

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/05/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. REPEAT DEFICIENCY Based on observation, interview, record review and policy review, it was determined that the facility failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 9/2/2025 at 10:00 AM, in the presence of the Food Services Director, the surveyor observed the following: In the food preparation area, the surveyor observed a thick black grease-like substance on 3 of the 12 burner stoves. The residue was easily dislodged using the tip of a pen. NJAC 8:39-17.2(g)		

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS, an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 1 (one) of 12 residents (Resident #23) during the review of resident assessment. This deficient practice was evidenced by the following: The MDS is a comprehensive tool, a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 9/3/25 at 11:38 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who stated that in April, she thought that she had submitted the Resident #23 admission MDS (A/MDS) assessment. The MDSC/RN revealed that she did not submit the assessment on time. On 9/4/25 at 10:38 AM, the MDSC/RN provided the surveyor with a final validation report (generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS) of Resident #23's submitted A/MDS assessment that was not submitted within fourteen days of completion. Resident #23 A/MDS assessment has an assessment reference date (ARD, the last day of the observation period) of 4/20/25. It was signed as completed on 4/22/25 and not transmitted until 9/3/25. On 9/4/25 12:02 PM, the surveyor met with the Licensed Nursing Home Administration (LNHA) and the Director of Nursing (DON) regarding the above concern; there is no information provided. The DON stated that they follow the RAI (Resident Assessment Instrument, a tool that helps gather information about a resident's strengths and needs, which is used to create an individualized care plan) manual. NJAC 8:39-11.1		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to follow up on the psychiatry (psych) consult recommended by the physician to address the dementia care of a resident who is receiving antipsychotic medications. This deficient practice was identified for 1 (one) of 1 resident (Resident #2) reviewed for dementia care. This deficient practice was evidenced by the following: On 9/3/25 at 12:20 AM, the surveyor observed Resident #2 sitting in a wheelchair inside the dining room having lunch. On 9/4/25 at 11:51 AM, the surveyor reviewed the electronic Health Record (eHR)/ hybrid medical record (paper and electronic) of Resident #2, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #2 was admitted with diagnoses that included but were not limited to unspecified dementia (loss of memory), unspecified severity, with other behavioral disturbance. A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) dated 7/17/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident had severe cognitive impairment. Further review of A/MDS reflected in Section N - High Risk Drug Classes: Use and Indication that Resident #2 was receiving antipsychotic and antidepressant medications while in the facility. A review of the Physician Order Sheet (OSR) revealed the following: 1. quetiapine (an antipsychotic medication) 25 mg (milligram) 1 tablet orally once daily for behavior disturbance with the start date of 7/12/25. 2. venlafaxine (a generic medication for brand name medication called Effexor, an antidepressant medication) 75 mg 1 tablet orally once daily for depression with a start date of 7/12/25. 3. donepezil (a generic medication for brand name medication called Aricept, a medication to treat Alzheimer's disease) 10 mg 1 tablet orally once daily for dementia with a start date of 7/11/25. A review of the [Name withheld] Physician Orders form with a handwritten order on 7/10/25 at 10:00 PM, a telephone order of psych consult - resident on quetiapine, divalproex, Aricept, and Effexor. A review of the physician's progress notes dated 7/11/25 and 7/17/25 revealed that the physician's plan of care includes dementia care. A review of Resident #2's Care Plan (CP) report revealed that Resident #2 was receiving antipsychotic and antidepressant drugs regularly and was at risk for falls related to dementia. On 9/4/25 at 9:54 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that there was a psych consult order dated 7/10/25. The LPN stated that the psych consult was recommended and noted that there was no psych consult done for this resident. On 9/5/25 at 9:43 AM, the surveyor interviewed the Director of Nursing (DON), who stated that there was an order for a psych consult on 7/10/25, but the psychiatrist was on vacation, which was why it was not done. A review of the facility policy titled Behavioral Management, with a revised date on 1/10/25, given by the DON, did not address dementia care for a resident who is on a psychotropic medication. On 9/5/25 at 12:29 PM, the surveyor interviewed the DON regarding a policy for dementia care or psychotropic use. Still, the DON stated that they only have a behavioral management policy, which is their general policy and no other information was provided. NJAC 8:39-45.1(a)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer a resident a COVID-19 Immunization and provide education regarding the vaccine. This deficient practice was identified for 1 of 5 residents reviewed for immunization (Resident #12). On 09/3/25 09:59 AM, the surveyor reviewed Resident #12's medical record which revealed the following information: A review of the Resident's Face Sheet (an admission summary) revealed Resident # 12 had been admitted to the facility with diagnoses which included hemiplegia following cerebral infarction affecting the right dominant side and chronic kidney disease. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 8/25/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of Resident #12's active Care Plan (CP) printed on 9/5/25 did not reveal any focus, goals, or interventions for vaccinations. A review of Resident #11's electronic Medical Record (eMR) under Immunization did not reveal a Covid-19 Immunization administration record. On 9/3/25 at 10:43 AM, the surveyor discussed the concern with the Director of Nursing (DON) that the historical record of the resident's COVID-19 immunization was not on the eMR. A review of the progress notes (PN) reflected an entry made by the Registered Nurse/Unit Manager (RN/UM) reflected the resident received vaccination back in 2022, after surveyor inquiry. A review of the paper based medical record (hard chart) did not reflect an offer, refusal and education provided to the resident upon and after admission. On 9/4/25 at 9:45 AM, during an interview with the Registered Nurse/Unit Manager (RN/UM) explained the process for immunization for admitted residents. The RN/UM stated the nurse on duty admitting the resident, recorded the historical information of the resident's vaccination record either via resident interview when capable, family interview or previous medical record. At 10:04 AM, the surveyor and the RN/UM reviewed the resident's medical record together. At that time, the RN confirmed that there was no documentation in the medical record of that the COVID-19 immunization was offered, administered or refused and the evidence that education provided. At 10:29 the DON confirmed that the medical record did not reflect the COVID-19 immunization was offered, administered/refused and an education was provided. On 9/4/25 at 9:15 AM, during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA) and the DON, the surveyor discussed the concern regarding the COVID-19 immunization. On 9/5/24 at 12:34 PM, in the presence of the survey team, and the LNHA, the DON stated that they had updated the immunization form of Immunization Information and Permission form which was updated to include the COVID-19 vaccine, acceptance or refusal and the education for the influenza, the pneumonia, the respiratory syncytial virus (RSV) and the COVID-19 vaccines. A review of the facility provided policy for Immunization, dated/ revised on 9/4/25 reflected that all residents would receive education regarding immunization benefits prior to being offered the vaccine. A right of refusal would also be included in the education for the resident/ resident representative and documented in the resident's medical record. N.J.A.C. 8:39-19.4(a)		