's roommate)"Progress Notes," dated NJ Ex Order 26.4(b)(1 at 12:13 PM and located under the "Progress Notes" tab of the EMR, revealed, ". . . Call placed to family, spoke to [relative identified and named] made aware resident roommate has NJ Exec Order 26.4b1 and NJ Ex Order 26.4(maintained, resident [R6] at present is NJ Exec Order 26.4b1 . . ." During an interview conducted on 03/11/25 at 11:43 AM, the Receptionist (REC1) stated she had posted the sign on the front door after the U.S. FOIA (b)(6) had called and instructed her to put the sign up. During an interview on 03/13/25 at 11:40 AM, R71 was asked if NJ Exec O was okay with the family of NJ Exec roommate being informed of NJ Exec O diagnosis of NJ Exec Order 26.4b1 R71 stated she NJ Exec Order 26.4b1 " R71 was asked if NJ Exec O would have minded if information regarding NJ Exec NJ Exec Order 26.4b1 diagnosis had been posted outside U.S. FOIA door. R71 responded, 'NJ Exec Order 26.4b1 When asked if NJ Exec O would have minded if NJ Exec O room/bed number and the diagnosis NJ Exec Order 26.4b1 had been posted at the front door, R71 stated, NJ Exec Order 26.4b1 During an interview on 03/13/25 at 12:25 PM, the U.S. FOIA (b)(6)) was asked if the posted health information with the resident room/bed identified was a confidentiality issue.	F 583	ensure that the deficient practice will not recur. The education will be included in subsequent new hire orientations and regular in servicing. In order to ensure that solutions are sustained the Director of Nursing or designee will monitor the resident progress notes of those with newly identified communicable disease1x a week for 4 weeks than monthly after. QI monitoring system will be implemented and reported to the QA and QAPI committee.	

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F 583	Continued From page 7 The [U.S. FOIA] stated [NJ Exec O] had developed a sign to be posted (showed on computer screen) that generally warned visitors of [NJ Exec Order 26.4b1] in the facility, but the survey team entered and that was not the sign used. The [U.S. FOIA] stated, "I would say no because of what we were told to be posting for [NJ Ex Order 26.4(d)] halls with room numbers. As a [NJ Ex Order 26] here, if [NJ Exec] room/bed number was posted, I wouldn't be upset. I feel it's a gray area." When asked what her expectation was regarding resident privacy and confidentiality, [U.S. FO] stated, "Not to post resident identifiable information." Review of the facility's policy titled, "Resident Rights," reviewed 2025, revealed, ". . . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . . . privacy and confidentiality . . ."	F 583		
F 656 SS=D	NJAC 8:39-4.1(a)18 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		4/30/25

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F 656	Continued From page 8 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to develop a comprehensive care plan for one of two residents (Resident (R) 7) reviewed for [redacted] in a total sample of 26. This had the potential for the	F 656	The IDT team immediatly met and updated resident R7's care plan reflecting on [redacted] care. An audit was completed and no other	

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F 656	Continued From page 9 resident not to receive appropriate monitoring and treatment. Findings include: Review of R7's undated "Face Sheet," located in the Electronic Medical Record (EMR) under the "Med [medical] Diag [diagnosis]" tab, revealed R7 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 [redacted] Review of an initial NJ Exec Order 26.4b1 Therapy Assessment," dated NJ Exec Order 26.4b1 and located under the "Assessment" tab of the EMR, indicated, "Rec [received] pt [patient] on NJ Exec Order 26.4b1 [at] NJ Exec Order 26.4b1 (+) [positive] NJ Exec Order 26.4b1 The initial assessment further indicated, "Recommendation for [redacted]: NJ Exec Order 26.4b1 as tolerated, maintain NJ Exec Order 26.4b1] NJ Ex Order 26.4(b)(1) . . . Goals of NJ Ex Order 26.4(b) [redacted] . ." Review of R7's "Progress Notes," dated NJ Exec Order 26.4b1 and located under the "Progress Notes" tab of the EMR, indicated, NJ Exec Order 26.4b1 recommendations: NJ Exec Order 26.4b1 [redacted], NJ Ex Order 26.4(b)(1) as tolerated, maintain NJ Exec Order 26.4b1] incentive NJ Ex Order 26.4(b)(1) while awake NJ Exec Order 26.4b1 goals of NJ Exec Order 26.4b1: prevent NJ Exec Order 26.4b1. U.S. FOIA (b)(6) [redacted] Review of R7's "Physician Order," dated NJ Exec Order 26.4b1	F 656	resident on respirator care ws affected by this deficient practice. The following measures have been put into place to prevent any further deficient practice: a. All residents on respiratory or specialized care were reviewed . b. All areas of care will be reviewed starting with the initial care plan meeting, baseline care plan meeting, quarterly, change of condition and all subsequent care meetings. c. All unit managers, supervisors, nurses and MDS coordinator were educated on how to update the care plans, and the new nurse hire and yearly competencies. d. The care plan policy and procedure was updated to reflect the above. The MDS coordinator or designee will audit all respiratory care plans weekly x4 weeks. QI monitoring system will be implemented and reported to the QA and QAPI committee.	

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F 656	Continued From page 10 and located under the "Orders" tab of the EMR, indicated, ". . . NJ Exec Order 26.4b1 continuous @ [at] NJ Exec Order 26.4b1 every shift everyday . . ." Review of R7's "Care Plan," dated NJ Exec Order 26.4b1 and located under the "Care Plan" tab of the EMR, indicated, " NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 [NJ Exec Order 26.4b1], NJ Exec Order 26.4b1 ." Further review of the care plan revealed no documentation of a care plan developed for NJ Exec Order 26.4b1. Further review of the EMR indicated even after the physician order dated NJ Exec Order 26.4b1 for R7 to have NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b) there was still no care plan developed for the use of NJ Ex Order 26.4(b) During an observation on NJ Exec Order 26.4b1 R7 was observed being taken to the NJ Exec Order 26.4b room by staff. R7 was observed wearing . Observation of R7's room revealed there to be an NJ Exec Order 26.4b1 in the room directly next to R7's bed with NJ Exec Order 26 connected to the NJ Exec Order 26.4b1 During an observation and interview made on NJ Exec Order 26.4b1 R7 was observed in NJ Ex O room sitting in a wheelchair eating lunch. At this time R7 was observed wearing . The NJ Exec Order 26.4b1 was observed connected to the NJ Exec Order 26.4b1. It was on and set at . R7 was asked why NJ Ex Or is receiving NJ Exec Order 26.4b1. R7 stated, "Because I have a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 During an observation made on 03/11/25 at 9:00 AM, R7 was observed in NJ Ex O room watching television and sitting in NJ Ex O wheelchair next to the	F 656		

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bed with NJ Ex Order 26.4(b)(1) .

During an observation made on NJ Ex Order 26.4(b)(1) R7 was observed in NJ Ex O room in NJ Ex O room, again watching television and sitting in NJ Ex O wheelchair next to the bed with NJ Ex Order 26.4(b)(1)

During an interview on 03/11/25 at 2:52 PM, Licensed Practical Nurse (LPN) 1 stated, 'NJ Ex Orc [referring to R7] is receiving NJ Exec Order 26.4b1 because NJ Ex Or has a diagnosis of NJ Exec Order 26.4b1 ."

During an observation made on 03/12/25 at 9:03 AM, R7 was observed to be lying in bed wearing NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was observed connected to the NJ Exec Order 26.4b1 which was on and set at NJ Exec Order 26.4b1.

