STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HOUSE HOME FOR THE JEWISH AGED	**53 WALTER STREET , TRENTON, New Jersey, 08628**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Complaint #: 2576378 and 2621162 Survey Dates: 03/23/26-03/26/26 Survey Census: 106 Sample Size: 27 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION VISIT.	F0000		04/14/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812	No residents were affected by deficient practice as dirty and wet nesting items were immediately removed, properly washed, sanitized, and dried before putting back in service. No residents were affected by deficient practice as the solution was immediately diluted in the sanitizer sink to meet sanitary standards. Service call was placed with [redacted] for recalibration, which was completed on the sanitizer dispenser on 3/26/26. All residents have the potential to be affected. An audit will be conducted of the drying and storing areas of the kitchen by the Director of Dietary and some adjustments will be made to permit proper drying and storage of all washed kitchen items. Cooks will document the status of the kitchen items at least once daily on their shift to ensure that items are being dried & stored properly. In addition, a weekly safety walk will be conducted with the Dietary Director/designee and members of the Dietary staff with documented findings that include a check on the drying & storage of kitchen items. All Dietary Department staff have been in-serviced on proper procedure for ware washing and storing	04/20/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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F0812 SS = F	Continued from page 1 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and policy review, the facility failed to ensure kitchen utensils were stored in a clean and sanitary manner. These failures had the potential to cause food-borne illness for 101 out of 106 residents who received meals prepared in the facility (five residents received nutrition via feeding tubes). Findings include: 1. During the initial kitchen inspection, completed with the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) U.S. FO) on 03/23/26 at 10:18 AM, the following concerns were noted: a. In a bin of serving utensils (spoons and scoops), the handle of one serving spoon was covered with a white substance on the handle. The U.S. FO stated the white substance was mayonnaise. b. On the three-compartment sink's metal counter were four out of 13 full sheet trays stacked wet. Also on the counter was a mixture of two-inch, four-inch, and six-inch hotel pans. Six of the pans were stacked wet and greasy to touch. The U.S. FOIA stated, "They (pans) were washed last night, and the drying rack was full, so they put them over here." c. On one of four drying rack carts were five two-inch hotel pans stacked wet and greasy to touch. 2. During a follow-up inspection on 03/25/26 at 11:10 AM, the following concerns were noted: a. One two-inch hotel pan was on one of four drying rack carts. The pan had a dried crusted substance on the inside of the rim. This was confirmed by the U.S. FO b. The three-compartment sink sanitizer was tested by the U.S. FO and registered between 700 and 848 parts per milliliter (PPM). According to NJ Exec Orde (used by the facility) recommendations for "Sink and Surface	F0812	Continued from page 1 items correctly. A repeat inservice will occur by 4/20/26. The Cooks have been in-serviced on proper use of the Daily Walkthrough Sheets, with sheets being turned in daily to the Dietary Director or Designee for compliance. All Dietary Department staff have been in-serviced on proper procedure for recording sanitizer check daily. A repeat inservice will occur by 4/20/26. The Cooks have been in-serviced on their responsibility to ensure that proper sanitation levels are recorded during their shift; any issues are immediately corrected. Dietary Director or designee will audit and document the compliance of the sink racks and drying racks at least three times a week to ensure there are no dirty, greasy, or wet nesting items and report monthly to QAPI on findings/corrective actions for six months. Weekly Safety Walks will be conducted that include sink and drying rack observations and will be shared with QAPI committee monthly for 6 months.	04/20/2026

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F0812 SS = F	Continued from page 2 Cleaner Sanitizer," the PPM should be between 272 and 700 PPM. An interview was conducted on 03/26/26 at 9:41 AM with the U.S. FOIA (b)(6) r, U.S. FOIA (b)(6) , and the U.S. FOIA (b)(6)). The concerns of stacked wet and greasy pans, soiled spoon, and high PPM of the sanitizer in the three-compartment sink were discussed. Review of the facility's policy titled, "Sanitation & Infection Control," with a revision date of 05/20/23, revealed, "All clean China, dishware, and cooking wares will be stored appropriately to prevent food soil, dust or any other debris from adhering to surface of dish or cooking wares. Procedure: 1. After coming out of dish machine or the sanitizer of the 3-pot sink; dishware, utensils, and cooking wares will be air dried prior to storage. 2. Clean dishware of cooking wares will be stored in an appropriate manner with either the top dish/plate or cooking ware inverted . . . 4. All utensils are stored in a clean bin." NJAC 8:39-17.2(g)	F0812		04/20/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	The U.S. FOIA (b)(6) was educated on enhanced barrier precautions without appropriate hand hygiene on 04/02/2026. Laundry Aide 1 and U.S. FOIA (b)(6) were educated on properly donning and doffing, hand hygiene, and sanitization of equipment on 04/06/2026. All laundry, environmental services, and nursing staff were re-educated on soiled linen policy. The cart used for soiled linen was cleaned and disinfected before being returned to use. All residents and staff have the potential to be affected by this deficient practice. The Infection Preventionist will conduct random 5 random audits weekly of staff to ensure proper donning and doffing and hand hygiene. Environmental Services Supervisor will change the sanitation schedule to daily and as needed and conduct random audits for the cleanliness of the dumb waiter. Greenwood House clinical staff will be educated by the Infection Preventionist on proper donning and doffing, enhanced barrier precautions, and hand hygiene on 5/1/2026. Environmental Services Supervisor will educate laundry staff and	05/15/2026

