STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315047	A. BUILDING **01** B. WING _____	**11/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE** **CINNAMINSON, NJ 08077**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 on 11/9/22. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/9/22 and was found to be in noncompliance with the 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 19 EXISTING Health Care Occupancy. Wynwood Rehabilitation and Healthcare Center is a three-story building, built in 1965. It is composed of Type II protected construction. The facility is divided into 4-smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 105 of 114.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 211		11/11/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/08/2022

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K 211	Continued From page 1 by: Based on observation and staff interview, the facility failed to ensure the force required to fully open any door leaf manually in a means of egress did not exceed 15 pounds of force (lbf) to release the latch, 30 lbf to set the door leaf in motion, and 15 lbf to open the door leaf and the means of egress was continuously maintained free of all obstructions to full use in case of an emergency in accordance with NFPA 101 (Life Safety Code) 2012 Edition Chapter 19.2.1., Chapter 7.2.1.4.5.1, 7.2.1.4.2 and 7.7.4. This deficient practice had the potential to affect 32 residents. Findings include: An observation on 11/9/22 at 1:25 PM revealed the exit door, located in the Occupational and Physical Therapy Room, was dragging against the door threshold, and required pressure of more than 30 lbf to set the door in motion. The Surveyor applied pressure with a door pressure gauge which ranged 0-35 lbf and the force required to open the door did not register on the gauge. During an interview at the time of the observation, the Maintenance Director confirmed the force to open the exit door exceeded 30 lbf. An observation on 11/9/22 at 1:54 PM revealed the exterior gate, located in the smoking area and leading to a public way, was side hinged, swung inward and did not swing in the direction of egress. During an interview at the time of the observation, the Maintenance Director confirmed the exterior	K 211	K211- Means of Egress It is the practice of the facility to maintain all Means of Egress to be in accordance with NFPA 101. The Maintenance Director adjusted the exit door in the Occupational and Physical therapy gym to ensure it opens and closes properly. The Maintenance Director adjusted the exterior gate in the smoking area to swing/open in the direction of egress. Residents have the potential to be affected by this practice. Maintenance staff were educated on the appropriate procedure to complete the inspections of the exit doors in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee will continue to inspect the exit doors. Audits of the logs will be completed once a week x4 weeks and monthly time two months. Results of the QA&A x3months will be reported to the QAPI Committee until compliance is achieved and committee determines that the problem is resolved or stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	

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K 211	Continued From page 2 gate swung inward and not in the direction of egress. During an interview on 11/9/22 at 4:40 pm, the Administrator informed an average of 15 residents utilized the Occupational and Physical Therapy Room and Activity/Dining Room and 17 residents utilized the smoking area. NJAC 8:39-31.1(c), 31.2(e)	K 211		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure directional signs, which showed the direction of travel, were placed in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101 (2012 edition) section 7.10.2.1. This deficient practice had the potential to affect 105 residents. Findings include: Observations at 1:31 PM and 2:14 PM revealed directional signs were not placed to indicate the direction of travel at the North and South nurse	K 293	K293- Exit Signage It is the practice of the facility to maintain all Exit and Directional signs in accordance with NFPA 101. The Maintenance Director installed exit signs by both North and South nurse stations. Residents have the potential to be affected by this practice. Maintenance staff were educated on the	11/15/22

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K 293	Continued From page 3 stations. During an interview at the time of the observations, the Director of Maintenance confirmed that the direction of travel was not apparent at the North and South nurse stations. NJAC 8:39-31.1(c), 31.2(e)	K 293	appropriate procedure to complete the inspections of the exit signs in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee will continue to inspect the exit signs to ensure they are in working order. Audits of the logs will be completed once a week x4 weeks and monthly time two months. Results of the QA&A x3 months will be reported to the QAPI Committee until compliance is achieved and committee determines that the problem is resolved or stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		11/11/22

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K 321	Continued From page 4 19.3.2.1, 19.3.5.9 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 square feet) g. 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 the door to a room used for storage of combustible supplies and equipment and over 50 square feet (sq. ft), located in one of four smoke compartments, was self-closing or automatically closing in accordance with NFPA 101 Life Safety Code (2012 Edition) 19.3213 and 19.3.2.1.5(7). This deficient practice could affect 16 residents who resided in smoke compartment two. Findings include: An observation on 11/9/22 at 1:43 PM revealed the Beauty Shop, located in smoke compartment two, was being utilized as a storage room and contained 38 cardboard boxes (varied in size), a residential air conditioning unit, various tools, and supplies. The room measured 208 sq. ft. and the door was not self-closing or automatically closing. During an interview at the time of the observation, the Maintenance Director confirmed the Beauty	K 321	K321- Hazardous Areas □ Enclosure It is the practice of the facility to maintain all Hazardous Areas □ Enclosures to be in accordance with NFPA 101. The Maintenance Director installed Door closure in the beauty salon to ensure it is a secure smoke compartment. Residents have the potential to be affected by this practice. Maintenance staff were educated on the appropriate procedure to complete the inspections of the beauty salon and any other smoke compartments in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee continue to inspect the door closure to ensure its in working order. Audits of the logs will be completed once a week x4	

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K 321	Continued From page 5 Shop was being used as a storage room, measured 16 feet by 13 feet (208 sq. ft) and did not have a self-closing or automatically closing door. NJAC 8:39-21.2(e)	K 321	weeks and monthly time two months. Results of the QA&A x3months will be reported to the QAPI Committee until compliance is achieved and committees determines that the problem is resolved or stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure deficiencies or	K 353	K353- Sprinkler System- Maintenance and Testing	11/11/22

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K 353	Continued From page 6 impairments that were found during the inspection, test, and maintenance of the sprinkler system were corrected in accordance with NFPA 25 (Standard for the Inspection, Testing, and Maintaining of Water based Fire Protection Systems) (2011 Edition) 4.1.4.1. This deficient practice had the potential to affect all 105 residents who reside in the facility. Findings include: Document review of the facility document titled, "Automatic Sprinkler Systems Quarterly Inspection Report" dated 10/12/22, revealed the inspector, in Section A of the report, indicated "SC" (see comments) and "N" (no) to the section "Are flow/pressure switches, lamp switches, electric bells provided and operating?" The comment section of the report revealed the "Outside Stem and Yoke (OS&Y)" valve in the pit was not tampered. There was no documentation to indicate a tamper switch had been added to the OS&Y valve. During an interview on 11/9/22 at 10:00 AM, the Maintenance Director confirmed a tamper switch had not been added to the OS&Y valve as noted in the "Automatic Sprinkler Systems Quarterly Inspection Report." NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	It is the practice of the facility to maintain all parts of the automatic sprinkler and standpipe system are inspected and tested and maintained in accordance with NFPA 25. Maintenance Director had a tamper switch installed. Residents have the potential to be affected by this practice. Maintenance staff were educated on the appropriate procedure to complete the inspections of the Automatic sprinkler system in accordance with NFPA 25 by the Administrator. The Maintenance Director or designee continue to inspect Automatic sprinkler system to ensure its in working order. Audits of the logs will be completed once a week x4 weeks and monthly time two months.The sprinkler company does quaterly inspections to ensure compliance. Results of the QA&A x3 months will be reported to the QAPI Committee until compliance is achieved and committees determines that the problem is resolved or stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	

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K 355	Continued From page 7	K 355		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable fire extinguishers, other than wheeled extinguishers, were installed securely on a hanger intended for the extinguisher in one of four smoke compartments in accordance with NFPA 10 (Standard for Portable Fire Extinguishers) 2010 Edition 6.1.3.4(1). This deficient practice had the potential to affect 18 residents who resided in smoke compartment three. Findings include: An observation on 11/9/22 revealed the Class K fire extinguisher located in the kitchen (smoke compartment three) was not installed securely on a hanger intended for the extinguisher. During an interview at the time of the observation, the Director Maintenance confirmed the Class K fire extinguisher was not installed securely on a hanger. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96	K 355	K355- Portable Fire Extinguishers It is the practice of the facility to maintain all Portable Fire Extinguisher in accordance with NFPA 101. The Maintenance Director hung the Class K Fire Extinguisher in the kitchen. Residents have the potential to be affected by this practice. Maintenance staff were educated on the appropriate procedure to complete the inspections of all Fire extinguishers in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee will continue to inspect all fire extinguishers to ensure they are hung properly. Audits of the logs will be completed once a week x4 weeks and monthly time two months. Results of the QA&A x3months will be reported to the QAPI Committee until compliance is achieved and committees determines that the problem is resolved or	11/11/22

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K 355	Continued From page 8	K 355	stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no	K 363		11/15/22

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K 363	Continued From page 9 restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure corridor doors closed and latched in their frames and were capable of resisting the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) 19.3.6.3 This deficient practice had the potential to affect 105 residents. Findings include: Observations on 8/30/22 between 1:11 PM and 2:05 PM revealed the following: 1. The doors to rooms [redacted] and [redacted] failed to latch when closed. 2. The doors to rooms [redacted] and [redacted] had a one-inch gap between the door and the door frame. The Director of Maintenance was present at the time of each observation and confirmed the doors to rooms [redacted] and [redacted] failed to latch when closed. The Director of Maintenance also confirmed the one-inch gap between the door and the door frames for rooms [redacted] and [redacted] NJAC 8:39-31.1(c), 31.2(e)	K 363	K363-Corridor- Doors It is the practice of the facility to maintain all Corridors/Doors to be in accordance with NFPA 101. The Maintenance Director repaired the 4 doors that where not latching and repaired the 3 doors with gaps between the doors and door frame.all correction swere completed by 11/15/22 Residents have the potential to be affected by this practice. Maintenance staff were educated on the appropriate procedure to complete the inspections of all Corridors/Doors in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee will continue to inspect all Corridors/Doors to ensure they are latching and that there are no gaps around any doors. Audits of the logs will be completed once a week x4 weeks and monthly time two months. Results of the QA&A x3months will be reported to the QAPI Committee until	

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K 363	Continued From page 10	K 363	compliance is achieved and committees determines that the problem is resolved or stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure penetrations in a smoke barrier were protected by a system or material capable of restricting the transfer of smoke. This deficient practice had the potential to affect 53 residents who resided in smoke compartments one and two - [redacted] Wing. Findings include: Observations on 11/09/22 at 10:20 AM revealed	K 372	K372- Subdivision of Building Spaces- Smoke Barrier It is the practice of the facility to maintain all Smoke Barriers in accordance with NFPA 101. The Maintenance Director repaired all observed penetrations in the attic. Residents have the potential to be	11/15/22

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K 372	Continued From page 11 the smoke barrier, located in the attic above Rooms [redacted] and [redacted] (smoke compartment one and two - [redacted] Wing), had a two-inch diameter pipe penetrating an unsealed opening, two one-inch pipes penetrating a 14 inch x 3 inch unsealed opening, three ½-inch flexible conduits penetrating an unsealed opening, one white wire penetrating a one-inch diameter unsealed opening, and a bundle of white wires penetrating a two-inch diameter unsealed opening. During an interview at the time of the observations, the Director of Maintenance confirmed the penetrations in the smoke barrier were not protected. NJAC 8:39-31.1(c), 31.2(e)	K 372	affected by this practice. Maintenance staff were educated on the appropriate procedure to complete the inspections of all Smoke Barriers in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee will continue to inspect all Smoke Barriers to ensure they are that there are no penetrations in the smoke compartments. Audits of the logs will be completed once a week x4 weeks and monthly time two months. Results of the QA&A x3 months will be reported to the QAPI Committee until compliance is achieved and committees determines that the problem is resolved or stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or	K 374		11/11/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315047	A. BUILDING **01** B. WING _____	**11/10/2022**

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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K 374	Continued From page 12 automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in smoke barriers closed the opening between doors, leaving only the minimum clearance necessary for proper operation, and provided an effective barrier to limit the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) 8.5.4.1 and 19.3.7.8. This deficient practice had the potential to affect 52 residents, who resided in smoke compartments three and four - North Wing. Findings include: An observation on 11/9/22 at 2:00 PM revealed the smoke barrier doors, located adjacent to the north nurses' station, had a ¾-inch gap between the doors when the smoke barrier doors were closed. During an interview at the time of the observation, the Maintenance Director confirmed the ¾-in gap between the doors when the smoke barrier doors were closed. NJAC 8:39-31.1(c), 31.2(e)	K 374	K374- Subdivision of Building Spaces-Smoke Barrier It is the practice of the facility to maintain all Smoke Barriers in accordance with NFPA 101. The Maintenance Director repaired/adjusted the smoke barrier doors to create a sealed smoke compartment. Residents have the potential to be affected by this practice. Maintenance staff were educated on the appropriate procedure to complete the inspections of all Smoke Barriers and smoke barrier doors in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee will continue to inspect all Smoke Barriers/ Smoke Barrier Doors to ensure they are that there are no gaps or penetrations in or around the doors. Audits of the logs will be completed once a week x4 weeks and monthly time two months. Results of the QA&A x3months will be reported to the QAPI Committee until compliance is achieved and committees determines that the problem is resolved or	

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	315047	A. BUILDING **01** B. WING _____	**11/10/2022**

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WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE** **CINNAMINSON, NJ 08077**

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K 374	Continued From page 13	K 374	stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by:	K 741		11/15/22

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	315047	A. BUILDING **01** B. WING _____	**11/10/2022**

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WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE** **CINNAMINSON, NJ 08077**

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K 741	Continued From page 14 Based on observation, interview, and document review, the facility failed to ensure ashtrays of noncombustible material and safe design, and a metal container with a self-closing cover device into which ashtray could be emptied, were readily available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (5)(6). This deficient practice had the potential to affect 17 residents who were smokers and utilized the smoking area. Findings include: A review of the facility policy titled, "Smoking Policy - Residents" dated July 2017, revealed "metal containers, with self-closing cover devices, are available in smoking areas ... ashtrays are emptied only into designated receptacles." A observation on 11/9/22 at 1:56 PM revealed the smoking area had three freestanding plastic cigarette butt receptacles and did not have an ashtray of noncombustible material and a metal container with a self-closing cover device. During an interview at the time of the observation, the Maintenance Director confirmed there was not an ashtray of noncombustible material and a metal container with a self-closing cover device in the designated smoking area. NJAC 8:39-31.2(e), 31.6(e)	K 741	K741 Smoking Regulations It is the practice of the facility to comply with Smoking Regulations in accordance with NFPA 101. A metal ashtray with a self-closing cover was placed in the smoking area to ensure the safety of the residents.The ashtray will be emptied during the weekly inspection. Residents have the potential to be affected by this practice. Maintenance staff were educated on the Smoking Regulations in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee will continue to inspect all the smoking area to ensure the facility complies Smoking Regulations. Audits of the logs will be completed once a week x4 weeks and monthly time two months. Results of the QA&A x3months will be reported to the QAPI Committee until compliance is achieved and committees determines that the problem is resolved or stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101	K 911		11/15/22

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K 911	Continued From page 15 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical junction boxes were maintained and closed with a suitable cover securely fastened in place in accordance with NFPA 70 (2011 Edition) section 314.72(E). This deficient practice had the potential to affect the 105 residents who reside in the facility. Findings include: An observation between 10:40 AM and 10:50 AM revealed three open junction boxes without covers in the attic located above Room [redacted] Room [redacted] and the [redacted] Nurses Station. During an interview at the time of the observation, the Maintenance Director confirmed the condition of the three junction boxes. NJAC 8:39-31.2(e) NFPA 70	K 911	K911 Electrical systems It is the practice of the facility to maintain all Electrical systems in accordance with NFPA 101. The Maintenance Director placed covers on all observed electrical junction boxes without covers. Residents have the potential to be affected by this practice. Maintenance staff were educated on the appropriate procedure to complete the inspections of all electrical junction boxes in accordance with NFPA 101 by the Administrator. The Maintenance Director or designee will continue to inspect all Junction boxes to ensure they are that there are covers on all electrical boxes. Audits of the logs will be completed once a week x4 weeks and monthly time two months. Results of the QA&A x3months will be reported to the QAPI Committee until compliance is achieved and committees determines that the problem is resolved or	

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K 911	Continued From page 16	K 911	stable. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary x3 months. The results will be used for training and system changes through the QA committee.	

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
315047 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077

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 K0211	11/11/2022	LSC K0293	11/15/2022	LSC K0321	11/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	11/11/2022	LSC K0355	11/11/2022	LSC K0363	11/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	11/15/2022	LSC K0374	11/15/2022	LSC K0741	11/15/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	11/15/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/10/2022	☐ YES ☐ NO