STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315047	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wynwood Rehabilitation and Healthcare Center	1700 Wynwood Drive Cinnaminson, NJ 08077

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of facility documents it was determined that the facility failed to provide a safe, clean, and comfortable environment in resident rooms and designated facility utility areas. The deficient practice was identified on 2 of 3 units. The deficient practice was evidenced by the following: On 12/01/2025 at 1:14 PM while in Resident # 89's room, the surveyor observed linens on the floor and a pile of debris that appeared to be swept but was left and not discarded. On 12/02/2025 at 12:17 PM, in the Soiled Utility room near room [ROOM NUMBER], the surveyor observed filled trash bags left on the floor in the room and not in the container. On the same date at 12:26 PM, the surveyor observed a linen cart outside of room [ROOM NUMBER] with personal bags, including a purse, on the top shelf among the clean linens and incontinence briefs. On 12/04/2025 at 11:12 AM, the surveyor observed a trash can with no bag liner in room [ROOM NUMBER]-1. On 12/05/2025 during an interview with the surveyor, the Licensed Nursing Home Administrator stated that the expectation is that they [housekeeping] do the rooms daily and they do deep cleans also. A review of the policy titled, Cleaning and Disinfecting Resident's Rooms, revised August of 2013, revealed that Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills, occur, and when these surfaces are visibly soiled. N.J.A.C. 8:39-31.4(a)

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

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to complete the Comprehensive Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 2 of 11 residents (Residents #30 and Resident #40) reviewed for Resident Assessment and was evidenced by the following: Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or look back) period that the assessment covered for the resident. At a minimum, facilities are required to complete a comprehensive assessment for each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident, where 12 months refers to a period within 366 days. The following residents were identified that the comprehensive MDS was not completed in a timely manner: 1. Resident #30: Annual MDS dated [DATE] which was completed on 6/9/25 (3 days late.) 2.Resident # 40: The Annual MDS dated [DATE] was completed on 10/22/2025 (6 days late.)On 12/05/2025 at 10:05 AM, during an interview with the surveyor, the regional MDS Coordinator stated that Annual MDSs should be completed within 14 days of the assessment reference date (ARD). She acknowledged that Resident #30 and Resident #40 Annual MDSs were completed late. Review of the facility provided policy titled, MDS Completion and Submission Timeframes, revised October 2023 reflected: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. NJAC 8:39-11.2 (e)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to complete the Quarterly Minimum Data Set (QMDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 11 residents (Resident #4) reviewed for Resident Assessment and was evidenced by the following: Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or look back) period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1). The Assessment Reference Date (ARD) of the Quarterly MDS was within 92 days after the ARD of the previous MDS and; 2). the completion date was no later than 14 days after the ARD. The following resident was identified that the quarterly MDS was not completed in a timely manner: 1.Resident # 4: The QMDS dated [DATE] was completed on 10/21/25. It was due to be completed on 10/18/25. On 12/05/2025 at 10:05 AM, during an interview with the surveyor, the regional MDS Coordinator stated that Quarterly MDSs should be completed within 14 days of the assessment reference date (ARD). She acknowledged that Resident #4's QMDS was completed late. Review of the facility provided policy titled, MDS Completion and Submission Timeframes, revised October 2023 reflected: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Review of the facility provided policy titled, Quarterly Assessments, undated, reflected that the MDS completion date will be no later than 14 days after the ARD. N.J.A.C. 8:39-11.1

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 2 of 32 residents reviewed, Resident #8 and Resident #51. This deficient practice was evidenced by the following:A review of the admission Record for Resident #8 which reflected that the resident was admitted with diagnoses that included Schizophrenia and Depression. A review of the level II Preadmission Screening and Resident Review (PASRR) revealed Resident #8 was positive for a mental illness. A review of Resident #8's Significant Change MDS dated [DATE] revealed that the section indicating if the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, was coded as zero (0), indicating that Resident #8 does not currently have a mental illness or intellectual disability. When interviewed on 12/05/2025 at 10:07AM, the Regional MDS Coordinator stated that Resident #8's Significant Change in Status MDS dated [DATE], should have been coded as one (1), indicating the resident had a serious mental illness or intellectual disability. A review of the admission Record for Resident #51 which reflected that the resident was admitted with diagnoses that included but was not limited to a mass and lump on neck and Dementia. A review of Resident #51's Significant Change MDS, an assessment tool used to facilitate the management of care, dated 5/8/25, indicating that Resident #51 was placed on Hospice on 5/1/25. On review of the quarterly MDS's dated 8/8/25 and 11/8/25, under Hospice, it was coded 0, indicating that the resident was not receiving Hospice Services. On review of Resident #51's current Individual Comprehensive Care Plan (ICCP), dated 5/1/25 with revision dates of 8/13/25 and 10/14/25, the ICCP included a focus area for Hospice Services related to senile degeneration of the brain. On 12/5/25 at 10:08 AM, the surveyor interviewed the Regional MDS Coordinator who acknowledged that the MDS did not reflect the current Hospice status for Resident #51. A review of the facility's Resident Assessment policy, revised 10/23, included under #12, Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. NJAC 8:39-2(e)1

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to ensure that medications for a discharged resident were properly removed from the medication storage area. The deficient practice was identified for 1 of 3 medication carts inspected during the Medication Storage and Labeling task. The deficient practice was evidenced by the following: On 12/02/2025 at 12:48 PM, the surveyor inspected Medication Cart 1 located outside of room [ROOM NUMBER]. At that time, in the presence of Licensed Practical Nursing # 1 (LPN # 1), the surveyor discovered a medication card for Gabapentin 100 milligram capsules located behind the bottom drawer of the cart. The medication card contained 16 remaining capsules and belonged to a resident who had been previously discharged from the facility. At that time, LPN # 1 said they should not have been in there because discharged resident's medications are returned to the pharmacy. The facility did not provide a policy regarding medication storage. N.J.A.C. 8:39-29.4 (g)

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview the facility failed to ensure resident beds and mattress were properly positioned and adjusted to meet residents' needs and ensure safety and comfort foe 1 of 2 residents (Resident # 118) observed for positioning. The deficient practice was evidenced by the following: During initial tour on 12/01/2025 at 10:04 AM the surveyor observed Resident #118 in bed with their feet extended over the mattress and their ankles resting on the foot board.Resident #118 stated he/she can't sleep at night because his/her feet are always hanging off the bed. Resident #118 said he/she thinks the told a nurse about the bed being too small.A review of Resident # 118 admission Minimum Data Set (MDS) dated [DATE] revealed under section C that Resident # 118 had a BIMS score of 14 indicating intact cognition. The MDS also revealed under section K that Resident # 118 had a height of 72 inches. During an interview on 12/04/2025 at 10:06 AM with the surveyor, the Assistant Director of Nursing (ADON) said residents are assessed for a larger bed if it is noticed that they don't fit or if they say they aren't comfortable. If resident asks for a new bed, they are first assessed what could be the cause. The ADON was unsure if there was a certain height that determine the need for a bed extender. The ADON also said that residents' feet should never be hanging off the end of the bed. During an interview on 12/05/2025 at 11:59 AM with the survey team, the Regional Director of Clinical Services (RDCS) said reasons a resident might need a different bed, or an extender could be their height, weight and sometimes just a preference. The RDCS said that Resident # 118 now has a bed extender. The RDCS also said that resident's feet should not be hanging of the bed, and that bed should be the right size for residents' comfort. A Review of a facility provided policy titled, Accommodation of Needs, revealed, 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and on an ongoing basis. N.J.A.C. 8:39-31.8 (c)(1)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observations on 12/02/2025 in the presence of the facility's Maintenance Assistant (MA), it was determined that the facility failed to provide hand rails on both sides of the corridor. This deficient practice had the potential to affect all 104 Residents in the facility.Observation on 12/02/2025 the surveyor observed, measured and recorded a six foot- nine inch (6'-9) section of wall in the South wing adjacent to the Physical Therapy area with no evidence of a hand rail for Residents to use.The MA confirmed the finding at the time of observation.The Administrator and MA were informed of the Life Safety Code deficiency during the survey exit at approximately 1:30 PM.NJAC 8:39-31.4 (a).