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F0880 SS = F	Continued from page 3 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880	Continued from page 3 housekeeping staff on the new schedule for cleaning of dumb waiter on 5/1/2026. The soiled linen policy was reviewed and revised to clearly define practices to reduce risk for cross-over contamination on 05/1/2026. Carts were clearly labeled and assigned for clean linen and dirty linen.A cleaning schedule to clean linen carts was established after dirty linen use. The Director of Nursing or designee will audit cleanliness of dumbwaiter, linen carts, and completion of Infection Preventionist audits weekly. Audits will be conducted weekly x 4 weeks then monthly x 3 months. Results of the monthly audits will be reported monthly to the facility Quality Performance Improvement Committee x 3 months.	05/15/2026

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F0880 SS = F	Continued from page 4 Based on observations, interviews, and facility policy review, the facility failed to ensure staff performed appropriate hand hygiene when moving between rooms, including one with NJ Ex Order 26.4(b)(1) [redacted]), creating a risk for cross-contamination. Additionally, the facility failed to process laundry in a clean and sanitary manner and did not ensure laundry staff consistently washed their hands. This failure has the potential to spread infection among the facility's 106 residents. Findings include: 1. On 03/23/26 at 3:13 PM, Licensed Practical Nurse (LPN) 3 was observed entering and exiting multiple resident rooms and touching surfaces in the rooms without washing or sanitizing his/her hands between residents' rooms. LPN3 left room [redacted] entered room [redacted] left room [redacted] entered room [redacted] left room [redacted] and entered room [redacted] The resident in room [redacted] was on [redacted] secondary to having an NJ Exec Order 26.4b1 [redacted]. LPN3 was immediately interviewed upon exiting room [redacted] and stated regarding [redacted] "Staff is supposed to gown if they are providing care to residents." Regarding washing or sanitizing his/her hands between residents, LPN3 stated he/she was unsure but would wash his/her hands before and after administering medications to residents. During an interview on 03/26/26 at 11:34 AM, the U.S. FOIA (b)(6) [redacted]) stated he/she expected staff to wash and/or use hand sanitizer when going into resident rooms. "If a resident is not on [redacted] they do not have to wash their hands, but I expect them to sanitize their hands." During an interview on 03/26/26 at 4:45 PM, the U.S. FOIA (b)(6) [redacted]) confirmed that staff should clean their hands when entering and exiting resident rooms. Observation of the [redacted] signs posted outside of the residents' doors (who were [redacted]) revealed "Wash hands when entering and exiting." Review of the facility's policy titled, "Hand Washing/Hand Hygiene" with revision dates of October 2023 and March 2026, revealed, "Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of	F0880		05/15/2026

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F0880 SS = F	Continued from page 5 healthcare-associated infections . . . All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors." 2. During a continuous observation and interview on 03/26/26 from 10:30 AM until 11:15 AM, the U.S. FOIA (b)(6)) demonstrated receiving dirty laundry from the utility closet on "B Hall". He/she stated staff take the bagged laundry, place it in a cart, and cover it with a sheet. He/she walked down the hall and entered a small hallway with two doors, one to access the dumbwaiter and the next door to enter the kitchen. Laundry staff placed dirty laundry in the dumbwaiter for it to go to the basement. Upon entering the basement there were two doors. The first door was opened and entered to retrieve the dirty laundry from the dumb waiter. The second door was closed, which was the entry to the clean linen. The U.S. FOIA stated he would wheel the dirty laundry through the area where the clean laundry would pass, then go towards the room where the dirty laundry was washed. Upon entry into the dirty laundry side, the U.S. FOIA wore a mask, gown, and gloves. He/she pushed the cart through the dirty laundry room door and began to sort the laundry. He/she threw a towel and sheet into the dirty laundry bin, which he/she confirmed had feces on the side of it. The U.S. FOIA stated laundry often received towels and wash clothes that had feces on them. The U.S. FOIA sorted all the laundry and removed his/her gloves. Without washing his/her hands, the U.S. FOIA opened the door to leave the dirty laundry room. Continuing not to wash his/her hands, the U.S. FOIA returned to the dirty laundry room without gloves and entered the clean laundry room. At 11:10 AM, Laundry Aide (LA) 1 was observed putting gloves on and taking a clean linen cart into the dirty laundry room. LA1 retrieved washed laundry and took it back into the clean laundry room to place into the dryer. LA1 was then observed putting on gloves, a mask, and a gown and stated he/she was going in the dirty laundry area to place dirty linen in the washers. LA1 stated he/she would put gloves and a mask on if he/she was retrieving clean linen from the washer to take back to the clean laundry room and would place a gown, gloves, and mask if he/she was returning to the dirty laundry room to sort dirty laundry. During an observation on 03/26/26 at 11:25 AM, LA1 wore gloves and entered the dirty laundry room with a cart. LA1 removed the gloves at the door of the clean linen room and opened the door with bare	F0880		05/15/2026

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F0880 SS = F	Continued from page 6 hands before returning to the dirty laundry room and washing his/her hands in the sink. LA1 returned to the clean laundry room after touching the door to enter the laundry room. During an interview and observation on 03/26/26 at 5:31 PM, the [U.S. FOIA] opened the dumbwaiter revealing visible white and black crumbs in the corners between the wall and the floor. The kitchen door was open. The [U.S. FOIA] stated it was open frequently, and to avoid cross contamination it should be closed. The [U.S. FOIA] stated the dumbwaiter was currently cleaned weekly but agreed it should be cleaned more frequently. The [U.S. FOIA] stated hands should be washed after leaving the dirty linen room and before entering the clean laundry room. During an interview on 03/26/26 at 5:45 PM, the [U.S. FOIA] stated that he/she expected laundry not to be cross-contaminated and all staff should wash their hands in between handling clean and dirty linen. Review of the facility's policy titled, "Isolation Laundry," dated 07/01/25, indicated, " . . . Procedure: Any employee transporting soiled linen, be it isolation or not, should follow all safety precautions and procedures . . . 12. Wash hands thoroughly following proper hand-washing techniques." Review of the undated facility's policy titled, "Personal Protective Equipment (PPE) Donning and Doffing Guide, Proper Order Prevents Infection Transmission," indicated, "Putting on PPE (Donning) 1. Perform hand hygiene. Wash hands or use alcohol sanitizer before touching PPE . . . 5. Put on gloves. Removing PPE (Doffing) 1. Remove gloves. Gloves are most contaminated. Remove carefully. 2. Perform hand hygiene. Clean hands immediately . . . " NJAC 8:39-19.4	F0880		05/15/2026
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F0804	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident R 70 and Resident R 135 were immediately interviewed by the Director of Dietary to discuss and resolve their concerns with the seasoning of their	04/20/2026

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F0804 SS = E	Continued from page 7 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that food was served at the correct temperature for two residents who received hamburgers (Residents (R) 19 and 90) and food served was palatable in taste for two residents (R 70 and R135). Specifically, the facility did not ensure that dietary staff followed appropriate processes to prepare and serve food palatable for 101 out of census of 106 residents during meal service. This failure had the potential to place residents at increased risk for meal dissatisfaction and the service of potentially unsafe food. Findings include: 1. Review of R70's undated "Face Sheet" provided by the facility indicated R70 was admitted to the facility on [redacted]. Review of R70's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab in the electronic medical record (EMR), with an Assessment Reference Date (ARD) of [redacted] indicated R70 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated R70 had [redacted]. During an interview on 03/23/26 at 3:26 PM, R70 stated he/she does not like the food. "They don't salt the food." 2. Review of R135's undated "Face Sheet" provided by the facility indicated R135 was admitted to the facility on [redacted]. Review of R135's admission "MDS," located under the "MDS" tab in the EMR, with an ARD of [redacted] indicated R135 had a "BIMS" score of [redacted] out of 15, which indicated R135 was [redacted]. During an interview on 03/24/26 at 10:05 AM, R135 stated the food is "edible, they don't put salt or	F0804	Continued from page 7 foods. After the temperature observation, Resident R 19 and Resident R 90 had their hamburger patties heated to the acceptable temperature prior to their meal leaving the kitchen; no further corrective action was required with these residents directly. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? An audit will be conducted by the Director of Dietary and the Dietician by 4/28/26 with a sample of 4 appropriate residents on the B, C, D & E units to determine any additional resident concerns with food palatability and temperatures of foods. In addition, the audit report results will be discussed at the next Food Committee meeting for next steps with resident input. All three diet consistencies were reviewed by the Dietician to ensure that any menu extensions contain the same elements as the regular items. Corrections made as needed to the extensions. All heating and holding equipment was inspected for proper function by 3/27/26 by the Facilities Director and no issues were identified. All Cooks and Dietary Supervisors have been in-serviced on properly following the recipes and extensions by 4/20/26. All Cooks and Dietary Supervisors have been in-serviced on proper food holding temperatures (both hot and cold) and procedures for maintaining same by 4/20/26. Education will be provided to the Nursing Staff on All Units by 4/20/26 on how to improve the taste of foods by offering residents the use of additional seasonings that are provided on the tray.	04/20/2026

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F0804 SS = E	Continued from page 8 seasoning in the food." R135 stated his/her [NJ Exec Order 2] and [NJ Exec Order 26.4] bring in food for him/her that he/she likes. 3. During lunch observation on 03/25/26 at 11:10 AM, lunch was observed being plated from the steam table in the kitchen. The food was plated directly onto individual plates, then covered with plastic lids before being placed onto a wheeled cart. Hamburger patties were plated for two residents (R19 and 90). The [U.S. FOIA (b)(6)]) took the temperature of the hamburger patties as they were being plated from the oven warmer. The temperature of the hamburger patties was 132 degrees Fahrenheit. According to the "FDA [U.S Food and Drug Administration] Food Code," dated 03/07/22, "All foods will be held at appropriate temperatures, greater than 135 F [Fahrenheit] for hot foods." 4. Further observation of the steam table revealed for "Regular" diets, the residents received beef stew, noodles, and the mixed steamed vegetables contained carrots. For residents on "Minced and Moist" diets, they received ground beef, mashed potatoes, and their steamed minced vegetables did not contain carrots. Review of the menu extensions revealed beef stew and noodles with mixed vegetables scheduled for both "Regular" and "Minced and Moist" diets. During an interview with the Cook on 03/25/26 at 11:15 AM, he/she confirmed the "Minced and Moist" steamed vegetables did not contain carrots but could not explain why. During an interview on 03/25/26 at 12:15 PM, the [U.S. FOIA (b)(6)]) stated the vegetables should have been the same for all three diet consistencies and contained carrots. During an interview on 03/26/26 at 10:39 AM, the [U.S. FOIA (b)(6)]) reviewed the menu and confirmed the residents who received the "Minced and Moist" diets should have received a variation of the beef stew, not ground beef, and chopped noodles, not mashed potatoes.	F0804	Continued from page 8 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into practice? Food Committee will provide a copy of the audit report of 16 residents with trended findings to the QAPI committee along with correction plan for any issues identified. Food Committee will provide their monthly report for 6 months to the QAPI Committee, which will include resident feedback on the palatability and temperatures of resident meals. Random test trays will be conducted at meals by the Dietary Director or Designee (at least three trays per shift per week) with written documentation to ensure that meals are meeting food palatability standards as defined on test meal audit tools. Results of these weekly audits will be shared with QAPI committee monthly with any action plan as indicated for 6 months.	04/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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GREENWOOD HOUSE HOME FOR THE JEWISH AGED	**53 WALTER STREET , TRENTON, New Jersey, 08628**

(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) COMPLETION DATE
F0804 SS = E	Continued from page 9 5. On 03/25/26 at 12:15 PM, tasting of a "Minced and Moist" test tray was conducted by two surveyors, the U.S. FOIA (b)(6)), and the U.S. FOIA (b)(6)) revealed the following: The ground beef was not seasoned; mashed potatoes were bland, not seasoned; and the steamed vegetables were bland, not seasoned, and the appearance was not appealing. An interview was conducted on 03/26/26 at 9:41 AM with the U.S. FOIA (b)(6), U.S. FOIA (b)(6), and the U.S. FOIA (b)(6)). The lack of seasoning with the food was discussed. On 03/26/26 at 12:30 PM, the U.S. FO stated the facility did not have a policy that addressed the palatability of food. "We address the concerns individually." NJAC 8:39-17.4(a)2	F0804		04/20/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F0628	Residents 129 and 138 are NJ Exec Order 26.4b1 residents at the facility. All residents have the potential of being affected by the deficient practice. Upon an emergency discharge from the facility all patients will receive a copy of the Long-Term Care Ombudsman "Notice of Emergency Transfer Form" and a copy of the Bed Hold Policy. The bed hold policy will be revised and/or updated by 04/30/2026. Licensed nurses, registered nurses, and the Social Workers of Greenwood House will be educated on the process by 04/30/2026 on providing all emergent discharges with a copy of the "Emergency Transfer Form." At the time of discharge. The resident representative will receive a mailed copy of the "Emergency Transfer Form" and copy of Greenwood House's "Bed Hold Policy". The Licensed Nursing Home Administrator or designee will audit all emergent discharges the next business day during morning meeting to ensure the Bed Hold Policy and a copy of the Emergency Transfer Form is being sent via mail to the resident representative. Audits will be conducted weekly x 4 weeks then monthly x 3 months. Results of the monthly audits will be reported monthly to the	05/15/2026

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F0628 SS = D	Continued from page 10 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F0628	Continued from page 10 facility Quality Performance Improvement Committee x 3 months.	05/15/2026

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F0628 SS = D	Continued from page 11 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is	F0628		05/15/2026

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F0628 SS = D	Continued from page 12 the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to	F0628		05/15/2026

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F0628 SS = D	Continued from page 13 authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and document review, the facility failed to provide residents and their [NJ Exec Order 26.4b1]) with the required written transfer notice following emergent hospital transfers for two of three residents (Resident (R) 129, and R138) reviewed for hospitalization out of 27 sampled residents. This failure created a risk that residents and their [NJ Exec Order 26.4b1]s would be uninformed about the reason and location of the transfer and their right to appeal it, if desired. Findings include: 1. Review of R129's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), revealed R129 was admitted to the facility on [NJ Exec Order 26.4b1]. Review of R129's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4b1] revealed a "Brief Interview for Mental Status (BIMS)" was unable to be completed due to R129[NJ Exec Order 26.4b1] being [NJ Exec Order 26.4b1]. Review of R129's "Progress Notes," dated [NJ Ex Order 26.4(b)] and located under the "Progress Notes" tab of the EMR, revealed R129 was, "[NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] towards staff, prn [as needed] medication given not effective. [U.S. FOIA (b)] spoke with [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] due to [NJ Exec Order 26.4b1] towards staff and to [himself/herself] [he/she] was [NJ Exec Order 26.4b1] to [hospital name] for eval [evaluation], [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] present for [NJ Exec Order 26.4b1] to hospital." Further review revealed that R129 was admitted to the hospital. 2. Review of R138's "Admission Record," located under the "Profile" tab in the EMR, revealed R12 was admitted to the facility on [NJ Exec Order 26.4b1] Review of R138's admission "MDS," with an ARD of [NJ Exec Order 26.4b1] and located under the "MDS" tab of the	F0628		05/15/2026

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F0628 SS = D	Continued from page 14 EMR, revealed a "BIMS" score of [redacted] out of 15, indicating R128 was NJ Exec Order 26.4b1. Review of R138's "Progress Notes," dated [redacted] and located under the "Progress Notes" tab of the EMR, revealed, "called to resident room, resident sitting on [his/her] wheelchair with family at bedside. Noted [redacted], NJ Exec Order 26.4b1 [redacted] with [redacted]. Resident [redacted] back to [redacted]. Put on [redacted] position. physician made aware, new order to [redacted] to [redacted] NJ Exec Order 26.4b1] for further evaluation and treatment. [redacted] rechecked [redacted].Resident more [redacted] than [he/she] was. Called [redacted] resident [redacted] to [redacted]] at 7:45PM. Report given to [redacted] nurse." Further review revealed that R138 was admitted to the hospital. During an interview on 03/25/26 at 2:13 PM, the U.S. FOIA (b)(6) said they were not sending or providing transfer notice forms to residents or their families when a resident was transferred. The U.S. FOIA (b)(6) stated the U.S. FOIA (b)(6) confirmed this was not happening. During an interview on 03/26/26 at 2:08 PM, the U.S. FOIA (b)(6)) stated the transfer notice should be provided to the resident or representative when a discharge occurred. Review of the facility's policy titled, "Emergency Transfer Forms for Long-Term Care Residents," revised 03/26/26, revealed, "Greenwood House works to ensure the Emergency Transfer Forms for long-term care residents are completed accurately, submitted timely to the Long-Term Care Ombudsman, and properly filed in accordance with regulatory requirements." NJAC 8:39-4.1(a)	F0628		05/15/2026
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F0640	A discharge return anticipated assessment was corrected, batched, submitted, and accepted for Resident # 18 on [redacted] by the Minimum Data Set Coordinator. The U.S. FOIA (b)(6) was re-educated on policy to submit discharge return anticipated assessments on 03/27/2026. All residents have the potential to be affected by this deficient practice.	05/15/2026

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F0640 SS = D	Continued from page 15 (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.	F0640	Continued from page 15 The Minimum Data Set Coordinator will submit missing assessment reports weekly to the Director of Nursing to identify any minimum data set assessments not transmitted in a timely manner. The Director of Nursing or designee will audit 10 missing assessments weekly. Audits will be conducted weekly x 4 weeks then monthly x 3 months. Results of the monthly audits will be reported monthly to the facility Quality Performance Improvement Committee x 3 months.	05/15/2026

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F0640 SS = D	Continued from page 16 This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure that one resident of 60 residents (Resident (R) 18) reviewed for missing Minimum Data Set (MDS) assessments over 120 days old had a tracking discharge assessment completed and transmitted in a timely manner. Failure to complete and transmit MDS data timely can lead to inaccurate federal reimbursement and quality measures. Findings include: Review of R18's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR) revealed R18 was admitted to the facility on [NJ Exec Order 26] and discharged on [NJ Exec Order 26]. Review of R18's discharge return anticipated "MDS" with an Assessment Reference Date (ARD) of [NJ Exec Order 26], located under the "MDS" tab in the EMR, indicated that the assessment was batched and accepted on [NJ Exec Order 26]. During an interview on 03/26/26 at 5:00 PM, the [U.S. FOIA (b)(6)] confirmed that the tracking assessment was late, but he/she was unsure why it was late. The [U.S. FOIA (b)(6)] confirmed that the [U.S. FOIA (b)(6)]) pulls the missing assessment report every Friday and lets her know of any residents in the report. She stated that she transmits the assessments on a weekly basis. During an interview on 03/26/26 at 5:10 PM, the [U.S. FOIA] confirmed that R18 was on the January 2026 missing assessment report. Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual," revised October 2025, revealed for a Discharge Assessment, " . . . MDS completion date (Item Z0500B) no later than discharge date + [plus] 14 calendar days . . . transmission date no later than MDS completion + 14 calendar days." NJAC 8:39-11.2	F0640		05/15/2026

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F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure that a comprehensive Minimum Data Set (MDS) assessment was submitted accurately for one resident (Resident (R) 83) reviewed for MDS assessments out of a total sample of 27 residents. This had the potential to affect quality measures and the resident's care planning process. Findings include:	F0641	Significant change minimum data set assessments for Resident #83 dated [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] were modified, batched, and completed on [NJ Ex Order 26.4(b)(1)] by the Minimum Data Set Coordinator. The U.S. FOIA (b)(6) was re-educated 03/27/2026 on the policy regarding accurate submission of significant change assessments. All residents have the potential to be affected by this deficient practice. Residents that had a previous significant change in assessment status within the last six months will be reviewed to ensure the correct information is being captured. The significant change report will be run 04/22/2026. The Director of Nursing or designee will audit 5 significant changes weekly. Audits will be conducted weekly x 4 weeks then monthly x 3 months. Results of the monthly audits will be reported monthly to the facility Quality Performance Improvement Committee x 3 months.	05/15/2026

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F0641 SS = D	Continued from page 18 Review of R83's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed admission to the facility on [NJ Exec Order 26.4] Review of R83's "Physician Orders" located under the "Orders, tab in the EMR revealed [NJ Exec Order 2] services were ordered on [NJ Exec Order 26.4b] Review of R83's quarterly "MDS" under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of [NJ Exec Order 26], revealed the "Brief Interview for Mental Status (BIMS)," was unable to be completed due to R83 [NJ Exec Ord] being [NJ Exec Order 26.4b1]. Further review revealed the resident was documented not to be receiving [NJ Exec Order 2] care. Review of R83's "Physician Orders" located under the "Orders" tab in the EMR revealed [NJ Exec Order 2] services were discontinued on [NJ Exec Order 26.4] Review of R83's quarterly "MDS" under the "MDS" tab of the EMR, with an ARD of [NJ Exec Order 26], revealed the "BIMS" was unable to be completed due to R83 [NJ Exec Ord] being [NJ Exec Order 26.4b1]. Further review revealed the resident was documented to be receiving [NJ Exec Order 2] services. During an interview on 03/26/26 at 10:06 AM, the U.S. FOIA (b)(6) stated both assessments were completed inaccurately. He/She said it was an error on his/her part. During an interview on 03/26/26 at 2:08 PM, the U.S. FOIA (b)(6)) said he/she expected MDS assessments to be completed accurately before they were submitted. Review of the facility's policy titled, "Leisre Chateau," revised 10/2025, revealed, "It is our policy to complete the RAI process according to the requirements and standards of the latest published RAI [Resident Assessment Instrument] manual." Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual," dated October 2025 and located at www.cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf, revealed, "Check	F0641		05/15/2026

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GREENWOOD HOUSE HOME FOR THE JEWISH AGED	**53 WALTER STREET , TRENTON, New Jersey, 08628**

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F0641 SS = D	Continued from page 19 all of the following treatments, procedures, or programs that were performed . . . while a resident of this facility and within the last 14 days . . . Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. NJAC 8:39-33.2(d)	F0641		05/15/2026
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure residents did not have [NJ Ex Order 26.4(b)] on beds when they had not been assessed for their use for one of four residents (Resident (R) 139) reviewed for [NJ Ex Order 26.4(b)] out of a total of 27 sampled residents. The lack of appropriate assessment placed residents at risk for [NJ Ex Order 26.4(b)(1)] and potential [NJ Ex Order 26.4(b)(1)] Findings include:	F0700	Resident 139 is [NJ Exec Order 26.4b1] a resident at the facility. All residents have the potential to be affected by this deficient practice. Upon admission to the facility all residents will be assessed for the need of bed rails. Residents will be assessed quarterly and as needed. Licensed and registered nurses of Greenwood House will be educated on properly assessing need for bed rails and will be completed by 04/30/2026. If bed rails are deemed necessary an order will be obtained, care plan to be updated, and an order placed in TELS (Technology Enabled Life Safety) for the maintenance department. Staff will discuss the risk versus benefits to the resident or resident representative. The Director of Nursing or designee will audit all admissions for the bed rail assessment, if applicable, a check for an order, care plan, and documented risk versus benefit discussion. Audits will be conducted weekly x 4 weeks then monthly x 3 months. Results of the monthly audits will be reported monthly to the facility Quality Performance Improvement Committee x 3 months.	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HOUSE HOME FOR THE JEWISH AGED	**53 WALTER STREET , TRENTON, New Jersey, 08628**

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F0700 SS = D	Continued from page 20 Review of R139's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R139 admitted to the facility on [NJ Exec Order 26.4] with a diagnosis of [NJ Exec Order 26.4b1]. Review of R139's "Admission/Readmission Evaluation Section-[NJ Ex Order 26.4(] completed by Licensed Practical Nurse (LPN) 2, dated [NJ Ex Order 26.4(] and located under the "Assessments" tab in the EMR, revealed [NJ Ex Order 26.4(] were not being considered at the time. Further review revealed no discussion of risks versus benefits and informed consent. Review of R139's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [NJ Exec Order 26] and located under the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of [NJ Ex] out of 15, indicating [NJ Exec O] [NJ Exec Order 26]. Review of R139's "Care Plan," dated 03/17/26 and located under the "Care Plan" tab of the EMR, revealed R139 was not care planned for [NJ Ex Order 26.4] on [NJ Ex Order 26.4(b)(] of the bed. Review of R139's "Physician Orders," located under the "Orders" tab in the EMR, dated [NJ Ex Order 26.4(b] revealed no current order for [NJ Ex Order 26.4(b)]. During observations on 03/23/26, 03/24/26, and 03/26/26 [NJ Ex Order 26.4(b)(] were observed on [NJ Ex Order 26.4(b)(] of R139's bed in the NJ Ex Order 26.4(b)(1). During an interview on 03/23/26 at 10:53 AM, R139 was sitting in a wheelchair at bedside eating. R139 said he/she was a new resident and had been there a few weeks. R139 stated the [NJ Ex Order 26.4] had been on the bed since he/she was admitted. R139 stated he/she did not recall signing anything related to the risks and benefits of [NJ Ex Order 2] use. During an interview on 03/26/26 at 10:17 AM, LPN2 said he/she was not the nurse who normally completed admission assessments related to [NJ Ex Order 26] use. He/She said there must not have been a [U.S. FOIA (b)(6)] working at the time of R139's admission, and therefore he/she completed R139's. He/She said when a resident has [NJ Ex Order 26.4] there should be	F0700		05/15/2026

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F0700 SS = D	Continued from page 21 an assessment, a physician's order, and it should be care planned. LPN2 was unsure of the facility's policy on [NJ Ex Order 26.4(b)(1)]. He/She stated that [NJ Ex Order 26.4] were already on R139's bed, and initially R139 did not want them but then decided he/she did. LPN2 agreed that another [NJ Ex Order 26] assessment should have been complete on [NJ Ex Order 26.] use prior to implementing [NJ Ex Order 26.4] for R139. He/She agreed that a resident should not have [NJ Ex Order 26.4] if not assessed to have them. During an interview on 03/26/26 at 2:08 PM, the [U.S. FOIA (b)(6)]) stated a resident should not have [NJ Ex Order 26.4(b)] unless they were assessed to require them. He/She also stated residents with [NJ Ex O] should be assessed prior to use, there should be an order, and it should be care planned. Review of the facility's undated policy titled "Side Rails" revealed, "It is the policy of the facility to ensure the safety and psychosocial well-being of its residents while avoiding the use of side rails a restraint." NJAC 8:39-27.1(a)	F0700		05/15/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F0842	Resident 132 is [NJ Exec Order 26.] a resident at the facility. All residents have the potential of being affected by this deficient practice. Upon admission the admitting nurse is required to transcribe all orders as written and/or as directed by the physician. Licensed and registered nurses of Greenwood House will be educated on the process of medication review and transcribing all orders properly and will be completed by 04/30/2026. The admitting nurse upon the resident's/patient's admission to the facility will all medications approved. The medications will be input in the Electronic Health Record. The night nurse or supervisor will provide a second check and the Nurse Manager will provide the final check to ensure accuracy and no transcription errors. An admission checklist will be implemented during the reviews. The checklist will ensure all medications along with other orders are placed in the Electronic Health Record accurately. The triple check ensures there are no duplicate orders in the system.	05/15/2026

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F0842 SS = D	Continued from page 22 (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and	F0842	Continued from page 22 The Director of Nursing or designee will audit all admissions for accuracy of transcribing orders. Audits will be conducted weekly x 4 weeks then monthly x 3 months. Results of the monthly audits will be reported monthly to the facility Quality Performance Improvement Committee x 3 months.	05/15/2026

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F0842 SS = D	Continued from page 23 resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and policy review, the facility failed to maintain accurate resident medical records, including physician orders and medication administration records (MARs), for one (Resident (R) 132) of five residents reviewed for medication administration and accuracy of medical records. R132 had a duplicate physician order for the same medication, which was transcribed as two separate entries on the resident's MAR. This documentation error created the potential for the medication to be administered more than once as prescribed, placing the resident at risk for medication errors and possible adverse health effects. Findings include: A review of R132's "Admission Record" found under the "Profile" tab in the electronic medical record (EMR) revealed R132 was admitted to the facility on [redacted] with diagnoses of [redacted], [redacted], and [redacted]. The resident was discharged from the facility on [redacted] to an assisted living facility. A review of R132's [redacted] "Physician Orders," located under the "Orders" tab in the EMR, revealed a duplicate order for [redacted] to be administered once daily for [redacted], which was entered by [redacted] on [redacted] to start on [redacted]. The duplicate order was removed on [redacted] by the [redacted]). A review of R132's [redacted] "Medication Administration Record (MAR)," located under the "Orders" tab in the EMR, revealed that the order for [redacted] appeared twice on the MAR for the dates of [redacted] and	F0842		05/15/2026

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F0842 SS = D	Continued from page 24 NJ Exec Order 26. Licensed Practical Nurse (LPN) 1 documented on the MAR that both orders were administered on those dates. An interview on 03/25/26 at 12:00 PM with the U.S. FOIA (b) revealed the order for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Ex Orde to be administered as one tablet by mouth NJ Exec O daily for NJ Exec Order 26.4b1, was inadvertently transcribed twice on the Physician Orders and MAR from NJ Exec Order 26. through NJ Exec Order 26.4 The U.S. FOIA (b) stated U.S. FOIA (b)(6 entered the duplicate order and is NJ Exec Order 26.4b1 at the facility. The U.S. FOIA (b) stated LPN1 signed off on both orders on the MAR during this period. The U.S. FOIA (b) further stated that the medication was verified on the medication cart at the time and administered only once each day. Additionally, the U.S. FOIA (b) stated LPN1 received a NJ Exec Order 26.4b1 regarding accurate documentation during medication administration. An interview on 03/25/26 at 12:33 PM with LPN 1 revealed he/she recalled being NJ Exec Order 26.4b by the U.S. FOIA (b) regarding the duplicate NJ Exec Order 26.4b order and its duplicate entry on the MAR. LPN 1 stated he/she accidentally signed off on both duplicate MAR entries. LPN 1 further stated he/she did not administer any additional NJ Exec Order 26.4b to the resident. An interview with the U.S. FOIA (b)(6)) on 03/25/26 at 1:30 PM revealed he/she was not working at the facility in NJ Exec Order 26.4b1. The U.S. FOIA stated he/she has the expectation that all documentation, including physician orders and MARs, must always be correct and that the nursing staff need to be aware of everything they document and sign off. A review of the facility policy titled, "Charting and Documentation," with a revision date of March 2026, revealed all documentation in the medical record must be objective, complete, and accurate. NJAC 8:39-4.1(a)	F0842		05/15/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 05/19/2026 in relation to the Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

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E0000 Bldg. 01	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 03/24/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		04/14/2026
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/24/2026. the facility 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 Occupancies. Greenwood House for Jewish Aged is a one-story building, with a partial basement, that was built in 1973 with additions in 1980 and 2002. It is composed of Type II (000) unprotected construction with concrete block bearing walls, concrete floors and steel truss roof. The facility is divided into seven smoke compartments. The facility has a Type II EPSS (emergency power supply system) with a 350KW diesel engine using 20% of its capacity under full load. The sprinkler system is a dry sprinkler system with 2 dry valves. The number of occupied beds was 106 out of 133.	K0000		04/14/2026
K0321 SS = E Bldg. 01	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	K0321	What action was taken to correct the issue for the resident(s) directly affected? No specific residents were affected. How did the facility identify other residents who may have been affected by the same issue? All residents have the potential to be affected by this	04/30/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

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K0321 SS = E Bldg. 01	Continued from page 1 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. 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 STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen fire doors and the boiler room fire doors were maintained to provide a continuous fire/smoke partition extending from the floor to the roof above when the corridor doors did not latch in accordance with NFPA 101 Life Safety Code (2012 Edition) section 8.4.2. This deficient practice had the potential to affect all 104 residents who resided at the facility. Findings include: Observation on 03/24/26 at 1:50 PM of the boiler room fire partition doors revealed the doors would not close and latch when closed. When the doors failed to latch, it was ajar and open thus failing to maintain the smoke partition.	K0321	Continued from page 1 issue. What changes will be implemented to ensure the deficiency does not recur? The Facilities Director has inspected the doors affected and found out that both doors are beyond repair and will be replaced. Two doors were able to be refurbished instead of new purchase; see attached photos of hardware purchased and invoice for labor to refurbish. Work is to be completed by 4/30/26. The Facilities Director has inspected all remaining doors throughout and found the rest to be complaint. Fire Doors inspections task has been integrated with our TELS notification system (TELS by Direct Supply is a comprehensive, building management system designed to manage maintenance and compliance) for inspection monthly) for monthly inspection. All Maintenance staff will be in-serviced on 4/30/26 on conducting & documenting Fire Door inspections. (see attached picture) How will the facility monitor to ensure the corrective actions are effective? The TELS tasks reporting system (TELS by Direct Supply is a comprehensive, building management system designed to manage maintenance and compliance) for inspection monthly) will be reviewed and verified by the Facilities Director and Assistant Director on a weekly basis. Facilities Director will include an update on the Fire Door Inspections in his monthly Maintenance Report to the QAPI Committee x 3 months. See the attched photos of before and after pictures of the boiler room and kitchen doors	04/30/2026

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K0321 SS = E Bldg. 01	Continued from page 2 Observation on 03/24/26 at 2:34 PM of the kitchen fire/smoke partition doors revealed the doors which opened into the corridor failed to latch when closed because the fire rated exit hardware was removed. During an interview at the time of each observation, the U.S. FOIA (b)(6) confirmed the fire rated exit hardware affected the corridor door latching to the kitchen and the doors to the boiler room did not latch when closed. N.J.A.C 8:39-31.2 (e)	K0321		04/30/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the kitchen's make-up air shuts down when the system is activated in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition)	K0324	No specific residents were affected. All residents could potentially be affected by this issue. After the survey was completed, the Facilities Director learned that the issue was in fact corrected on January of 2023, 2025 but no supporting documentation was found at the time of the Survey (supporting documents from vendor attached). The Facilities Director reviewed all the reports from the last 24 months and found no other discrepancies for any other areas in the building. The Facilities Director will perform a thorough review of all third-party Life Safety related inspection reports immediately after received to determine any next steps. Facilities Director will include an update on the status of Life Safety vendor inspections in his monthly Maintenance Report to the QAPI Committee x 3 months.	04/15/2026

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GREENWOOD HOUSE HOME FOR THE JEWISH AGED	**53 WALTER STREET , TRENTON, New Jersey, 08628**

(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) COMPLETION DATE
K0324 SS = E Bldg. 01	Continued from page 3 Section 8.3.2. This deficient practice had the potential to affect all 22 residents who resided in that section of the facility. Findings include: Review of the facility's automatic extinguishing reports dated 10/21/25 from NJ Exec Order 26.4b1 revealed that the exhaust hood "make-up air does not shut down when the system is activated" during testing. Observation on 03/24/26 at 1:10 PM of the kitchen revealed that a griddle and six burner stove was under the exhaust hood that was protected by the automatic extinguishing system. During an interview on 03/24/26 at 12:30 PM, the U.S. FOIA (b)(6) confirmed the make-up air did not shut down during testing of the automatic extinguishing system. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 96, 17A	K0324		04/15/2026
K0355 SS = E Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on document review and interview, the facility failed to ensure the carbon dioxide (CO2) fire extinguisher hose assemblies were tested for conductivity annually in accordance with NFPA 10, Standard for Portable Fire Extinguishers (2010 Edition) Section 7.3.1.3. and 7.3.1.3.2. This deficient practice had the potential to affect all 22 residents who resided in the section of the facility. Findings include: During an observation on 03/24/26 at 2:10 PM of the boiler room and electrical room revealed three 10-pound CO2 fire extinguishers hoses had not been conductivity tested annually. The hoses of the CO2	K0355	What action was taken to correct the issue for the resident(s) directly affected? No specific residents were affected. How did the facility identify other residents who may have been affected by the same issue? All residents could be potentially affected by this issue. What changes will be implemented to ensure the deficiency does not recur? The Facilities Director immediately contacted the vendor to schedule the proper inspection of the (3) CO2 fire extinguishers. The Facilities Director conducted a thorough inspection of all the fire extinguishers throughout on 4/6/26 and found the rest to be complaint with K355. During vendor visits, The Facilities Director will	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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GREENWOOD HOUSE HOME FOR THE JEWISH AGED	53 WALTER STREET , TRENTON, New Jersey, 08628

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K0355 SS = E Bldg. 01	Continued from page 4 fire extinguishers did not have a label indicating that a conductivity test was completed. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the CO2 fire extinguishers hoses were not tested for conductivity. N.J.A.C 8:39-31.1(c) 31.2 (e) NFPA 10	K0355	Continued from page 4 assign a maintenance staff member to assure proper completion of their inspection. How will the facility monitor to ensure the corrective actions are effective? The Facilities Director or the Assistant Director, will meet the vendor immediately after the inspection/testing has been completed and verify the work before the technician leaves the facility. Facilities Director will include an update on the status of vendor inspections in his monthly Maintenance Report to the QAPI Committee x 3 months. See fire extinguishers photos under attachments	04/30/2026
K0521 SS = E Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure resident bathrooms were provided with ventilation that was adequately maintained in accordance with the NFPA 101 (2012 edition) Life Safety Code section 9.4.2 to NFPA 99 (2012 edition) Health Care Facilities Code section 9.3.7.5.2.5. This deficient practice had the potential to affect all 8 residents who resided in those rooms at the facility. Findings include: Observation on 03/24/26 at 2:57 PM of the resident bathrooms for resident rooms NJ Ex Order 26.4(b)(1) revealed the ventilation systems did not function. The surveyor requested that the U.S. FOIA (b)(6) U.S. FOIA (b)(6) confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and	K0521	What action was taken to correct the issue for the resident(s) directly affected? Residents in Rooms NJ Ex Order 26.4(b)(1) were made aware of the issues with their bathroom ventilation system and that new equipment was ordered to solve the issues. Residents were given options to temporarily relocate to another room if desired until the bathroom venting could be fixed, but none were interested. How did the facility identify other residents who may have been affected by the same issue? All residents have the potential to be affected by this issue. What changes will be implemented to ensure the deficiency does not recur? The Facilities Director ordered two new rooftop motors for the non-functional ones that service Rooms NJ Ex Order 26.4(b)(1). See attached photo of two new rooftop motors and photo of purchase/delivery invoice. The Facilities Director inspected the remaining 12 rooftop ventilation systems and they were found to be in a good working condition.	04/30/2026

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K0521 SS = E Bldg. 01	Continued from page 5 require reliance on mechanical ventilation. During an interview at the time of each observation, the U.S. FOIA (b)(6) confirmed that the resident bathroom ventilation fans were inoperative. N.J.A.C. 8:39 - 31.2(e) N.J.A.C. 8:39-31.4(b)&(f). 19.5.2.1 Heating, Ventilating, and Air-Conditioning.	K0521	Continued from page 5 How will the facility monitor to ensure the corrective actions are effective? The Facilities Director implemented a weekly rooftop vent systems check. All maintenance staff will be in-serviced on 4/30/26 on this practice. Facilities Director will include an update on the status of the repairs and weekly rooftop vent systems check in his monthly Maintenance Report to the QAPI Committee x 3 months. See attachments of photos for CFM (cubic feet per minute) Meter test. There will be a log, the policy, and in-service attached as well.	04/30/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 03/24/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		04/14/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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E0000 Bldg. 01	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 05/19/2026 in relation to the 03/26/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 05/19/2026 in relation to the 03/26/2026 Life Safety Code survey. The facility was found to be in compliance 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.	K0000		

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