

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2026
NAME OF PROVIDER OR SUPPLIER  Winchester Gardens Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  333 Elmwood Avenue Maplewood, NJ 07040	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT #2706331, 2717796 Based on interviews, review of medical records and other pertinent facility documentation on 2/19/26 and 2/20/26, it was determined that the facility failed to maintain a complete medical record when no evidence was provided that : 1) a private aide assigned to Resident #1 was educated on the resident's care needs, and 2) Resident #3's vital signs and pain level were assessed when their foley catheter became dislodged. This deficient practice was identified for 2 residents reviewed (Resident #1 & Resident #3) and was evidenced by the following:1). Resident #1 was not at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: mid-cervical fracture of the left femur, fracture of the right humerus, lack of coordination, and cognitive impairment. Review of Resident #1's comprehensive Assessment Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated 1/1/26, indicated that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating that the resident's cognition was moderately impaired. Further review of the MDS revealed that the resident required, Substantial/Maximal assistance with all transfers. The MDS also indicated that the resident had one fall that occurred prior to admission to the facility and another fall that occurred prior to the current fall. A review of Resident #1's baseline care plan (BCP) indicated that Resident #1 required a one-person assist for all activities of daily living (ADLs). A review of Resident #1's comprehensive care plan (CCP) revealed a focus related to the resident was a fall risk and an actual fall with a right shoulder fracture that was initiated on 12/16/25. A review of the Facility Reportable Event (FRE) which the facility sent to the New Jersey Department of Health (NJDOH), indicated that on 1/1/26 at 5:50 AM, Resident #1's Private Aide (PA #1) informed the Registered Nurse (RN #1) that at approximately 4:15 AM, Resident #1 fell and that PA #1 helped the resident back to bed. The FRE further indicated that staff informed the medical doctor (MD) of the incident, an x-ray was obtained that revealed that the resident had an, .acute right femoral neck fracture [right leg fracture]. A review of the statement provided by RN #1 revealed that she rounded at 11 PM and re-educated PA #1 on Resident #1's high fall risk and that the PA was to call for assistance if she needed a break. RN #1 further indicated that at 2:30 AM she returned to the room and observed the resident sleeping and she then offered PA #1 a break, which was declined. RN #1 next returned to the room at 5:50 AM to administer medication when PA #1 informed her that at 4:15 AM PA #1 used the bathroom in the resident's room and when she opened the door to re-enter the room PA #1 observed the resident standing at the foot of the bed and before reaching the resident PA #1 observed Resident #1 slide down onto the floor mat. PA #1 then picked the resident up and placed them back in bed without calling for assistance. A review of the statement provided by the assigned Certified Nursing Assistant (CNA #1), revealed that she rounded at 11 PM and that at that time she  (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  315527	Facility ID:  315527  If continuation sheet Page 1 of 3

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>explained to PA #1 not to attempt to provide care and to use the call bell if anything was needed. On 2/19/26 at 1:16 PM, the surveyor attempted to contact CNA #1 for an interview without success. During an interview on 2/19/26 at 1:29 PM, NS #1 stated that the role of a PA was to provide companionship to residents, and that all care was to be provided by facility staff only. NS #1 further stated that upon a PAs arrival to the unit, they were to report to the nurse who would verbally remind them of what level of care their resident required and that they were not to provide any hands-on care but to call for assistance when needed. When asked if any of this information was documented anywhere, NS #1 stated that it was provided verbally to the PA. During a telephone interview on 2/19/26 at 2:02 PM, RN #1 stated that rounds were conducted at the start of each shift and they verbally remind all PAs that they were not to provide any hands-on care and that they were to inform staff if a resident requires any type of assistance. RN #1 stated that at the start of the shift on 12/31/26 she reminded PA #1 of Resident #1's required care level. RN #1 further stated that prior to the incident they rounded and entered Resident #1's room at 2:30 AM on 1/1/26, and offered PA #1 an opportunity for a break, which she declined. RN #1 stated that due to a new admission and a fall on the other side of the unit that night, they did not return to resident #1's room until 5:50 AM. RN #1 stated that the call bell did not ring, nor were any staff informed of what happened until RN #1 entered Resident #1's room. During a joint interview with the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), and the Assistant Nurse, on 2/19/26 at 3:06 PM, the DON stated receiving a phone call about the incident on the morning of 1/1/26 and that the NS #1 was told to initiate the protocol and to immediately collect statements prior to anyone leaving. The DON further stated that there were no existing contracts with PA agencies and that families were able to select any agency to provide companionship for their loved one. The DON further stated that PAs were instructed to report to either the NS or the assigned nurse on the floor where they would receive verbal instructions regarding any updates related to their resident's care status and that they were not to provide any hands-on care but to use the call bell and/or seek staff for any assistance the resident required. When asked how the facility ensured that PAs understood those instructions, the DON stated that the PAs would verbally repeat the instructions back to the staff member. There was no documentation that PA #1 was educated and understood what level of care Resident #1 required. 2). Resident #3 was not at the facility at the time of the survey. A closed medical review was conducted. A review of the admission Record revealed that Resident #3 was admitted to the facility with diagnoses that included but were not limited to: encephalopathy, dementia, urine retention, diarrhea, Non-[NAME] Lymphoma. The comprehensive Minimum Data Set (MDS), an assessment tool, dated 10/24/25, revealed a Brief Interview of Mental Status (BIMS) of 4 out of 15, which indicated that the resident was severely cognitively impaired. Further review of the MDS indicated that Resident #3 had an indwelling catheter. A review of Resident #3's care plan (CP), revealed a focus related to the resident being on enhanced barrier precautions due to the presence of an indwelling urinary catheter. The interventions included the monitoring of the resident's vital signs, labs and diagnostics as ordered by the physician that was initiated on 10/21/25. A review of Resident #3's progress notes (PN), included a change in condition (CIC) note created by Registered Nurse (RN #2) dated 11/10/25 at 8 PM, that indicated that the resident's foley had dislodged and they were to report to the physician as necessary. Further review of the PN did not indicate that vital signs were taken and/or that pain was assessed. On 2/20/26 at 10:12 AM, surveyor attempted to reach RN #2 via telephone, without success. On 2/20/26 at 2:19 PM, the surveyor conducted a joint interview with the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), and the Assistant Nurse (AN), the DON stated that if a foley becomes dislodged</p> <p>(continued on next page)</p>		

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