During an observation and interview on 03/12/25 at 9:06 AM, in the presence of the U.S. FOIA (b)(6) R7 was observed to be lying in bed wearing the NJ Exec Order 26.4b1 . The NJ Exec Order 26.4b1 was observed connected to the NJ Exec Order 26.4b1 which was on and set at NJ . During an interview, the U.S. FOIA (b) verified that R7 was on U.S. FOIA (b)(6) and the NJ Exec Order 26.4b1

During an interview on 03/12/25 at 9:33 AM, R7's EMR was reviewed with the U.S. FOIA (b). The U.S. FOIA (b)(6) was asked if there was a care plan for the NJ Ex Order 26.4b NJ Exec Order 26.4 that R7 was receiving. The U.S. FOIA (b) stated, "I don't see one here. Our process is to meet every morning for morning report with the U.S. FOIA myself and our MDS (Minimum Data Set) person goes through them with a fine-tooth comb. Anything that comes up in

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WEDGWOOD GARDENS CARE CENTER	**3419 HIGHWAY 9 FREEHOLD, NJ 07728**

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F 656	Continued From page 12	F 656		

our morning meetings we will add to the care plan." The [U.S. FOIA (b)] stated, "Normally yes, I would expect there to be a care plan for [NJ Ex O] [referring to R7] [NJ Ex Order 26.4b], but I'm not seeing it."

During an interview and review of R7's EMR with the U.S. FOIA (b)(6) on 03/12/25 at 9:42 AM, the U.S. FOIA (b)(6) confirmed that she completed R7's Admission MDS with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4b]. The [U.S. FOIA (b)] stated, "The NJ Exec Order 26.4b1 was started on [NJ Exec Order 26.4b1]. This was after the ARD date of [NJ Exec Order 26.4b1] and I just missed it." The [U.S. FOIA (b)] stated, "[NJ Ex Or] care plan was completed on [NJ Exec Order 26.4b1] and the NJ Ex Order 26.4(b)(1) was started the next day on [NJ Exec Order 26.4b1]. I see where there should have been a [NJ Exec Order 26.4b1] care plan developed when [NJ Ex Or] was started on the [NJ Exec Order 26] y on [NJ Exec Order 26.4b1], and it was not. I'm also seeing in [NJ Ex O] chart where we need to have a care plan developed. I don't know how I missed that."

During an interview on 03/13/25 at 11:02 AM, the U.S. FOIA (b)(6)) stated, "My expectation would be either the U.S. FOIA (b) (6) or the nurse that took the order for the [NJ Ex Order 26.4] should have put a care plan in place and notified the MDS person. The nurse is also responsible for implementing a care plan and they could have communicated this to the [U.S. FOIA (b)] as well. That would be my expectation, and there should be a care plan in place."

During an interview on 03/13/25 at 11:24 AM, the U.S. FOIA (b)(6) stated, "I see where the [U.S. FO] [U.S. FOIA (b)(6)] assessed [NJ Ex O] [referring to R7] on [NJ Exec Order 2] and he recommended to add NJ Exec Order 26.4b1 and [NJ Ex Order 26.4(b)(] as tolerated. When at rest or lying flat, [NJ Ex Or] will be exerting

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F 656	Continued From page 13 NJ Exec Order 26.4b1." When reviewing the EMR of R7 with the [redacted], she stated, "I can say, it was not in [redacted] care plan. There was a miscommunication with the [redacted] and he did not communicate to me or the U.S. FOIA (b) (6) or the U.S. FOIA (b) (6). I see [redacted] the order was also not transcribed on the care plan for [redacted] to have NJ Exec Order 26.4b1." The [redacted] stated, "Who ever took the order would be responsible for putting it on the care plan, and I can say it was not carried over into the care plan." Review of the facility's policy titled, "Care Planning-Interdisciplinary Team," dated 2025, indicated, ". . . Our facility's Care Planning Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident . . ." Review of the facility's policy titled, "Comprehensive Assessments and the Care Delivery Process," dated 2025, indicated, ". . . Comprehensive assessments will be conducted to assist in developing person-centered care plans . . . The objective of the information collection (assessment) phase is to obtain, organize, and subsequently analyze information about a patient. a. Assess the individual. (1) Gather relevant information from multiple sources, including: (h) evaluations from other disciplines (for example dietary, respiratory, social services, etc.) . . . Information analysis . . . define current treatments and services . . . identify the current interventions and treatments . . . Identify overall care goals and specific objectives of individual treatments . . ." NJAC 8:39-11.2(e)thru(i) NJAC 8:39-27.1(a)	F 656		

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F 880	Continued From page 14	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		4/30/25

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F 880	Continued From page 15 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of Centers for Disease Control and Prevention (CDC) and American Society of Heating, Refrigerating and Air-Conditioning (ASHRAE) recommendations, the facility failed to implement their water management program to reduce the potential for exposure to opportunistic waterborne pathogens including Legionnaire's disease (a serious pneumonia infection). This had the	F 880	The water management plan and policy was reviewed and updated to include the water flow diagram. No residents were affected by this dificent practice. The U.S. FOIA (b) (6) and maintenance department were educated	

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F 880	Continued From page 16 potential to affect 92 of 92 residents who resided at the facility. Findings Include: Review of the CDC document titled "Legionella . . . Prevention and Control, dated 03/25/21 and located at https://www.cdc.gov/legionella/index.html, indicated ". . . The key to preventing Legionnaires' disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella . . . Key Elements . . . Describe the building water systems using text and flow diagrams . . . Identify areas where Legionella could grow and spread . . . Decide where control measures should be applied and how to monitor them . . . Establish ways to intervene when control limits are not met . . . Make sure the program is running as designed (verification) and is effective (validation) . . . Document and communicate all the activities . . . Principles . . . In general, the principles of effective water management include . . ." Review of the ASHRAE document titled, "Risk Management For Legionellosis," dated 10/2015 and located at https://www.ashrae.org/, indicated, ". . . The design engineer first needs to evaluate which requirements of the standard apply to their project. This evaluation determines if the project contains any of the following building risk factors . . . Health-care facility with patient stays over 24 hours . . . Facilities designated for housing occupants over age 65 . . . The risk of disease or illness from exposure to Legionella bacteria is not as simple as the bacteria being present in a water system. Other factors that contribute to the risk	F 880	on the waterflow diagram. The Administrator, IP or designee will monitor the plan monthly and report the findings throught the QI monitoring system and report to the QA and QAPI committee.	

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F 880	Continued From page 17 are environmental conditions that promote the growth and amplification of the bacteria in the system, a means of transmitting this bacteria (via water aerosols generated by the system), and the ultimate exposure of susceptible persons to the colonized water that is inhaled or aspirated by the host providing a pathway to the lungs. The bacteria are not transmitted person-to-person, or from normal ingestion of water. Susceptible persons at high risk for legionellosis include, among others, the elderly, dialysis patients, persons who smoke, and persons with medical conditions that weaken the immune system . . ." A review of a folder provided by the facility titled, "Water Management Program" included a "Water Management Program" policy, with a revision date of 2025. The policy indicated, ". . . Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella . . . The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program. The water management program includes the following elements . . . The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria . . . Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants); The control limits or parameters that are acceptable and that are monitored, A diagram of where control measures are applied; a system to	F 880		

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F 880	Continued From page 18 monitor control limits and the effectiveness of control measures; a plan for when control limits are not met and/or control measures are not effective . . ." During an interview on 03/12/25 at 1:10 PM, the U.S. FOIA (b)(6) acknowledged that she and the U.S. FOIA (b)(6) were responsible for the Water Management Program. At that time, a copy of the facility's water flow diagram that showed areas of water stagnation and where Legionella could grow was requested. During an interview on 03/13/25 at 11:45 AM, the U.S. FOIA (b)(6)) was asked to provide the facility's water flow diagram. She stated she would ask the building manager to provide the information. During an interview on 03/13/25 at 2:00 PM, the U.S. FOIA (b)(6) provided the blue prints of the building but were unable to provide any information on the water flow diagram of the building. NJAC 8:39-19.4	F 880		

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (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 review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	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	4/30/25

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

Electronically Signed | 04/10/25

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer 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. 1. For the week of Complaint staffing from 05/07/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -05/07/2023 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. 2. For the week of Complaint staffing from 07/09/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -07/09/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -07/10/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -07/11/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -07/15/23 had 8 CNAs for 98 residents on the day shift, required at least 12 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.	

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S 560	Continued From page 2 3. For the week of Complaint staffing from 04/07/2024 to 04/13/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -04/07/24 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -04/08/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -04/09/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -04/10/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -04/11/24 had 9 CNAs for 102 residents on the day shift, required at least 12 CNAs. -04/12/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -04/13/24 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. 4. For the 2 weeks of staffing prior to survey from 02/23/2025 to 03/08/2025, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -02/23/25 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/24/25 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/25/25 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/26/25 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/27/25 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -02/28/25 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -03/04/25 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -03/05/25 had 9 CNAs for 97 residents on the day	S 560		

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S 560	Continued From page 3 shift, required at least 12 CNAs. -03/06/25 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -03/07/25 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -03/08/25 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced	S1680		4/30/25

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S1680	Continued From page 4 neuromuscular/orthopedic care 1.50 hours/day This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 02/23/2025 to 03/08/2025, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 03/02/25 Required Staffing Hours: 304.75 -03/08/25 had 288 actual staffing hours, for a difference of -16.75 hours.	S1680	The corrective action accomplished for the deficient practice was to review weekend staffing hours to the present for compliance with minimum standards. Since staffing hours affect all residents and patients, this POC applies to all residents and patients. The systematic changes made to prevent recurrence are: a. Added the "Insta shift" option to all of our agency sign ups for employment. b. Implemented an overtime and open shift book which is located near the time	

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 _____	C 03/19/2025

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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S1680	Continued From page 5	S1680	clock c. The facility will utilize the State of New Jersey SUPPLEMENTARY NURSE STAFFING REPORT d. Nursing Administration including Unit Managers; DON; and Nursing Supervisors will be required to cover any shortfall to maintain compliance. To monitor the corrective action, the weekend staffing schedules are reviewed each Wednesday, for three (3) months to ensure all hours are in compliance with minimum standards. Results of the three month review will be submitted to the QI monitoring system will be implemented and reported to the QA and QAPI committee.	

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	5/22/2025 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 F0577	Correction	ID Prefix F0583	Correction	ID Prefix F0656	Correction
Reg. # 483.10(g)(10)(11)	Completed	Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	04/30/2025	LSC	04/30/2025	LSC	04/30/2025
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/30/2025	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/19/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13004 Y1	A. Building B. Wing Y2	5/22/2025 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 S1680	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed	Reg. #	Completed
LSC	04/30/2025	LSC	04/30/2025	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	
3/19/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315504	A. BUILDING **01** B. WING _____	**03/19/2025**

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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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/19/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/19/25 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Wedgwood Gardens Care Center is a two-story building constructed in 1977 and renovated in 2008. It is composed of Type I (222) construction and is divided into four smoke compartments. The facility has a complete automatic sprinkler system (wet with antifreeze). The diesel generator powers 75% of the building. The number of beds occupied was 92 out of 151.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking	K 222		4/30/25

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

Electronically Signed | 04/10/2025

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

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K 222	Continued From page 1 arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING	K 222		

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 222	Continued From page 2 ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to meet the delayed egress locking system requirements of NFPA 101 (2012), Section 7.2.1.6.1. This deficient practice had the potential to affect staff and 92 residents and was evidenced by the following: Observations on 03/19/25 at 10:08 AM of the designated exit door, located by the Dining Room and Kitchen, revealed the delayed egress locking system did not release in the direction of egress after 15 seconds and upon loss of power controlling the device. The locking device and adjacent keypad did not appear to have power supplied to them, but the locking device was still engaged. A sign on the door indicated "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS;" however, neither occurred after the U.S. FOIA (b) (6) applied pressure for over 40 seconds to the door. During an interview at the time of the observation, the U.S. FOIA (b)(6)	K 222	The alarm company was called to schedule maintenance on the failed egress door for repair. No resident was affected by this deficiency. The maintenance department was educated by the Assistant Administrator to the upgrade of the preventative maintenance program and the scheduled egress door checks. The Maintenance Supervisor or designee will monitor the egress doors once weekly for 4 weeks than monthly moving forward, all finding will be placed into the preventive maintenance care system any findings will be reported to the QA and QAPI committee for review. Competition date: 4/30/2025	

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K 222	Continued From page 3 U.S. FOIA (b)(6) confirmed the finding and stated the facility was unaware the delayed egress locking device was not functioning prior to the survey.	K 222		
K 353 SS=F	NJAC 8:39-31.1(c), 31.2(e) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 96 residents and was evidenced by the following:	K 353	Facility sprinkler system had the annual inspection on 3/4/2025, report was received on 3/14/2025, report indicated that the anti freeze system needed to be charged. This was completed on April 23, 2025. No residents were affected by this	4/30/25

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K 353	Continued From page 4 A review of the facility's most recent sprinkler inspection report dated 03/04/25, indicated that the antifreeze system was impaired, the solution was undetectable, and the antifreeze system needed to be recharged. During an interview at the time of the review, the U.S. FOIA (b)(6) confirmed the findings and stated the facility had not corrected the impairment because they just found out about it. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353	deficiency. The Assistant Administrator educated the Maintenance Department on the regulation, testing and scheduling and repairs of the required testing of the system. All contracted companies that provide inspections will be asked at the end of the inspection process of any deficient findings, so that scheduling repairs can be completed in a timely manner. All finding will be reported through the QI monitoring system and reported to the QA and QAPI committee. Completion date: 4/30/2025	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K 363		4/30/25

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K 363	Continued From page 5 with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 40 residents and was evidenced by the following: An observation on 03/19/25 at 10:33 AM revealed the corridor door of Room 316 failed to close and latch in the door frame. An observation on 03/19/25 at 10:57 AM revealed the corridor door of room 330 failed to close and latch in the door frame. The door was also held open by an armoire.	K 363	The 2 affected doors were repaired immediately on March 19, 2025. The preventative maintenance program was upgraded to include checking all corridor doors 1x a week for 1 month than monthly after. No residents were affected by this deficiency. The Assistant Administrator educated the maintenance department on the upgrade to the preventative maintenance program. The Maintenance supervisor or designee will monitor all corridor doors 1x a week for 1 month than monthly after. All results	

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 363	Continued From page 6 During an interview at the time of the observations, the U.S. FOIA (b)(6) [redacted] confirmed the findings and stated the facility was unaware the doors were not closing and latching prior to the survey. NJAC 8:39-31.2(e)	K 363	from the inspection will be reported to the QA and QAPI committee Completion date: 4/30/2025	
K 371 SS=F	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to meet the travel distance requirements for smoke compartments in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.7. This deficient practice had the potential to affect staff and all 92 residents and was evidenced by the following: An observation on 03/19/25 at 9:30 AM of the facility's smoke compartments revealed one of the facility's four smoke compartments exceeded the maximum travel distance of 200 feet from Room 101 to the smoke door in at the 200 Hall	K 371	1. Request for Time-Limited Waiver (TLW): The facility is formally requesting a Time-Limited Waiver (TLW) to allow additional time to bring the building into full compliance with Life Safety Code requirements for smoke compartmentation. 2. Reason for TLW and Corrective Action Plan: A TLW is necessary because the facility cannot immediately construct the	12/21/26

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K 371	Continued From page 7 Activities Area. The travel distance from Room 202 to the smoke door in the Lobby also exceeded 200 feet. The travel distance measured over 210 feet, based off measuring and counting ceiling tiles. Door openings in the Corridor were observed without doors by Rooms 113, 114, 128, 131, and 211. A review of the facility's drawings titled A101.0 and dated 09/13/06, revealed the travel distance between Room 202 and the smoke door at the Lobby measured 220 feet. Also, the travel distance from Room 101 to the smoke door at the 200 Hall Activities Room measured 225 feet. According to demolition drawings, doors were removed from the corridors at Room 114, Room 113, Room 128, Room 129, Room 131, and Room 211. During an interview at the time of the observations, the U.S. FOIA (b)(6) [redacted] confirmed the finding and stated the facility was unaware that the travel distance from any point in the smoke compartment to a smoke door cannot exceed 200 feet. They also verified the facility only has four smoke compartments and has not had doors in the door openings at the locations identified since they have been opened. NJAC 8:39-31.2(e)	K 371	additional smoke barriers required to subdivide the building into the number of smoke compartments required by code. The facility is actively working with its architectural and engineering team to complete the design and approval process needed to implement these upgrades. Upon completion of the review and permitting process, construction will proceed immediately. 3. Interim Safety Measures: To ensure the safety of residents, staff, and visitors during the waiver period, the facility will rely on the two existing smoke compartments, supported by compliant exit arrangements and functioning life safety systems (including fire alarm and sprinkler systems), all of which are tested and maintained by regulation. 4. Enhanced Life Safety Measures Beyond Minimum Requirements: The facility will implement additional life safety measures, including: " Conducting an additional fire drill each quarter per shift, resulting in a total of 16 fire drills annually (rather than the standard 12). " Provide monthly life safety training to all staff including new, existing, and temporary staff covering fire protection devices and evacuation responsibilities in their assigned areas. 5. Monitoring Responsibility and Frequency:	

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WEDGWOOD GARDENS CARE CENTER	**3419 HIGHWAY 9** **FREEHOLD, NJ 07728**

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K 371	Continued From page 8	K 371	" The Director of Maintenance will oversee daily inspections and ongoing monitoring of life safety systems and interim measures. " The Administrator will track the progress of the project milestones and report monthly updates. 6. Project Milestones: " Site and Architectural Survey / Laser Scan and Draft: May 15, 2025 June 14, 2025 " Architectural Design: June 14, 2025 September 12, 2025 " DOH Approval: September 12, 2025 November 11, 2025 " DCA Approval: November 11, 2025 February 9, 2026 " Local Building Approval: February 9, 2026 March 26, 2026 " Construction: March 26, 2026 July 24, 2026 " Local Inspections: July 24, 2026 August 23, 2026 " DCA Approval (Post-Construction): August 23, 2026 September 22, 2026 " DOH Final Inspection: September 22, 2026 December 21, 2026 7. QAPI Involvement: The facilitys QAPI Committee will review the status of this corrective project monthly to monitor implementation, ensure safety goals are met, and verify that all milestone deadlines are progressing as planned. 8. Anticipated Completion Date:	

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 _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 371	Continued From page 9	K 371	The final completion date for the corrective workincluding final inspections and signoffsis December 21, 2026.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6.2. This deficient practice had the potential to affect staff and all 92 residents and was evidenced by the following: An observation on 03/19/25 at 9:40 AM of the smoke barrier located in the Corridor by the Lobby revealed a two-inch by four-inch unsealed gap in the wall above the smoke doors and ceiling tile.	K 372	All areas of the building were inspected to locate the areas affected, the affected areas were sealed with 3M barrier sealant. No residents were affected by this deficiency. The following products were purchased and used to fill in the areas of potential penetration: a. [redacted] fire barrier sealant was purchased and features the following: " Expands with heat to maintain the penetration seal (Intumescent property). " Controls the spread of fire, smoke	5/5/25

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 _____	03/19/2025

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K 372	Continued From page 10 An observation on 03/19/25 at 10:10 AM of the smoke barrier located in the Corridor by the Kitchen revealed a six-inch by eight-inch unsealed overcut around a wire penetration above the smoke doors and ceiling tile. An observation on 03/19/25 at 10:20 AM of the smoke barrier located by Room 331 revealed a four-inch unsealed overcut around a group of wire penetrations above the smoke doors and ceiling tile. During an interview at the time of the observations, the U.S. FOIA (b)(6) [redacted] confirmed the findings and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K 372	and noxious gasses before, during and after exposure to a fire. " Sag resistant. " Fire Rating: 4 hour F-rating for through-penetrations. " Smoke Sealing: L-rated " Sound Barrier: STC-54 walls assembly rated " ASTM E 814 and UL 1479 rated " Certifications: o Intertek Warnock Hersey o Omega Point Laboratories o ULC o FM approved The Maintenance Supervisor or designee will inspect all areas of the smoke barrier walls quarterly for any signs of penetration. Results will be reported to the QA and QAPI committee. Completion date: 5/5/2025	

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	5/9/2025 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 K0222	04/30/2025	LSC K0353	04/30/2025	LSC K0363	04/30/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0371	04/29/2025	LSC K0372	05/05/2025	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	
3/19/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO