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 11/09/2022

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 Complaint#: NJ159023 CENSUS: 91 SAMPLE SIZE: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F678 IJ Based on observation, interviews, medical record review, and review of other pertinent facility documentation on 10/31/2022, 11/1/2022, and 11/9/2022, it was determined that the facility failed to activate the Emergency Response System (ERS), which included: calling for other staff to assist, calling 911, getting the NJ Exec Order 26.4b1 and (emergency supplies), getting the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Ord [redacted] until the Emergency Medical Technicians (EMTs) arrived for a resident (Resident #2). Resident #2 had a Physician's Order and a Plan of Care for a NJ Exec Order 26.4b1 and a known diagnosis of NJ Exec Order 26.4b1 [redacted], and NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 at approximately 4:30 a.m., on the 11-7 shift, the Registered Nurse (RN) found Resident #2 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1	F 000		

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

Electronically Signed | 12/11/2022

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		

NJ Exec Orde. The RN failed to place the NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 to ensure a firm surface under Resident #2 when NJ Exec Order 26.4b1.

According to the RN, she first saw Resident #2 at approximately 1:30 a.m. during her rounds, when the Resident was observed sleeping peacefully in bed. Resident #2 was NJ Exec Order 26.4b1 Then at 4:30 a.m., she went into Resident #2's room to administer a NJ Exec Order 26.4b when she saw that it looked like the Resident NJ Exec Order 26.4b1 The RN shook Resident #2, did NJ Exec Order 26.4b1, and got no response. The RN believed it would take 5-10 minutes to get another staff and told the Surveyors she NJ Exec Order 26.4b1 and did not call a code because she did not want to waste time.

According to the Electronic Death Registration System (EDRS), the time of date for Resident #2 was 5:54 a.m. After NJ Exec Order 26.4b1 the RN notified the Director of Nursing (DON) on NJ Exec Order 26.4b at approximately 5:30 a.m.-5:40 a.m., advising her that Resident #2 NJ Exec The DON spoke to the RN about the incident. However, the DON did not investigate how NJ Exec Order 26.4b1 the ERS not being activated for NJ Exec Orc or did not report the incident. In addition, the facility failed to follow its policy titled "Emergencies."

The facility staff failure to provide NJ Exec Order 26.4b1 and activate the ERS when Resident #2 was found NJ Exec Order 26.4b1 placed Resident #2 and all other residents who were a NJ Exec Order 26.4b at risk for an Immediate Jeopardy (IJ) situation. The Surveyor identified the IJ on 11/1/2022, Day 2 of the

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F 000	Continued From page 2 survey. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), the Director of Nursing (DON), and Social Worker (SW) on 11/1/2022 at 7:25 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on NJ Ex.Order 26.4(b)(and continued through 11/2/2022 when all licensed and unlicensed staff were in-serviced and re-educated on the Emergency policy and procedures for activating the ERS. On 11/9/2022, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, educating all staff on CPR, the Emergency Response System, Code Status, and the Communication of STAT (urgent) situations.	F 000		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: C#: NJ159023 Based on observation, interviews, medical record review, and review of other pertinent facility documentation on 10/31/2022, 11/1/2022, and 11/9/2022, it was determined that the facility failed to activate the Emergency Response System (ERS), which included: calling for other staff to	F 678	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Resident #2 is no longer in the facility as he/she NJ Exec Order 26.4b1 II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE	12/20/22

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	315504	A. BUILDING _____ B. WING _____	C 11/09/2022

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F 678	Continued From page 3 assist, calling 911, getting the NJ Exec Order 26.4b1 and (emergency supplies), getting the NJ Exec Order 26.4b1 and continuing NJ Exec Order 26.4b1 until the Emergency Medical Technicians (EMTs) arrived for a resident (Resident #2). Resident #2 had a Physician's Order and a Plan of Care for a NJ Exec Order 26.4b1 and a known diagnosis of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 at approximately 4:30 a.m., on the 11-7 shift, the Registered Nurse (RN) found Resident #2 NJ Exec Order 26.4b1 The RN failed to place the NJ Exec Order 26.4b1 to ensure a firm surface under Resident #2 when NJ Exec Order 26.4b1 According to the RN, she first saw Resident #2 at approximately 1:30 a.m. during her rounds, when the Resident was observed sleeping peacefully in bed. Resident #2 was NJ Exec Order 26.4b1 Then at 4:30 a.m., she went into Resident #2's room to administer a NJ Exec Order 26.4b when she saw that it looked like the Resident was NJ Exec Order 26.4b1. The RN NJ Exec Order Resident #2, did NJ Exec Order 26.4b1, and got NJ Ex. The RN believed it would take 5-10 minutes to get another staff and told the Surveyors she didn't call 911 NJ Exec Order 26.4b1 and did not call a code because she did not want to waste time. According to the Electronic Death Registration System (EDRS), the time of date for Resident #2 was 5:54 a.m. After pronouncing Resident #2's NJ Exec Order the RN notified the Director of Nursing	F 678	AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents in the facility who have a Physician's Order and a Plan of Care for a Full Code have the potential to be affected by the same deficient practice. ¿ The Assistant Administrator, Director of Nursing and Director of Social Services conducted a review of all the current residents charts to determine the Code Status of each resident. A list of residents and their current Code Status was generated. Residents who have a Physician's Order and a Plan of Care for a Full Code were highlighted. ¿ Staff interviews and review of medical record of all the residents with Full Code Status were conducted by the Assistant Administrator, DON or Designee to identify if there were other residents who were affected. No other residents were affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All staff were in-serviced on the regulations governing F-678 and were re-educated on the Facility s Policy on "Emergencies. Emphasis was made on the policy s purpose and specific procedures, as detailed below: PURPOSE: To provide nurses with information to enable them to identify emergency situations and intervene promptly in order to prevent negative resident outcome. PROCEDURE: Regardless of the type of	

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F 678	Continued From page 4 (DON) on NJ Exec Order 26.4b at approximately 5:30 a.m.-5:40 a.m., advising her that Resident #2 NJ Exec [redacted] The DON spoke to the RN about the incident. However, the DON did not investigate how NJ Exec C was done on an air mattress, the ERS not being activated for NJ Exec O, or did not report the incident. In addition, the facility failed to follow its policy titled "Emergencies." The facility staff failure to provide NJ Exec C correctly and activate the ERS when Resident #2 was found NJ Exec Order 26.4b1 [redacted] placed Resident #2 and all other residents who were a NJ Exec Order 26.4b at risk for an Immediate Jeopardy (IJ) situation. The Surveyor identified the IJ on 11/1/2022, Day 2 of the survey. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), the Director of Nursing (DON), and Social Worker (SW) on 11/1/2022 at 7:25 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on NJ Exec Order 26.4b and continued through 11/2/2022 when all licensed and unlicensed staff were in-serviced and re-educated on the Emergency policy and procedures for activating the ERS. On 11/9/2022, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, educating all staff on CPR, the Emergency Response System, Code Status, and the Communication of STAT (urgent) situations. This deficient practice was identified for 1 of 4 residents (Resident #2) and evidenced by the following:	F 678	emergency, the following basis principles should guide nursing actions: (1) Maintain life functions as indicated (this may be determined by advanced directives, living will, or DNR (Do Not Resuscitate) order; and (2) If it is determined by the RN or Supervisor that a resident is in need of emergency care due to a life-threatening problem, (i.e., sudden and unexpected cardiopulmonary arrest, Resident is choking and becomes unresponsive or persistent seizure activity, etc.), (a) Perform CPR, (b) Notify Physician, and (c) Call family/significant other. ¿ All facility staff were re-educated on the facility□s policies on o Code Status o CPR (Including training on safety precautions for CPR, such as deflating air mattresses) o Communication of a STAT (urgent) situation - proper use of telephone and paging system to call STAT o Activating the Emergency Response System, including the following: Calling for other staff to assist, calling 911, getting the crash cart and emergency supplies, getting the Automatic External Defibrillator (AED) and continuing Cardiopulmonary Resuscitation (CPR) until the Emergency Medical Technicians (EMTs) arrived. Education and retraining included but not limited to; CPR Training and Recertification Emergency Policy & Procedure	

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F 678	Continued From page 5 According to the Admission Record (AR), Resident #2 was originally admitted to the facility on NJ Exec Order 26.4b1 and readmitted on NJ Exec Order 26.4b1 with diagnoses which included but were not limited to NJ Exec Order 26.4b1 According to the Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident #2 had a Brief Interview of Mental Status (BIMS) score of NJ E/15, which indicated the Resident was NJ Exec Order 26.4b1. The MDS also showed Resident #2 needed extensive assistance with Activities of Daily Living (ADLs). A review of the Resident's Care Plan (CP) initiated on NJ Exec Order 26.4b1 revealed under "Focus": that Resident #2 "does not have an NJ Exec Order 26.4b Under "Goal," showed "NJ Exec Order 26.4b1 status will be maintained through the review period." Under "Interventions," included " .. NJ Exec Order 26.4b1 date initiated NJ Exec Order 26.4b1 ..." A review of Resident #2's "Order Summary Report (OSR)" Order Date Range NJ Exec Order 26.4b1 revealed the following Physician Orders (POs): NJ Exec Order 26.4b1 (every) shift, order date NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, order date NJ Exec Order 26.4b1	F 678	AED Emergency Response System Drill CODE Status Audit Activing Emergency Response 11/1/2022 11/2/2022 11/3/2022 11/7/2022 11/16/2022 11/21/2022 11/23/2022 12/5/2022 12/10/2022 12/19/2022 12/20/2022 Contracted Education Provider for CPR Certification/ Recertification RN DON RN IP RN DON Social Worker RN DON IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Director of Nursing or Designee will conduct Staff Interviews on 3 Nursing Personnel per shift per month x 6 months to ensure that they are equipped with the proper competencies on the following: (1) Determining Residents□ Code Status, (2) Performing CPR (Cardio-pulmonary Resuscitation) (3) Proper Communication of a STAT (urgent) situation, and	

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F 678	Continued From page 6 A review of Resident #2's Treatment Administration Record (TAR) dated NJ Exec Order 26.4b1 [redacted] revealed the above PO to check the function, and the placement of the NJ Exec Order 26.4b1 [redacted] n the night shift by the RN. A review of Resident #2's Progress Notes (PNs) revealed the following: On NJ Exec Order 26.4b1 [redacted] at 2:11 p.m., the Social Worker (SW) sat with the Resident to discuss living will/POLST/POA. The Resident has no interest in filling anything out at this time. The SW provided support and stressed the importance of having these documents. On NJ Exec Order 26.4b [redacted] at 5:17 a.m., the PNs, written by the RN, revealed, "Resident approached and attempt (ed) made to NJ Exec Order 26.4b1 TX (treatment) and meds (medications). Resident [was] NJ Exec Order 26.4b1 [redacted] [were] done. Pronounced by RN, call, and [a] message left with Doctor [Physician], report given to the DON, messages left with both daughters." The Surveyor reviewed the "Assignment Sheet (AS)" dated NJ Exec Order 26.4b [redacted] on the 11:00 p.m. -7:00 a.m. shift, which revealed there were three nurses: (1) RN and (2) Licensed Practice Nurses (LPNs) and (3) Certified Nursing Assistants (CNAs)on the Garden unit. The AS for the building revealed a total of 12 staff members: 6 nurses and 6 CNAs. However, there was no evidence of training provided at the time of the survey for staff working that night on the facility's ERS. There was also no camera footage for the incident, and the facility could not provide the Surveyor with the crash cart binder sign-off sheet for September	F 678	(4) Activating the Emergency Response System (5) Proper Notification of the Physician and Resident□s Representative/Responsible Party regarding Significant Changes in Resident□s Status or Condition Any identified issues will be immediately rectified. Administrator will monitor findings on a monthly and will be reported to the QAPI Committee on a monthly basis and presented in the quarterly QA (Quality Assurance) Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	

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F 678	Continued From page 7	F 678		

2022.

During an interview on 10/31/2022 at 12:53 p.m., the SW stated she remembered Resident #2 "if no[NJ Exec Order 26.4b1], you [resident] are a [NJ Exec] She continued, [NJ Exec Order 26.4b1] ...Resident #2 did not have an [NJ Exec Order 26.4b1] ... the Resident was a [NJ Exec]." She indicated the Resident was always a [NJ Exec Order 26.4b1]

During a telephone interview on [NJ Exec Order 26.4b1] at 9.51 a.m., when the Surveyor asked about the incident with Resident #2, the RN stated the following: "the night of the incident at 1:30 a.m., I checked on him/her, the Resident was sleeping peacefully, [NJ Exec Order 26.4b1], so I thought he/she was asleep. At 4:30 a.m., I went in to give him/her a morning medication and a [NJ Exec Order 26.4b] The RN explained that Resident #2 [NJ Exec Order 26.4b1] When the Surveyor asked the RN if anyone else was there, she replied, "no, there was nobody else there with me. Nurses were doing med (medication) pass, and aides were doing their changes, so nobody was around. It was basically just me ..." His/her [NJ Exec Order 26.4b1] I don't think it would've helped. (Resident #2) wanted to be left alone, that's my opinion. When I found the patient [Resident] [NJ Exec Order 26.4b1] the Resident was a [NJ Exec Order 26.4b], to my knowledge. But I knew [NJ Exec Order 26.4b1] The RN continued to say, "even if (the Resident was) [NJ Exec Order 26.4b1], by the time I got someone there,

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F 678		F 678		

Continued From page 8

he/she NJ Exec Order 26.4b1 She stated, "If I went down [the] hall to get the NJ Exec Order 26.4b1 it wouldn't have done any good."

In the same telephone interview, when the Surveyor asked her if she had called 911, she stated, "No, I didn't call 911 because NJ Exec Order 26.4b1 It takes time to call, and he/she was way down the hall. It would've taken 5-10 minutes to get somebody. I didn't know where Nurse [s] or aides were; they were in rooms doing changes. I didn't call 911 or any staff for help because NJ Exec Order 26.4b1 When the Surveyor asked the RN about an emergency code, and if she should have called a code, she replied, "an emergency code is called as soon as you see the patient [resident] in distress." The RN said she did not call a code because NJ Exec Order 26.4b1, not wasting time, I did NJ Exec Order 26 him/her. It didn't work because NJ Exec

During an interview on 11/1/2022 at 10:57 a.m., the Licensed Practical Nurse (LPN) working the Garden Unit on NJ Exec Order 26.4b on the 11:00 p.m. to 7:00 a.m. shift revealed that he had an NJ Exec Order 26.4b1 The LPN further stated he did not remember the name of the other Nurse he worked with that night but said that when he came out to the Nurse's station, the Nurse informed him that her Resident (Resident #2) had NJ Exec Order 26.4b1 The LPN stated, "No, I didn't hear anyone yelling out for help or hear a

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F 678	Continued From page 9	F 678		

STAT Code/Emergency called that night." The LPN said if a resident is a NJ Exec Order 26.4b1 and found NJ Exec Order 26.4b1, "I will have to start NJ Exec Or and alert someone to call 911 and get the NJ Exec Order 26.4b1."

During an interview on 11/1/2022 at 12:12 p.m., when the Surveyor asked the DON if a resident was NJ Exec Order 26.4b1 what is done, she replied, "Initially if a resident is NJ Exec Order 26.4b1 and NJ Exec , anyone should tap the person [Resident] anywhere on the body to see if [Resident] responds to stimuli. If (there is) no response, time is of the essence, yell for staff for assistance." She further stated as the primary Nurse, she would know the code status of the Resident, and if the Resident was a NJ Exec Order 26.4b1, she would start NJ Exec O, someone would call 911, and someone would bring the NJ Exec Order 26.4b1. "Any staff can call 911 and bring the NJ Exec Order 26.4b1, all hands on deck. Usually, the Charge Nurse will be directing other staff members to get stuff. Time is of the essence; get things done as quickly as possible."

In the same interview, when the Surveyor asked what happened with Resident #2 and the RN on NJ Exec Order 26.4b1, the DON stated, "At about 5:30-5:40 a.m., I got a phone call from the RN; she advised me that Resident #2 NJ Exec Order 26.4b1 and I thanked her for letting me know. That was the end of the conversation. When I came into work, I made sure all the documentation was done, and that was the end of it." The DON continued to say, "I did speak to the RN about what happened. She said she walked into Resident #2's room at about 1:45 a.m., and the Resident was sleeping during her rounds. Then she went in again [to the room] closer to 5:00 a.m. to administer meds (medications) and NJ Exec Order 26.4b1, and then that's when she noted the Resident was

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	315504	A. BUILDING _____ B. WING _____	C 11/09/2022

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WEDGWOOD GARDENS CARE CENTER	3419 HIGHWAY 9 FREEHOLD, NJ 07728

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F 678	Continued From page 10	F 678		

NJ Exec Order 26.4b1. She said she started NJ Exec O and it was futile, "the man/lady NJ Exec Order 26.4b1 Yes, that was it."

In the same interview, when the Surveyor asked the DON if the RN yelled for help, she replied the RN told her, "Yes, she yelled out for assistance, but she said nobody came. That was it. I did ask a few people in the building if they heard [someone] yell out for assistance, but they didn't hear anything. They were doing meds (medications) and giving care. I spoke to (3) other nurses, and they didn't hear anything." The DON continued, "I don't remember if the RN told me she called 911. 911 is a given."

When the Surveyor asked the DON if she investigated the incident for Resident #2, she replied, "No, NJ Exec Order 26.4b1 was not investigated. No, I did not go back and look to see if [the] procedure was followed. For [the] incident that night, the Nurse should've called 911 when she found patient [the Resident] NJ Exec Order 26.4b1. On [the] phone system, we have a page all ...when she [RN] was getting NJ Ex she should've run out of the room and used the pager system to get help. Time is of the essence, and return to [the] Resident and continue NJ Exec Ord"

During an interview on 11/1/2022 at 1:11 p.m., when the Surveyor asked the Assistant Administrator (AA) if the RN followed the protocol for an emergency, she replied, "if a resident was NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1, I expect the Nurse to call a code or start NJ Exec Ord on (their) own, yell for someone to come and help you, pick up the phone, call STAT (urgent) Code with (the) unit and room number. The RN was not following our

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 11/09/2022

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 678	Continued From page 11 protocol ..." During a telephone interview on 11/1/2022 at 2:48 p.m., the Surveyor asked the Medical Director (MD) if a resident was found NJ Exec Order 26.4b1 [redacted], what is expected of the Nurse. The MD stated it would be expected for the Nurse to start NJ Exec Ord and activate the emergency code in the building. During a telephone interview on 11/1/2022 at 3:00 p.m., the Licensed Practice Nurse (LPN) who worked on the night shift on NJ Exec Order 26.4b on another unit stated," [the] Nurse didn't call for assistance, I did not hear [a] call for help. I wasn't aware of anything. I said goodbye to the RN around 7:20 a.m." She said at the end of her shift, she had a patient [Resident] NJ Exec Order 26.4b1 and that was it. She continued to say, "a code is never a single person, a team effort, it's all hands on deck ... I assumed when she told me a person [Resident] NJ Exec Order 26.4b1, it was a NJ Exec Order 26.4b1 I did not hear a code." According to the LPN, the overnight Nurse checks the NJ Exec Order 26.4b1 to ensure nothing is expired; all is up to date, NJ Exec Order 26 is full, NJ Exec Order 2 is connected, and anything we need. It's checked every night, overnight, [on] a sign-out sheet kept in a binder with [the] NJ Exec Order 26.4b1 During a second interview on 11/1/2022 at 3:48 p.m., the DON stated, if there's an NJ Exec Order 26.4b1, it can be pulled, [an] emergency pull activates the bed, [located] on the side of the bed for NJ Exec Ord mode." This Resident had an NJ Exec Order 26.4b1. The Nurse should have activated the NJ Exec Order 26.4b1 [redacted] During a second telephone interview on 11/1/2022 at 4:06 p.m., when the surveyors	F 678		

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	315504	A. BUILDING _____ B. WING _____	C 11/09/2022

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F 678	Continued From page 12	F 678		

asked her how Resident #2's was done [NJ Exec O], the RN stated, "I gave the Resident [NJ Exec Or] on his/her bed. When the Surveyor asked the RN if she did anything else before starting [NJ Exec O], the RN said, No, I didn't do anything in the room, indicating she did not deflate the NJ Exec Order 26.4b1."

On 11/9/2022, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, educating all facility staff on CPR, the Emergency Response System, Code Status, and the Communication of a STAT (urgent) situation. So, the noncompliance remained on 11/2/2022 as a level D for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy" based on the following: The RN no longer works at the facility and all staff have been educated on the ERS, review and update Emergency Response System Policy, re-educated nursing staff on CPR and Emergency Response with emphasis placed on the immediate and effective calling of an emergency (STAT) situation, hands-on training, and drills. Residents' records/charts are updated to clearly indicate and identify Code Status or None-code Status. Training on safety precautions for CPR, such as deflating air mattresses and proper use of telephone and paging system to call STAT. Identify Residents who may be at risk by obtaining a list of all Residents who are Full Code, Crash cart review, AED review, and Demonstration of AED application, Demonstration of proper chest compression and hand placement, and notification to NJDOH, the Ombudsman, and NJ State Board of Nursing.

A review of the facility's undated policy titled "Emergencies" included but was not limited to the following: Under "Purpose: To provide nurses

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	315504	A. BUILDING _____ B. WING _____	C 11/09/2022

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F 678	Continued From page 13 with information to enable them to identify emergency situations and intervene promptly in order to prevent negative resident outcome. Under Procedure: Step 1A. Regardless of the type of emergency, the following basis principles should guide nursing actions: 1. Maintain life functions as indicated (this may be determined by advanced directives, living will, or DNR). C. If it is determined by the RN or Supervisor that a resident is in need of emergency care due to a life-threatening problem, (i.e., sudden and unexpected cardiopulmonary arrest, Resident is choking and becomes unresponsive or persistent seizure activity, etc. ...) 1. Perform CPR 2. Notify Physician 3. Call family/significant other. N.J.A.C: 8:39-27.1(a)	F 678		

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 11/09/2022

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 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 facility document review on 10/31/2022, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 13 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. 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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and	S 560	S-560 - 8:39-5.1(a) Mandatory Access to Care □ STATE□S STAFFING RATIOS I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ 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. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by this situation. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ Facility□s Recruitment and Retention Strategies and Efforts to comply with the	12/20/22

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

Electronically Signed | 12/11/22

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 11/09/2022

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S 560	Continued From page 1 perform CNA duties. 1. For the week of 9/4/2022 to 9/10/2022, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: On 9/4/2022 had 8 CNAs for 87 residents on the day shift, required 11 CNAs. On 9/06/2022 had 10 CNAs for 85 residents on the day shift, required 11CNAs. On 9/07/2022 had 10 CNAs for 85 residents on the day shift, required 11CNAs On 9/08/2022 had 8 CNAs for 85 residents on the day shift, required 11 CNAs. On 9/09/2022 had 9 CNAs for 85 residents on the day shift, required 11 CNAs. On 9/10/2022 had 9 CNAs for 85 residents on the day shift, required 11 CNAs. 2. For the week of 10/23/2022 to 10/29/2022, the facility was deficient in CNA staffing for residents on 7of 7 day shifts as follows: On 10/23/2022 had 9 CNAs for 92 residents on the day shift, required 11 CNAs. On 10/24/2022 had 9 CNAs for 91 residents on the day shift, required 11 CNAs. On 10/25/2022 had 9 CNAs on the day shift for 91 residents, required 11 CNAs. On 10/26/2022 had 8 CNAs for 91 residents on the day shift, required 11 CNAs. ON 10/27/2022 had 9 CNAs for 91 residents on the day shift, required 11 CNAs. On 10/28/2022 had 9 CNAs for 91 residents on the day shift, required 11 CNAs. On 10/29/2022 had 9 CNAs for 91 residents on the day shift, required 11 CNAs.	S 560	State□s Staffing Ratios have been in progress, which include but are not limited to the following: o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage referrals from current staff o Offering daily and weekend bonuses to attract overtime or PRN staff shifts o Aggressively running ads in various social media o Currently have contracts with multiple staffing agencies All critical staffing will be reported immediatly to the Administrator IV. MONITORING OF CORRECTIVE ACTIONS ¿ The Licensed Nursing Home Administrator will directly monitor the the State staffing ratios as for maintaining of the State staffing and ahererance to same. By way of review of daily census and staffing levels,weekly reports to the Administrator or designee by the Director of Nursing or designee will provide regarding all efforts made to try to comply with the State□s Staffing Ratios. Reports will be submitted to the QAPI Committee monthly X 3 months then quarterly thereafter. ¿ Assistant Administrator will submit monthly reports to the Administrator to document status of all recruitment efforts. This will be reported monthly to the QAPI Committee X 3 months then quarterly thereafter.	

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	12/29/2022 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 F0678	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.24(a)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/20/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/9/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13004 Y1	A. Building B. Wing Y2	12/29/2022 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	12/20/2022	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	
11/9/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO