STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30a000	A. BUILDING: _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER GARDENS ASSISTED LIVING CI	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) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00147344 CENSUS: 59 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/30/21

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint# NJ0147344

Based on observation, interview and record review it was determined that the facility failed to implement and enforce its policy and procedure titled, Ex Order 26. 4B1 and Ex Order 26. 4B1 for 2 of 3 residents reviewed for Ex Order 26. 4B1, Residents #1 and #2. This deficient practice was evidenced by the following:

On 8/26/21 at 10:30 a.m., the surveyor interviewed the Executive Director (ED) regarding a Reportable Event Report (RER) of Ex Order 26. 4B1 that was reported to the Department of Health (DOH) on Ex Order 26. 4B1.

The ED told the surveyor that on Ex Order 26. 4B1, a visitor of another resident told the Assistant Executive Director (AED) that he/she had witnessed Resident #1 placing a Ex Order 26. 4B1 of Resident #2 and was Ex Order 26. 4B1 Resident #2's Ex Order 26. 4B1 The AED told the surveyor that he/she had interviewed the Licensed Practical Nurse (LPN) on Ex Order 26. 4B1 who had reported that Resident #1's Ex Order 26. had not been under Resident #2's Ex Order 26. 4B1. Further, the ED stated that due to this Ex Order 26. 4B1, the security video was reviewed which substantiated this finding.
The ED told the surveyor that the AED provided in-service education to all staff on the facility's reporting policy and procedure regarding Ex Order 26. 4B1 .

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A 310	Continued From page 2 At 10:45 a.m., the surveyor interviewed the LPN regarding the Ex Order 26. 4B1 of Ex Order 26. 4B1 by Resident #1 to Resident #2. The LPN stated that around 1:10 p.m., she observed Resident #1 walking from the room to the common area where the residents were waiting to begin activities. The LPN reported having become involved with the care for another resident when she heard a visitor yell out Ex Order 26. 4B1 The LPN told the surveyor that when she heard this, she rushed over to Resident #1 and Resident #2 and separated the two residents. In addition, the LPN stated that Resident #1 was to be supervised when around others due to history of Ex Order 26. 4B1, so when the visitor yelled Ex Order 26, Resident #1 removed his/her Ex Order 26 away from Resident #2. The LPN told the surveyor that there were two Aides on duty but she did not know where they were at the time of the Ex Order 26. 4B1. The surveyor further asked the LPN to explain what was done after she separated Resident #1 and Resident #2, and the LPN stated that she documented the Ex Order 26. 4B1 in the residents' charts and the twenty-four-hour report. In addition, the LPN stated that she notified the supervisor. The surveyor asked the LPN what supervisor was notified, and the LPN named the Assisted Living Coordinator (ALC). At 11:25 a.m., the surveyor requested to view the security video that was recorded on Ex Order 26. 4B1 at the time of the Ex Order 26. 4B1 between Residents #1 and #2. The AED, in the presence of the ED, played the video for the surveyor. The surveyor observed that Resident #1 and Resident #2 were seated in chairs next to each other. Resident #1 reached over and Ex Order 26. 4B1 of Resident	A 310		

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A 310	Continued From page 3	A 310		

#2 and Resident #2 reached over and Ex Order 26. 4B1 of Resident #1. Resident #1 proceeded to Ex Order 26. 4B Resident #2's shoulder and move down and Ex Order 26. and Ex Order 26. 4B Resident #2's Ex Order 26. 4B1 over the Ex Order 26. 4B1. The video also, showed that Resident #1 attempted to NJ Ex Order 26. Resident #2's Ex Order 26. 4B1 but was unable to do so. The video further revealed that a visitor came over and stopped Resident #1 from Ex Order 26. 4B1 Resident #2's Ex Order 26. 4B1.

At 12:30 p.m., the surveyor toured the Memory Care Unit and began review of medical records.

Resident #1 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1. According to the Ex Order 26. 4B1 Progress Note (PPN) dated Ex Order 26. 4B1, Resident #1 was NJ Ex Order 26., NJ Ex Ord and NJ Ex Order 26.4b1.

Surveyor review of Resident #1's Interdisciplinary Progress Notes (IPN) dated Ex Order 26. 4B1 identified that the LPN documented that at 1:10 p.m., Resident #1 had been seated by another resident and attempted to place Ex Order 26. 4B1 another Ex Order 26. 4B1 and the LPN redirected Resident #1 as ordered. In addition, the LPN documented that safety precautions were maintained.

During tour of the Memory Care Unit, the surveyor observed Resident #1 seated in his/her private apartment alone shuffling cards. The surveyor was unable to interview Resident #1 due to Ex Order 26. 4B1.

Resident #2 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1. According to the PPN dated Ex Order 26. 4B1, Resident #2 was NJ Ex Order 26., NJ Ex Ord and NJ Ex Order 26.4b1. Surveyor review of Resident #2's IPN dated

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A 310	Continued From page 4 Ex Order 26. 4B1 identified that the LPN had documented that Resident #2 had an encounter with another resident at 1:10 p.m. and was separated and moved to another area. The LPN continued that Resident #2 was NJ Ex Order 26 upon assessment with NJ Ex and that Resident #2 would be monitored closely for safety. The note had no name or signature except for the word "supervisor." During tour of the Memory Care Unit the surveyor observed Resident #2 sitting in the common area engaged in activities. The surveyor was unable to interview Resident #2 due to *Ex Order 26. 4B1*. At 1:45 p.m., the Director of Nursing (DON) told the surveyor during an interview that the facility policy and procedure for *Ex Order 26. 4B1* was to remove or separate residents for protection and report immediately to whoever was in charge. The DON told the surveyor that she was on duty on Ex Order 26. 4B1 but had not been notified of the Ex Order 26. 4B1 of *Ex Order 26. 4B1* between Residents #1 and #2. She further stated that since she had not been made aware of the Ex Order 26. 4B1, she had not documented the Ex Order 26. 4B1 in either residents' medical record. At 2:00 p.m., the surveyor interviewed the ALC over the telephone. The surveyor asked the ALC if she had been notified of the Ex Order 26. 4B1 of Ex Order 26. 4B1 between Resident #1 and #2 on Ex Order 26. 4B1 by the LPN. The ALC said that she was not working on Ex Order 26. 4B1 and the LPN did not inform her of the Ex Order 26. 4B1. She stated that she had not been made aware of the Ex Order 26. 4B1 until returning to work. The ALC further stated that she had returned to work on Ex Order 26. 4B1 but was not sure of the date the LPN made her aware of the Ex Order 26. 4B1. The LPN informed the ALC that the Ex Order 26. 4B1 was being handled. Additionally, the ALC stated that she	A 310		

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A 310	Continued From page 5 informally educated the LPN on what should have been done in regard to the Ex Order 26. 4B1 or an Ex Order 26. 4B1. At 2:15 p.m., the surveyor interviewed the AED who stated that she was not made aware of the Ex Order 26. 4B1 of Ex Order 26. 4B1. The AED further stated that a visitor brought the Ex Order 26. 4B1 to her attention on Ex Order 26. 4B1 at which time she then informed the ED which initiated an investigation and included staff interview, in-service education on Ex Order 26. 4B1 and Ex Order 26. 4B1 accident reporting. At 2:30 p.m., the surveyor reviewed the facility policy and procedure titled "Incident Reporting" which required, " ... Incident Form Processing/Notification: 1. Incidents will immediately be reported to the nurse in charge, attending physician, supervisor, or department manager, depending upon the circumstances and the individuals involved (e.g. resident, staff, visitor, and employee) ...." The surveyor reviewed the facility policy and procedure titled "Abuse (Elder Abuse)" which required, " ... 5. Investigation of Any Violation Which is Suspected and/or Substantiated A. The nursing supervisor on duty shall IMMEDIATELY report any alleged violations of this prevention policy to the Administrator or designee. ...."	A 310		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
30a000 Y1	A. Building B. Wing Y2	9/30/2021 Y3

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

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 09/13/2021	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 8/26/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			