STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315527	A. BUILDING _____ B. WING _____	C 05/31/2024

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WINCHESTER GARDENS HEALTH CARE CENTER	333 ELMWOOD AVENUE MAPLEWOOD, NJ 07040

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F 000	INITIAL COMMENTS Complaint #: NJ173628 Survey Date: 5/28/24 through 5/31/24 Census: 26 Sample: 12 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey. Deficiencies were cited for this survey.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		7/22/24

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

Electronically Signed | 06/21/2024

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F 761	Continued From page 1 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that expired medications were removed from the medication room and treatment cart. This deficient practice was identified for 1 of 1 floor inspected and was evidenced by the following: On 05/28/24 7:45 PM, the surveyor inspected the 4th floor medication storage room and treatment cart (high side) in the presence of the U.S. FOIA (b) (6) found the following expired medication: a. 2 bottles of Adult low dose Enteric Coated 81mg that had 120 tablets each bottle with an expiration date of 8/2023 b. 1 tube of unopened Bacitracin Ointment 1 oz (28.4g) with an expiration date of 1/2024. c. 1 tube of opened Bacitracin Ointment 1 oz (28.4g) with an expiration date of 1/2024 inside the treatment cart. On 5/28/2024 at 8:30 PM, the surveyor discussed the above concern to the facility's U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FOIA (b) (6) who acknowledged that the above medications were expired.	F 761	1. No residents were affected by deficient practice. 2. All residents have the potential to be affected by deficient practice. 3. An in-service was initiated by the DON and Nursing Supervisor on June 3, 2024, regarding checking the dates of medications/ treatment supplies before use to make sure it is not expired (medication). The nursing staff were informed that they are not to use any expired medication and/or treatment. The DON will be informed by the nursing staff if any expired medication/ treatment is found, going forward. 4. The Director of Nursing or designee will maintain logs weekly x 4, monthly x 3 to ensure compliance. Any issues of non-compliance will be reported to the Administrator for resolution. Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations.	

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F 761	Continued From page 2 NJAC 8:39-29.2 (d)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store potentially hazardous foods in a manner to prevent food borne illness. This repeat deficient practice was observed and evidenced by the following: On 5/28/24 at 06:01 PM, while on 4th floor, in the area labeled Den, the surveyor observed a staff	F 812	1. No residents were affected by deficient practice. 2. All residents are at risk to be potentially affected by the deficient practice 3. At time of survey the Surveyor observed: A. Several items in the 4th floor Den without proper labeling and dating, undated and unlabeled items were discarded immediately. A walkthrough of all other areas was conducted to ensure no other items were found. In-services were conducted on proper labeling and	7/22/24

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F 812	Continued From page 3 refrigerator with signage that stated, "all items must be labeled with name and date." The surveyor observed a 2 liter bottle of [NJ Ex Order 26.4(b)(1)], a container of salad and brown bag with a container of food. All items were missing labels including names and dates. On 5/28/24 at 6:24 PM, the surveyor in the presence of the U.S. FOIA (b) (6) observed the following during the kitchen tour: 1. Upon entering the kitchen the surveyor observed two servers (dietary aides) server #1 and #2 with hair not fully restrained, servers #3 and #4 without hairnets, and server #5 with beard guard improperly placed. The [U.S. FO] could not explain why those servers were not wearing hair and beard restraints properly. 2. In the standing drink refrigerator, the surveyor observed an opened 60 ounce (oz) bottle of cranberry juice without a label and an opened 60 oz bottle of grape juice with an open date of 4/25/24. The [U.S. FO] stated all items that have been opened need to be labeled with the open date and use by date. The [U.S. FO] acknowledged the grape juice should have been discarded after three days. 3. Surveyor observed servers #6 and #7 scooping ice cream into a bowl, both observed not wearing disposable gloves and both servers' hands were touching the inside of bowl. The [U.S. FO] stated gloves should be worn whenever preparing any food items. 4. Surveyor observed in the standing refrigerator, a 1/2 gallon fat free milk, a 24 ounce (oz) bottle of chocolate syrup, a 1 gallon Caesar dressing, a 5	F 812	dating procedures. Completed 6/14/2024. B. Staff in the main kitchen with hair not fully restrained, without hairnets and improper use of beard guards. Hair net usage was checked immediately. In-services were conducted on proper hairnet/beard guard usage. Completed 6/14/2024. C. Items in the standing drink refrigerator which were not labeled and/or outdated were discarded immediately. D. Staff were not wearing gloves while scooping ice cream and handling serving bowls. The ice cream bowls were sent to the dish room and washed immediately. Glove usage was checked immediately. In-services were conducted on proper glove usage. Completed 6/14/2024. E. The items in the standing refrigerator which were not labeled and/or outdated were discarded immediately. F. The items in the dual door standing refrigerator which were not labeled and/or outdated were discarded immediately. G. The items in the freezer next to the tray line which were not labeled and/or outdated were discarded immediately. H. The items in the walk-in refrigerator which were not labeled and/or outdated were discarded immediately. I. The items in the walk-in freezer in the main kitchen which were not labeled and/or outdated were discarded immediately. J. In the dish washing area, a four shelve storage dish rack with three full size catering dishes with wet nesting. Items were immediately unstacked, re-washed and air dried properly. Staff were	

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F 812	Continued From page 4 lb. tub sour cream, all opened and missing open/use by labels. The U.S. F[redacted] stated all items that have been opened need to be labeled with the open date and use by date. 5. Surveyor observed in the dual door standing refrigerator, an open bag of fresh broccoli and cauliflower, both missing open/use by labels. 6. Surveyor observed a freezer next to the tray line, one bag of frozen tater tots and one bag of premade biscuits, both open and missing open/use by labels. 7. Surveyor observed in the walk-in refrigerator in the main kitchen area, an open bag of shredded carrots missing an open/use by label 8. Surveyor observed in the walk-in freezer in the main kitchen area, an opened package of coffee cake missing an open/use by label. 9. Surveyor observed in the dish washing area, a four shelve storage dish rack with three full size catering dishes with wet nesting. The U.S. F[redacted] stated all items in the shelving unit should be completely dry before being stored. 10. Surveyor observed in the walk in refrigerator located in the dry storage area, two fans with a black colored debris and an open bag a grated parmesan cheese missing an open/use by label. The U.S. F[redacted] stated he would alert the maintenance department is responsible for clean the fans. 11. Surveyor observed in the walk in freezer located in dry storage area, frost build up and multiple boxes of frozen food stored higher than 18 inches from ceiling. The U.S. F[redacted] stated he would	F 812	in-service on proper drying procedures and safety concerns with stacking items while wet. Completed 6/14/2024. K. In the walk-in refrigerator located in the dry storage area, two fans with black colored debris. Management alerted maintenance to have fans cleaned immediately. L. In the walk-in freezer located in dry storage area, frost build up and multiple boxes of frozen food stored higher than 18 inches from ceiling. The Executive Chef moved boxes to appropriate levels and alerted maintenance of the frost build-up. All gaskets located around the freezer door have been replaced on 6/2/2024. In-servicing was completed for those responsible for stocking shelves on 6/14/2024. 4. The Senior Dining Director or designee will maintain logs weekly x 4, monthly x 3 to ensure compliance. The Senior Dining Director or designee will monitor staff performance daily/weekly. Any issues of non-compliance will be reported to the Administrator for resolution. Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations and to monitor compliance.	

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F 812	Continued From page 5	F 812		

alert the maintenance department regarding the frost and would move the boxes to the proper distance from the ceiling.

On 5/29/24 at 11:30 AM, the U.S. FOIA (b) (6) provided the surveyor with multiple facility policies including, Unit pantry stock, Dress guidelines for food service management and clinical nutrition staff, Uniform dress code, Food and supply storage, and Refrigerated storage life of foods. The Unit pantry stock policy with a revised date of 1/2024 states under the procedures section, "Label, date and discard outdated items per the food storage policy. Ensure all items are covered, labeled, and dated." The Dress guidelines for food service management and clinical nutrition staff policy with a revised date of 1/2022 states under the procedure section, "hair restraints are worn by all when in the kitchen." The Uniform dress code policy with a revised date of 1/2022 states under the procedure section, "restrain all facial hair with a beard net/restraint." The Food and supply storage policy with a revised date of 1/2024 states under the procedures section, "cover, label and date unused portions and open packages. Complete all sections on the Morrison orange label or use the Medvantage/Freshdate labeling system. Refer to the food storage chart in this policy to determine discard dates for food items. Store food items 6 inches (in) above the floor and 18in below the ceiling/sprinklers." The food storage chart revealed that re-sealable juice should be discarded after 3 days after opening.

On 5/30/24 at 1:31 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), NJ Ex Order 26.4(b) , and NJ Ex Order 26.4(b)(1)

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F 812	Continued From page 6 U.S. FOIA (b) (6)) to review concerns. No comments made by staff regarding kitchen concerns. On 5/31/24 at 10:14 AM, the U.S. FOIA (b) met with the surveyor and stated, "The kitchen not up to my standards." No further comments made. NJAC 8:39-17.2(g)	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		7/22/24

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F 842	Continued From page 7	F 842		

representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 6 of 15 residents reviewed (Resident # 4, 17, 19, 7, 11, 18). This deficient practice was evidenced by the following: 1. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #4. According to the Admission Record (AR) (an admission summary), Resident #4 had diagnoses that included but were not limited to: U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FOIA (b) (6). A Quarterly Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated NJ Ex Order 26.4, indicated the facility assessed the resident's NJ Exec Order 26.4 using a Brief Interview Mental Status (BIMS) test. Resident #4 scored NJ out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1). A review of physician progress notes (PPN) in the hybrid medical record revealed there were no physician progress notes documented by the resident's primary physician. 2. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #17. According to the AR, Resident #17 had diagnoses	F 842	1. Six residents affected by deficient practice. 2. All residents have the potential to be affected by deficient practice. 3. An in-service was initiated by the DON and Nursing Supervisor on June 3rd, 2024, to the licensed nursing staff on the importance of having the resident records identifiable and information readily available. A change in Medical Directors, effective NJ Ex Order 26.4(b)(1). The DON, or her designee, will continue to check the individual resident's medical record weekly to ensure that deficient practice does not recur. The new Medical Director will be informed by the Administrator and DON to make sure that documentation that is completed regarding the resident that has been seen and examined is in the resident's medical record. 4. The DON or designee will maintain logs weekly x 4, monthly x 3 to ensure compliance. Any issues of non-compliance will be reported to the Administrator for resolution. Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations.	

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F 842	Continued From page 9 that included but were not limited to U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6). An Annual MDS assessment, a tool used to facilitate management of care, dated NJ Ex Order 26 indicated the facility assessed the resident's cognition using a BIMS test. Resident #17 scored NJ E out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1). A review of PPN in the hybrid medical record revealed there were no physician progress notes documented by the resident's primary physician. 3. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #19. According to the AR, Resident #19 had diagnoses that included but were not limited to U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6). A Quarterly MDS assessment, dated NJ Ex Order 2, indicated Resident #19 was NJ Ex Order 26.4(b)(1) and a BIMS test could not be performed to assess the resident's NJ Exec Order 26.4b A review of PPN in the hybrid medical record revealed there were no physician progress notes documented by the resident's primary physician. 4. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #7. According to the AR, Resident #7 had diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)).	F 842		

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A Quarterly MDS assessment, a tool used to facilitate management of care, dated [redacted], indicated the facility assessed the resident's [redacted] using a BIMS test. Resident #7 scored [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1).

A review of PPN in the hybrid medical record revealed there were no physician progress notes documented by the resident's primary physician.

5. 4. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #11.

According to the AR, Resident #11 had diagnoses that included but were not limited to: [redacted], NJ Ex Order 26.4(b)(1), [redacted], NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

A comprehensive MDS assessment dated [redacted] indicated Resident #11 was [redacted] and a BIMS test could not be performed to assess the resident's [redacted]

A review of PPN in the hybrid medical record revealed there were no physician progress notes documented by the resident's primary physician.

6. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #18.

According to the AR, Resident #18 had diagnoses that included but were not limited to: [redacted], NJ Ex Order 26.4(b)(1), [redacted], and NJ Ex Order 26.4(b)(1).

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F 842	Continued From page 11 A Quarterly MDS assessment, dated [NJ Ex Order 26.4(b)] indicated Resident #18 was [NJ Ex Order 26.4(b)(1)] [redacted] and a BIMS test could not be performed to assess the resident's [NJ Exec Order 26.4(b)] A review of PPN in the hybrid medical record revealed there were no physician progress notes documented by the resident's primary physician. On 5/29/24 at 12:30 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] at the nurses' station about where physician progress notes were documented in a resident's medical records. The [U.S. FOIA (b) (6)] stated the physicians would document in the electronic medical record (EMR) under the "assessments" section. She further explained the facility was transitioning for all physician progress notes to be in the resident's EMR and that some physician progress notes may be found in the resident's paper chart. On 5/30/24 at 1:31 PM, the survey team met with the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)] [redacted] the [U.S. FOIA] [redacted], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] [redacted], and [U.S. FOIA (b) (6)]. The surveyors informed the facility about the concern of no physician progress notes by the resident's primary physician being found in the hybrid medical records for the residents identified. The [U.S. FOIA] stated it was expected for physicians to visit and document their progress notes at least every 30 days and every other month when alternating visits with a nurse practitioner. On 5/31/24 at 9:30 AM, the [U.S. FOIA] and [U.S. FOIA] [redacted] provided the survey team with a copy	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315527	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER GARDENS HEALTH CARE CENTER	333 ELMWOOD AVENUE MAPLEWOOD, NJ 07040

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F 842	Continued From page 12	F 842		

of physician progress notes from NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) for the residents. The U.S. FOIA stated it was faxed from the physician's office yesterday to the facility. The U.S. FOIA (b) (6) further explained they were transitioning to have the physicians' document in the EMR directly instead of in their own documentation systems. The U.S. FOIA stated that physician progress notes not written in the EMR were to be faxed to the facility within 24 hours of the physician's visit to be placed in the resident's medical records. The U.S. FOIA acknowledged the physician progress notes should have been in the resident's medical records and readily accessible. There was no additional information provided by the facility.

The primary physician was unavailable for interview.

A review of the facility's policy titled "Physician Visits", with a revised date of 5/18/23 read under Procedure: "1. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation."

A review of the facility's undated policy titled "Physician Visits", under Policy Interpretation and Implementation it read: " ...5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation ..."

N.J.A.C. 8:39-35.2(d)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315527	A. Building B. Wing	7/31/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER GARDENS HEALTH CARE CENTER	333 ELMWOOD AVENUE MAPLEWOOD, NJ 07040

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 F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 07/22/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 07/22/2024	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 07/22/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
5/31/2024	☐ 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
	315527	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER GARDENS HEALTH CARE CENTER	**333 ELMWOOD AVENUE** **MAPLEWOOD, NJ 07040**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 05/29/24. The facility was found not to be in compliance with 42 CFR 483.73.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004		7/22/24

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

Electronically Signed | 06/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315527	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER GARDENS HEALTH CARE CENTER	**333 ELMWOOD AVENUE** **MAPLEWOOD, NJ 07040**

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E 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness plan had been reviewed annually. The deficient practice had the potential to affect all 26 residents. Findings include: A review of the facility's "Emergency Preparedness Plan," provided by the facility revealed the facility had not reviewed their Emergency Preparedness Plan annually. Continued review revealed the plan was last reviewed February 2022. During an interview on 05/29/24 at 4:30 PM, the U.S. FOIA (b) (6) stated he could not find a signature form or documented evidence showing the Emergency Preparedness Plan had been reviewed in the past 12 months.	E 004	1. No residents were affected by deficient practice. 2. All residents have the potential to be affected by deficient practice. 3. The Surveyor did not find the Emergency Preparedness Plan annual sign- off sheet. The management team reviewed the Plan and signed off on June 3, 2024. The Plan will be signed off annually in January at the QAPI meeting. A work order reminder was also placed in our work order system. 4. The Director of Plant Operations or designee T will maintain logs weekly x 4, monthly x 3 to ensure compliance. Any issues of non-compliance will be reported to the Administrator for resolution. Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315527	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 004	Continued From page 2 NJAC 8:39-31.2(e), 31.6(i)1	E 004		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/29/24 and was found not to be in compliance with 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 18 NEW health care occupancy. Winchester Gardens Healthcare Center was constructed in 2017. The facility is a two-story building with a brick façade, stucco second floor, concrete bearing walls, concrete flooring, and a flat concrete roof. The facility is a Type II (222) non-combustible construction type. The facility has three smoke zones. The facility has an 880 KW (kilowatt) diesel generator. The facility has 26 occupied beds.	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of	K 321		7/22/24

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 321	Continued From page 3 hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one of two soiled linen room doors with hazardous contents were provided with at least a one-hour fire barrier. This deficient practice had the potential to affect 12 residents in the area. Findings include: An observation on 05/29/24 at 9:30 AM of the soiled utility room door revealed the door lacked a one-hour fire rating tag. The room contained one 96-gallon trash container full of waste. During an interview at the time of the observation, the U.S. FOIA (b) (6) verified the door lacked fire rating and stated the facility contractor was to install the door from last year's survey; however, the door was either installed at the wrong location or not at all.	K 321	1. No residents were affected by deficient practice. 2 All residents have the potential to be affected by deficient practice. 3. The vendor came out to the facility on 6/1/24 and recertified that the door in question is fire rated, see attached. As of 6/14/2024 inspection, all doors in healthcare that need to be fire rated are in compliance. 4. The Director of Plant Operations or designee will maintain fire door inspection logs weekly x 4, monthly x 3 to ensure compliance. During fire door inspection, the placement and condition of the sticker/label will be audited for proper position and placement. Any issues of non-compliance will be reported to the Administrator for resolution. Results will be provided to the QAPI Committee	

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K 321	Continued From page 4 NJAC 8:39-31.2(e)	K 321	monthly and ongoing for review/recommendations.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the alarm system was maintained in accordance with NFPA 101 (2012 edition) section 9.6.1.3. This deficient practice had the potential to affect all 26 residents. Findings include: An observation on 05/29/24 at 9:00 AM of the fire alarm annunciator panel located in the nursing office on the Sheffield Center unit revealed a message which indicated "Trouble, disabled active sounder power monitor." During an interview at the time of the observation, the U.S. FOIA (b) (6) indicated he was not aware of the message and would call the alarm contractor for clarification. Continued interview revealed the U.S. FOIA (b) (6) indicated he did not know what the message meant. At the time of the exit conference, the alarm system was still noted in trouble.	K 345	1. No residents were affected by deficient practice. 2. All residents have the potential to be affected by deficient practice. 3. Our alarm vendor NJ Ex Ord was notified, came into the facility, and corrected the problem on 5/31/2024, see attached. 4. The Director of Plant Operations or designee will maintain logs weekly x 4, monthly x 3 to ensure compliance. Security will actively monitor the fire panel and alert Director of Plant Operations as well as the vendor when there is an alert on the fire panel. Any issues of non-compliance will be reported to the Administrator for resolution. Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations.	7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315527	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 5 NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on policy review and interview, the facility failed to ensure a policy and procedure was developed to implement fire watch in the event the sprinkler system was out of service in accordance with NFPA 25 (2011 edition) section 15.5.2.(4). This deficient practice had the potential to affect all 26 residents. Findings include: A review of the facility's fire safety policies provided by the facility revealed the policies did not include a policy or procedure related to if the sprinkler system was out of service.	K 354	1. No residents were affected by deficient practice. 2. All residents have the potential to be affected by deficient practice. 3. Upon the Surveyors review, it was determined that in addition to our Loss of Fire Alarm System that was part of the Emergency Preparedness Plan, a Policy needed to be drafted if our fire alarm detects Loss of Fire Sprinkler Alarm. The policy was drafted and approved by our corporate clinical and risk management teams on 6/3/2024, see attached. The Policy will be reviewed annually in January.	7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315527	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 354	Continued From page 6 During an interview on 05/29/24 at 4:30 PM, the U.S. FOIA (b) (6) revealed the facility did not have a policy for related to the sprinkler system being out of service sprinkler which would include a fire watch. NJAC 8:39-31.2(e)	K 354	4. Policies will be provided to the QAPI Committee monthly and ongoing for review/recommendations.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that non-hospital grade receptacles were tested at intervals not exceeding 12 months in accordance with NFPA	K 914	1. No residents were affected by deficient practice. 2 All residents have the potential to be affected by deficient practice.	7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315527	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 914	Continued From page 7 99 (2012 edition) section 6.3.4.1.3. This deficient practice had the potential to affect all 26 residents. Findings include: A review of the facility's untitled fire safety records provided by the facility revealed the facility had completed monthly checks of the facility ground fault circuit interrupter (GFCI) throughout the past twelve months with a simple check that the device passed. There were no records of an annual check of additional receptacles in the Sheffield or certified area and the additional Cambridge (assisted living) area where the fire door separates survey boundaries. During an interview on 05/29/24 at 3:30 PM, the U.S. FOIA (b) (6) stated he was not aware of the requirement. The U.S. FOIA (b) (6) also stated he tested what he was instructed to do; however, he was not instructed to test all outlets in Sheffield and Cambridge areas. NJAC 8:39-31.2(e) NFPA 99	K 914	3. On June 6, 2024, our licensed electrical contractor performed an annual GFI/Outlet inspection in our Sheffield and Cambridge Communities, see attached. The licensed electrical contractor completed all repairs on 07/10/24, see attached. A annual reminder was placed in the work order system for vendor to conduct annual GFI/Outlet inspection. 4 Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315527	A. Building B. Wing	7/31/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER GARDENS HEALTH CARE CENTER	333 ELMWOOD AVENUE MAPLEWOOD, NJ 07040

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 E0004 Reg. # 483.73(a) LSC	Correction Completed 07/22/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
5/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315527 Y1	A. Building 01 - MAIN B. Wing Y2	7/31/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER GARDENS HEALTH CARE CENTER	333 ELMWOOD AVENUE MAPLEWOOD, NJ 07040

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 K0321	07/22/2024	LSC K0345	07/22/2024	LSC K0354	07/22/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0914	07/22/2024	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	
5/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO