WYNWOOD REHABILITATION AND HEALTHCARE CENTER 1700 WYNWOOD DRIVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
WWWOOD REHABILITATION AND HEALTHCARE CENTER Too WYWWOOD DRIVE CINNAMISON, NJ 06077 (M) D PREFIX TAG SUMMAY STATEMENT OF DEFICIENCIES (EACH EDRIVENCY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX CONSECTIVE ADDRECTIVE OF TO HEADPHORMATION D PREFIX TAG E 000 Initial Comments E 000 E 000 D D D D CARE TO THE APPROPRIATE DEFICIENCY D D D D D D D D D D D D D D D D D D D			315047	B. WING		09/22/2020	
Image Submary Stretuent or Descriptions Description Period Baseline Construction Description Image Initial Comments Period Baseline Construction Period Baseline Construction Description E 000 Initial Comments E 000 E 000 Initial Comments E 000 This facility is in substantial compliance with Appendix Z.Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities. K 000 LIFE SAFETY CODE 101:2012 This FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE ROUTE ASS SURVEYED UNDER CMS-2786R. K 222 10/20/20 Egress Doors Care (LTC) Facilities. K 222 10/20/20 Egress Doors CLINCAL NEEDS OR SECURITY THREAT LOCKING K 222 10/20/20 Where special locking arrangements for the equipped with a latio or lock that requires the use of a tool or key from the egress sidel unless using one of the following special locking arrangements: CLINCAL NEEDS OR SECURITY THREAT LOCKING K 222 10/20/20 Bereicking device shall be permitted on each door and provisions shall be made for the tripid removal of occupants by: remote control of locks, keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. SeeLine Contreline control of locks, keying	NAME OF PROVIDER OR SUPPLIER WYNWOOD REHABILITATION AND HEALTHCARE CENTER				1700 WYNWOOD DRIVE		
This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.K 000K000INITIAL COMMENTSK 000LIFE SAFETY CODE 101:2012THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R.K 222K 222Egress DoorsK 222Doors in a required means of egress shall not be equipped with a latch or a lock that requires the uses of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, and in locks or key carried by staff at al times; or other subcing locking requirements areK 102.22.5.1, 18.2.2.6, 19.2.2.5.1, 19.2.2.6 SPECIAL NEEDS LOCKING ARRANCEMENTS	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE COMPLETION	
Appendix 2:Emergency Preparedness for All Provider and Suppler Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities. K 000 INITIAL COMMENTS LIFE SAFETY CODE 101:2012 THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R. K 222 Egress Doors DOORs in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid locks; keying of all locks or keys carried by staff at all times; or other such of the Size SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the clinical or Security Locking requirements are clinical or Security Locking requir	E 000	Initial Comments		EOC	00		
THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R.K 222Egress Doors SbepCR(s): NFPA 101Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on eeach door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times: navailable to the staff at all times. 18.2.2.2.6.1, 18.2.2.2.6, 19.2.2.2.6. SPECIAL NEEDS LOCKING ARRANCEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements areImage: test of the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 000	Appendix Z-Emerge Provider and Supplie Guidance 483.73, R Care (LTC) Facilities	ncy Preparedness for All er Types Interpretive equirements for Long Term s.	К 00	00		
COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R. 10/20/20 K 222 Egress Doors K 222 SS=D CFR(s): NFPA 101 K 222 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be parmitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.22.2.5.1, 19.2.2.2.6. SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the clinical or security Locking requirements are		LIFE SAFETY COD	E 101:2012				
SS=D CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be parmitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are		COMPLIANCE WITH SAFETY CODE REC	H THE MINIMUM LIFE QUIREMENTS AS				
Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.6.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are				K 22	22	10/20/20	
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Doors in a required to equipped with a latch use of a tool or key for using one of the follow arrangements: CLINICAL NEEDS CO LOCKING Where special locking clinical security needs only one locking deve each door and provision rapid removal of occu- locks; keying of all to at all times; or other available to the staff 18.2.2.2.5.1, 18.2.2. SPECIAL NEEDS LO Where special locking safety needs of the p	h or a lock that requires the from the egress side unless owing special locking DR SECURITY THREAT and arrangements for the ds of the patient are used, trice shall be permitted on sions shall be made for the supants by: remote control of bocks or keys carried by staff such reliable means at all times. 2.6, 19.2.2.2.5.1, 19.2.2.2.6 DCKING ARRANGEMENTS and arrangements for the boatient are used, all of the				
	BORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE	

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.

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					O. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		DNSTRUCTION	(X3) DAT	E SURVEY PLETED
		315047	B. WING			09	/22/2020
NAME OF PF	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				1700	WYNWOOD DRIVE		
WINWOO	D REHADILITATION AND) HEALTHCARE CENTER		CINI	NAMINSON, NJ 08077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 222	Continued From page being met. In addition electrical locks that fa upon loss of power to protected by a superv system and the locker complete smoke dete constantly monitored within the locked space and detection system doors upon activation 18.2.2.2.5.2, 19.2.2.2 DELAYED-EGRESS ARRANGEMENTS Approved, listed delay installed in accordance permitted on door ass ordinary hazard conte throughout by an app automatic fire detection supervised automatic 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLL ARRANGEMENTS Access-Controlled Eg installed in accordance permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY E ARRANGEMENTS Elevator lobby exit acc	e 1 , the locks must be il safely so as to release the device; the building is rised automatic sprinkler d space is protected by a ction system (or is at an attended location ce); and both the sprinkler s are arranged to unlock the .5.2, TIA 12-4 LOCKING yed-egress locking systems se with 7.2.1.6.1 shall be semblies serving low and ents in buildings protected roved, supervised on system or an approved, sprinkler system. LED EGRESS LOCKING ress Door assemblies se with 7.2.1.6.2 shall be EXIT ACCESS LOCKING cess door locking in 1.6.3 shall be permitted on uildings protected roved, supervised on system and an		222			
	system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT by:	is not met as evidenced					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDIN			. ,	LETED	
		315047	B. WING			09/2	22/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
WYNWOO	D REHABILITATION AN	D HEALTHCARE CENTER						
				CIN	INAMINSON, NJ 08077			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
K 222	Continued From pag	e 2	К 2	22				
	Based on observation		112		Submission of this Plan of Correction			
	09/21/2020, in the pr				does not constitute an admission or			
	-	determined that the facility			agreement by the provider on the			
		staff and residents were			statement of deficiencies. This plan of			
		ns to unlock exit access			Correction is prepared and submitted			
	doors at all times.				because of requirements under State a	nd		
					Federal law. Please accept this plan of			
	This deficient practic	e was evidenced by the			correction as our credible allegation of			
	following:				compliance.			
	-	acility starting at 9:30 AM, in			Corrective action taken:			
	-	acility's Administrator, the						
		n the corridor between			The PT door knob was immediately			
	resident rooms #21 and #22, a heavy gauge				unlocked and will be kept unlocked			
	· · ·	ng from the ceiling. The			throughout working hours. For after hour	irs		
		ecured to the ceiling and revented access to the			a key to unlock the door will be kept on the nurses key ring. The supervisor will			
		plastic curtain, the surveyor			also have a key to unlock it. Staff was			
		kit sign attached to a surface			in-serviced on the new plans. Facility			
	-	. This plastic exit sign had a			wide audit was done to ensure no other			
		v, which directed traffic to			exits had similar issues.			
		orridor to the Physical						
		he PT area was equipped			No residents were affected by this			
	with a combination lo	ock door knob that required a			practice. No other exits are in an office	or		
		o allow the user to pass			have a similar issue.			
		get to the exit door. The PT						
	-	tized and does not release to			Maintenance Director/Designee will do			
	the fire alarm and no	access code was available.			weekly rounds and audits to ensure that	t		
	At that time the aver	over conducted on interview			doors leading to exits are accessible.			
		eyor conducted an interview r who stated the COVID unit			These audits will be reviewed together with the Administrator/Designee weekly			
		e of the plastic curtain and			X3 then monthly X4 and presented to			
	that traffic should exi	•			quarterly QAPI to ensure compliance.			
		ned that the PT door access						
		ble and that traffic could not						
	exit the door without	it.						
	NJAC 8:39-31.2(e)							
K 293	Exit Signage		K 2	93			10/20/20	

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Event ID: JTE221

Facility ID: NJ60314

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED
		315047	B. WING		09/22/2020
	ROVIDER OR SUPPLIER	D HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIO THE APPROPRIATE DATE
K 293 SS=D	CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional si accordance with 7.10 illumination also serve lighting system. 19.2.10.1 (Indicate N/A in one-s with less than 30 occu travel is obvious.) This REQUIREMENT by: Based on observatio on 09/21/2020, in the management, it was of failed to ensure the et illuminated at all time: This deficient practice following: At 1:50 PM, the surve Corporate Maintenan observed that the exit corridor above the sm resident rooms #49 a	gns are displayed in with continuous ed by the emergency story existing occupancies upants where the line of exit is not met as evidenced in and interview conducted presence of facility determined that the facility kit directional signs were s. e was evidenced by the eyor, in the presence of the	K 2	 93 Submission of this Plan of does not constitute an adm agreement by the provider statement of deficiencies. T Correction is prepared and because of requirements u Federal law. Please accept correction as our credible a compliance. Corrective Action Taken: The exit sign bulb was replwide audit was conducted to other exit signs were not ille No residents were affected Maintenance Director/Designee illuminated. Weekly rounds and audits to the Administrator/Designee Maintenance Director/Designee 	ission or on the This plan of submitted nder State and this plan of illegation of aced. Facility to ensure no uminated. by this. gnee to do xit signs are to be done by and

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Event ID: JTE221

Facility ID: NJ60314

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315047		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SU COMPLE	
		B. WING		09/22	/2020	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	•	2020
				1700 WYNWOOD DRIVE		
WYNWOO	D REHABILITATION ANI	D HEALTHCARE CENTER		CINNAMINSON, NJ 08077	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE
K 293	Continued From page	÷ 4	K 2	293 X3 thereafter monthly quarterly at QAPI me compliance.		
K 521 SS=D	HVAC CFR(s): NFPA 101		K 5	21	10)/20/20
	HVAC Heating, ventilation, a comply with 9.2 and s accordance with the r specifications. 18.5.2.1, 19.5.2.1, 9.2	nanufacturer's				
	This REQUIREMENT	is not met as evidenced				
	Based on observatio 09/21/2020, in the pre Management, it was of failed to ensure that t being properly mainta			Submission of this P does not constitute a agreement by the pro statement of deficien Correction is prepare because of requirement Federal law. Please a	n admission or ovider on the cies. This plan of ed and submitted ents under State and	
	This deficient practice following:	e was evidenced by the		correction as our creation compliance.		
	the facility's Corporate (CMD) and facility Dir	acility, in the presence of e Maintenance Director ector of Maintenance performed an inspection of		The exhaust fan was replaced. Facility wid other exhaust fans w	le audit to ensure all	
	four (4) Resident bath	performed an inspection of prooms and found that the of 4 resident bathrooms was		No residents were af	fected by this.	
	not functioning prope	-		Maintenance Directo daily rounds to ensur		
	surveyor observed a	nt room #50 bathroom, the ventilation grill that was in size. The ventilation was		Wookly rounds and a	audits to be done by	

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Facility ID: NJ60314

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
315047		B. WING		09/22/2020	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COL	
WYNWOO	D REHABILITATION AN	D HEALTHCARE CENTER		1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE DATE
K 521	Continued From page	e 5	K 52	1	
	grill. The tissue did no the ventilation was no bathrooms had no wi	ngle-ply of tissue across the ot hold in place, indicating ot functioning properly. All ndow with an area that d on mechanical ventilation.		Administrator/Designee and Director/Designee X3, thereat X4 which will be presented to QAPI to ensure compliance.	ifter monthly
	During the time of the observation, the surveyor interviewed the CMD who confirmed that the bathroom exhaust system did not function properly.				
	NFPA 90A NJAC 8:39-31.2 (e)				
K 914 SS=D	Electrical Systems - I CFR(s): NFPA 101	Maintenance and Testing	K 91	4	10/20/20
	Hospital-grade recep locations and where a anesthesia is adminis installation, replacem testing is performed a documented perform listed as hospital-grad tested at intervals not isolation monitors (LI intervals of less than actuating the LIM tes which activates both For LIM circuits with a manual test is perform equal to 12 months. I 6.3.3.2 after any re electric distribution sy maintained of require	deep sedation or general stered, are tested after initial eent or servicing. Additional at intervals defined by ance data. Receptacles not de at these locations are t exceeding 12 months. Line M), if installed, are tested at or equal to 1 month by t switch per 6.3.2.6.3.6, visual and audible alarm. automated self-testing, this med at intervals less than or LIM circuits are tested per pair or renovation to the ystem. Records are ed tests and associated ns, containing date, room or			

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PRINTED: 11/19/2020

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

PRINTED: 11/19/2020 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED
315047		B. WING		09/22/2020	
NAME OF PROVIDER OR SUPPLIER WYNWOOD REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETIC E APPROPRIATE DATE
K 914	by: Based on observatio provided documentat presence of facility m determined that the fa receptacles in resider accordance with NFP This deficient practice following: During a tour of the fa in the presence of the (DOM), the surveyor rooms were provided that were less than he required testing for gr retention. A review of the facility documentation for the identified that the last inspection was perfor	n and review of facility ion on 09/21/2020 in the anagement, it was acility failed to test electrical nt rooms every 12 months in A 99. e was evidenced by the acility, starting at 10:00 AM e Director of Maintenance observed that the resident with electrical receptricals ospital grade, which rounding, polarity, and blade t's electrical inspection e previous 19 months clicensed electrical med on 03/19/2020 with the onducted on 12/05/2020,	K 91	 Submission of this Plan of C does not constitute an admis agreement by the provider o statement of deficiencies. Th Correction is prepared and s because of requirements und Federal law. Please accept t correction as our credible all compliance. Electrical Inspection was per 03/19/2020 upon Maintenand becoming aware of its deling No residents were affected b practice. Maintenance Director/Design weekly audits of the life safe to ensure that no inspections outstanding. These audits wi reviewed together with the Administrator/Designee wee monthly X4 and presented to QAPI to ensure compliance. 	ssion or n the nis plan of submitted der State and his plan of egation of formed on ce Director juency. by this nee will do ty paperwork s are ill be kly X3 then

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