STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315215	A. BUILDING ______ B. WING ______	C 12/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 12/12/22 Census: 98 Sample: 20+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 700 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	F 700		1/4/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 01/05/2023

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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F 700	Continued From page 1 by: Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure informed consent was obtained, an assessment was completed, and inspections were completed for [redacted] The deficient practice was identified for 1 of 2 residents (Resident #72) reviewed for EX Order 26 § 4b1 and was evidenced by the following: On 11/29/22 at 11:03 AM, the surveyor observed Resident #72 in bed with his/her eyes open. The surveyor observed the resident's bed had EX Order EX Order EX Order 26 § 4b1 [redacted]. On 12/2/22 at 12:00 PM, the surveyor observed Resident#72 out of bed sitting in a EX Order 26 § 4b1 [redacted] in the hallway just outside of his/her room. At that time, the surveyor observed EX Order 26 § 4b1 [redacted] EX Order On 12/5/22 at 10:52 AM, the surveyor observed Resident #72 in bed with their eyes closed with EX Order 26 § 4b1 [redacted] The surveyor reviewed the medical record for Resident #72. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in EX Order 26 § 4b1 with diagnoses EX Order 26 § 4b1 [redacted] A review of the most recent quarterly Minimum	F 700	F-700 Element one: I.CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #72 is currently not in the facility. Resident was discharged to the EX Order 26 § 4b on [redacted] and has not returned. Prior to discharge, a Bed Safety Rail Risk Assessment was completed on 12/5/2022. Risks and benefits of EX Order 26 § 4b1 were reviewed with Resident #72 and resident□s [redacted], who both requested and consented to the use of EX Order 26 § 4b EX Order 26 § 4b1. Director of Maintenance performed a thorough inspection of the half EX Order EX Order for proper installation (in accordance with manufacturer□s guidelines) and to ensure resident□s optimal safety from risks of entrapment. Review of records revealed that Resident #72 was not adversely affected by the deficient practice. F-700 Element Two II.IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE Residents with EX Order or EX Order EX Order have the potential to be affected by the same deficient practice. The Unit Managers and Director of Maintenance/Designee conducted observational rounds to identify all residents with EX Order on their beds.	

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F 700	Continued From page 2 Data Set (MDS), an assessment tool dated [redacted], reflected a brief interview of mental status (BIMS) score of [EX Or] out of [redacted] which indicated the resident had a [EX Order 26 § 4b1] [redacted] A review of the November 2022 Order Summary Report reflected a physician order dated [redacted] for [EX Order 26 § 4b1] [EX Order] [EX Order 2] On 12/5/22 at 10:47 AM, the surveyor interviewed the Director of Maintenance who confirmed he was in charge of the installation and inspection of [EX Order] [EX Order 2]. The DM stated he inspected the [redacted] [EX Order] upon installation only and it was not part of their routine to check afterwards. The DM stated if the [redacted] was loose, he expected the nurses to inform him since nursing staff saw the resident daily. At this time, the Maintenance worker confirmed he did not inspect [EX Order] [EX Order] after installation, it was not part of his routine inspections. On 12/5/22 at 11:44 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) on the North Unit who stated that Resident #72 used the [EX Order] [EX Order] for [EX Order] [EX Order 26 § 4b1] The RN/UM stated that a [EX Order] [EX Ord] assessment should be completed for every resident upon admission and then quarterly. The RN/UM further stated consent for [EX Order 26 § 4b1] should be obtained upon admission and quarterly. The RN/UM stated both forms should be in the resident's hybrid (paper) chart. On 12/5/22 at 11:46 AM, the RN/UM informed the surveyor that she was unable to locate a consent form or a [EX Order] [EX Ord] assessment for Resident #72.	F 700	Audits were conducted on these residents to make sure that no other residents were affected by the same deficient practice, i.e., Bed Safety Rail Risk Assessments were completed, Informed Consents were obtained from the residents or the resident□s representatives, and the Maintenance Department completed inspections of the side rails F-700 Element Three III.MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All staff were re-educated on the regulations governing F-700 (Bed Rails) and the facility□s policy on Side Rails. Emphasis was made in ensuring that (a) Bed Safety Rail Risk Assessments are completed prior to installation of the rails and at least quarterly thereafter, (b) Informed Consents are obtained from resident/resident□s representative for the use of side or bed rails, and (c) Inspections of side or bed rails are performed by the Maintenance Department upon installation and at least quarterly. Inspection of side or bed rails was included in the list of Preventative Maintenance tasks to be completed by the Director of Maintenance or designee. This is to be done upon installation of the rail(s) and at least quarterly thereafter, in order to promote the bed safety of residents with side or bed rails.	

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F 700	Continued From page 3 On 12/7/22 at 11:47 AM, the surveyor interviewed the RN/UM who acknowledged that the [EX Order] [EX Order] assessment for Resident #72 was never completed, nor was consent obtained from the resident or resident representative. On 12/8/22 at 1:31 PM, the survey team discussed the above concerns with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (Assist Admin), and the Director of Nursing (DON). The DON acknowledged that the facility was not following their [EX Order] [EX Order] policy and that Resident #72 should have had a [EX Order] [EX Order] assessment and consent for the use of [EX Order] [EX Order] At this time, the Assist Admin confirmed that the facility had not been inspecting the [EX Order] [EX Order] quarterly per the facility's policy. A review of the facility's "Side Rails" policy dated revised August/September 2019, included the following: the objective of the bed rail policy is to determine if the use of side rails are safe and appropriate for that resident. Information from the routine bed inspections and the individual resident evaluation will be used to determine the need and use of bed rails in order to promote positive outcomes...prior to admission, prospective residents will be screened to determine if care needs require the use of specialized beds and the possible need for side rails. A comprehensive side rail screening will be done upon admission...Residents will further be assessed to identify appropriate alternatives prior to installing/using side rails. If side rails are indicated, each resident will be assessed for the risk of entrapment from bed rails prior to installation or use...Informed consent will be obtained prior to the use of any bed rail/ side	F 700	F-700 Element Four IV.MONITORING OF CORRECTIVE ACTIONS: The Unit Manager or designee will conduct Medical Record audits on 3 residents with side rails monthly x 6 months to ensure that: (a) Bed Safety Rail Risk Assessment was completed prior to installation of rails and at least quarterly thereafter, and (b) Informed Consent for use of side rails was obtained from the residents or resident□s representative prior to using the side rail(s). Any issues will be corrected immediately. Findings will be reported to the Administrator and Director of Nursing monthly and will be presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans. The Assistant Administrator or Designee will audit the Preventative Maintenance Logs monthly x 6 months to make sure that Inspections of the side or bed rails were completed by the Maintenance Department upon installation of the rails and quarterly thereafter. Findings will be reported to the Administrator and Director of Nursing monthly and will be presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	

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F 700	Continued From page 4 rail...Physician orders will be obtained for the use of the bed rail/side rail and will include the medical symptom necessitating the need...The facility will conduct quarterly inspections of all bed frames, mattresses and bed rails as part of the facility's regular preventative maintenance program to identify areas of possible risks and entrapment. Results of inspections will be recorded and incorporated into the facility's QAPI and Preventative Maintenance Programs...Resident care plans will be initiated/updated to include the use of side rails and the reason for the use... NJAC 8:39-27.1(a)	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		1/4/23

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F 755	Continued From page 5 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to accurately document the administration of controlled medication for an unsampled resident. This deficient practice was identified on 1 of 5 medication carts ([redacted]) reviewed and evidenced by the following: On 12/5/22 at 9:49 AM, the surveyor in the presence of the Registered Nurse (RN) inspected [redacted] medication cart. The surveyor in the presence of the RN reviewed the narcotic medication located in the secured and locked narcotic box. When the narcotic medication inventory was compared to the declining inventory sheet, the surveyor identified an unsampled resident's [redacted] [redacted], a medication used for [redacted], [redacted], did not match. The blister pack contained 22 capsules and the declining inventory sheet indicated there should be 23 capsules remaining. The RN stated she had forgotten to sign the declining inventory sheet for the dose she had administered that morning. She further acknowledged she should have	F 755	F-755 Element One I.CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were adversely affected by the deficient practice. The involved resident's medication record was immediately corrected. The RN (Registered Nurse) who failed to accurately sign the declining inventory sheet upon administration of a controlled medication for an unsampled resident was counseled and in-serviced on facility□s policy on Controlled Substances. Reinforced the importance of accurately signing the declining inventory sheet immediately upon the removal of the medication from inventory and administration of a controlled medication. F-755 Element Two II. IDENTIFICATION OF RESIDENTS	

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F 755	Continued From page 6 documented on the declining inventory sheet immediately after she had removed the medication from inventory. On 12/8/22 at 12:01 PM, the surveyor interviewed the Director of Nursing (DON) who acknowledged the nurse should have signed the declining inventory sheet immediately following medication administration. A review of the facility provided policy "Controlled Substances" with a revised date of Aug/Sept 2019 included... Separate records will be maintained on all dose-controlled drugs. This will be in the form of declining inventory records. Such records will be accurately maintained... NJAC 8:39- 29.2(d)	F 755	WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by the same deficient practice. All the narcotic boxes in the medication carts were checked to identify any discrepancies between the narcotic medication inventory and the declining inventory sheets. No other discrepancies were identified, and no residents were affected by the deficient practice. F-755 Element Three III.MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All licensed nurses were educated on the facility□s policy re: Controlled Substances. Emphasis was made on the importance of proper documentation, i.e., accurately signing the declining inventory sheet immediately upon administration of a controlled medication. This is to maintain accurate accountability and reconciliation for controlled medications in the facility. F-755 Element Four IV.MONITORING OF CORRECTIVE ACTIONS: The Pharmacy Consultant or designee will conduct reconciliation audits of the narcotic medications (located in the secured and locked narcotic boxes) in the	

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F 755	Continued From page 7	F 755	5 medication carts monthly x 3 months. Focus will be on identifying any discrepancies between the narcotic medication inventory and the declining inventory sheets. Audit Findings will be reported to the Director of Nursing monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		1/4/23

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F 761	Continued From page 8 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) maintain a refrigerator temperature log to ensure medications were stored at appropriate temperature and b.) properly label and date medications in accordance with manufacturer recommendations. This deficient practice was observed in 1 of 2 medication [redacted]) storage rooms and 1 of 5 medication carts ([redacted]) inspected and was evidenced by the following: 1. On 12/5/22 at 10:16 AM, the surveyor in the presence of the Registered Nurse/Unit Manager (RN/UM) inspected the [redacted] medication cart. The surveyor observed an opened and undated [redacted] in active inventory. The RN/UM stated the pen was supposed to be dated when it was opened. The RN/UM acknowledged the pen did not have an opened date or expiration date indicated on the pen. The RN/UM further acknowledged that the nurses needed to make sure they dated the medication once removed from the refrigerator because the medication had shortened dating once opened. A review of the manufacture's storage instructions for [redacted] revealed once opened, vials and prefilled pens and cartridges should be thrown away after 28 days. 2. On 12/5/22 at 10:38 AM, the surveyor in the presence of the RN/UM inspected the [redacted] medication room. Upon inspection of the medication refrigerator the surveyor did not	F 761	F-761 Element One I.CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ No residents were directly affected by the deficient practice. The opened and undated [redacted] [redacted] pen found in the [redacted] medication cart was immediately discarded. The Medication Refrigerator Temperature Accountability Log for [redacted] was placed by the Medication Refrigerator in the [redacted] Medication Room for easy access and visibility - to remind the night nurses to check and document the temperature of the refrigerator on a daily basis. Unit Manager was in-serviced to ensure that the Med Refrigerator Temperature Accountability logs are properly completed and maintained. Involved Nursing Staff were immediately counseled and educated on the facility□s protocol re: the following: (a) Maintain a refrigerator temperature log to ensure medications were stored at appropriate temperature and b.) Properly label and date medications in accordance with manufacturer□s recommendations. F-761 Element Two	

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F 761	Continued From page 9 observe a temperature log. On 12/5/22 at 10:40 AM, the RN/UM was able to provide a temperature log for the medication refrigerator. The RN/UM stated the 11-7 shift was responsible for filling out the log. The RN/UM stated the last log was dated September/October, which included dates for September, October, November, and December of 2022, but was not completed daily. The RN/UM acknowledged there should be logs for the medication refrigerator daily because you need to maintain the integrity of the medications by making sure the medications do not get too hot or too cold. A review of the RN/UM provided "Med Refrigerator Temperatures Accountability" log dated September/October revealed the log had been completed on the following dates: 9/30/22, 10/1/22, 10/2/22, 10/3/22, 10/4/22, 10/7/22, 10/11/22, 10/12/22, 10/15/22, 10/16/22, 10/18/22, 10/26/22, 10/28/22, 11/1/22, 11/4/22, 11/8/22, 11/10/22, 11/18/22, 11/27/22, 11/28/22, 12/2/22, 12/4/22. On 12/8/22 at 11:52 AM, the surveyor interviewed the Director of Nursing (DON) who stated when the nurse removed insulin from the refrigerator for the first dose, the nurse should date the insulin pen upon opening because insulin had shortened dating. The DON further stated the medication refrigerator temperature logs were to be maintained by the night nurse daily. The DON acknowledged the temperature log provided by the RN/UM was incomplete and had many dates missing starting in September of 2022 up until December 2022.	F 761	II.IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents in the facility have the potential to be affected by the same deficient practice. F-761 Element Three III.MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All nurses were educated on the regulations related to Proper Labeling and Storage of Drugs and Biologicals, with emphasis on the following: (a) Maintain a refrigerator temperature log to ensure that medications are stored at appropriate temperature, and (b) Properly label and date medications in accordance with manufacturer□s recommendations. F-761 Element Four IV.MONITORING OF CORRECTIVE ACTIONS: The Pharmacy Consultant or designee will conduct observation/inspection audits of the facility□s 3 medication rooms and 5 medication carts monthly x 3 months to ensure that the facility is in compliance with the following: (a) Medication Temperature Logs in the Medication Rooms are in place and daily temperatures are properly documented in the logs, and (b) Medications are properly	

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F 761	Continued From page 10 A review of the undated facility provided "Refrigerated Drug Storage" policy included...C. Inspect once a day for correct temperature range... NJAC 8:39- 29.4(d)(h)	F 761	labeled and dated in accordance with manufacturer□s recommendations. Audit Findings will be reported to the Director of Nursing monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	
F 812 SS=D	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 food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) handle potentially hazardous foods and maintain	F 812	F-812 Element One I.CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS	1/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315215	A. BUILDING ______ B. WING ______	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HOUSE HOME FOR THE JEWISH AGED	53 WALTER STREET TRENTON, NJ 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
F 812	Continued From page 11 sanitation in a safe, consistent manner designed to prevent foodborne illness and b.) maintain kitchen equipment in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 11/29/22 at 9:28 AM, the surveyor toured the kitchen with the Director of Dietary (DD) and observed the following: In the walk-in refrigerator: 1. One five-pound container of sour cream with an expiration date of 11/22/22. The DD confirmed it needed to be discarded. 2. One opened cottage cheese container with an expiration date of 1/2/23. The container was not labeled the date opened or when to discard. The DD stated that cottage cheese should be discarded three days after it was opened. In the meat preparation refrigerator, the bottom had a pinkish liquid and white debris. The DD stated the facility cleaned the refrigerator once a week and confirmed the refrigerator needed to be cleaned. On a rack, there were one large green, three large white, and one small green cutting boards all deeply pitted and discolored. The DD stated cutting board were replaced every six months and confirmed these cutting boards should not be in use for risk of cross-contamination and bacteria. On 12/7/22 at 1:47 PM, the survey in the presence of the Licensed Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, and Assistant Administrator	F 812	FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The following corrective actions were immediately implemented: The five- pound container of sour cream which was labeled with an expired date was immediately discarded The open cottage cheese container that was not labeled was immediately discarded. The meat preparation refrigerator was emptied out and completely cleaned, including the pinkish liquid and white debris on the bottom. The cutting boards that were pitted and/or discolored were discarded and replaced with new ones. F-812 Element Two II.IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by the same deficient practice. F-812 Element Three III.SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR All Dietary Staff were in-serviced on the regulations and facility□s policies on the following: Properly handling and storage of potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses.	

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	315215	A. BUILDING ______ B. WING ______	C 12/12/2022

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

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F 812	Continued From page 12 informed them of the above findings. A review of the facility's "Section 11: Sanitation & Infection Control Labeling & Dating" policy dated 1/2016, included all foods are labeled, dated, and securely covered and use-by dates are monitored and followed... A review of the facility provided "Greenwood House Policy and Procedure Dietary Manual" dated revised March 2020, included...Equipment and utensils must be cleaned regularly and effective...All equipment should be stored, cleaned, and maintained according to Chapter 24 of the Retail Food Establishment Code of New Jersey... NJAC 8:39-17.2(g)	F 812	Maintaining equipment and kitchen areas in a manner to prevent microbial growth and cross contamination F-812 Element Four IV. MONITORING OF CORRECTIVE ACTIONS Dietary Supervisor or designee will conduct Kitchen Observation Audits weekly x 1 month; then thereafter x 6 months. Emphasis will be made on proper handling and storage of foods and maintaining equipment and kitchen areas in a clean and sanitary manner. Any issues identified in the audits will be rectified immediately. Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program for on-going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031101	A. BUILDING: ______ B. WING ______	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HOUSE HOME FOR THE JEWISH AGEI	53 WALTER STREET TRENTON, NJ 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) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) ensure staff were up to date with all COVID-19 vaccinations as eligible and b.) develop facility COVID-19 vaccination policies in accordance with State requirements. This deficient practice was identified for 9 out of 18 staff members reviewed for COVID-19 vaccination status (Staff #1, #2, #3, #4, #5, #6, #7, #8, and #9) and was evidenced by the following: Reference: New Jersey Executive Directive 290, dated 3/2/22: 2. b. All covered workers must provide adequate proof that they are up to date with their COVID-19 vaccination by May 11, 2022;	S 560	F-560 Element One I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: -Staff #1, a Certified Nursing Aide (CNA), received their completed primary series dose on 3/14/22 and provided proof of receiving a booster dose on 12/9/22 -Staff #2, a Registered Nurse (RN), received their completed primary series dose on 4/19/22 and provided proof of receiving a booster dose on 12/8/22 - Staff #3, a CNA, received their completed primary series dose on 3/1/22 and provided proof of receiving a booster	1/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE 01/05/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031101	A. BUILDING: ___ B. WING ___	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
GREENWOOD HOUSE HOME FOR THE JEWISH AGEI	53 WALTER STREET TRENTON, NJ 08628

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S 560	Continued From page 1 provided however, that as to having received a booster dose, covered workers must provide adequate proof that they are up to date with their COVID-19 vaccinations by May 11, 2022, or within 3 weeks of becoming eligible for a booster dose, whichever is later. During entrance conference on 11/29/22 at 10:01 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) to complete the "COVID-19 Staff Vaccination Status for Providers" matrix for all their staff including contracted staff. At this time, the DON informed the surveyor that the Infection Preventionist/Registered Nurse (IP/RN) was in charge of the facility's COVID-19 vaccination program for staff and residents. On 12/5/22 at 11:10 AM, the surveyor reviewed the completed "COVID-19 Staff Vaccination Status for Providers" for all facility staff that included 188 staff members. The surveyor selected eighteen staff members from both the staff and contracted staff matrixes provided and requested from facility administration to provide a copy of their COVID-19 vaccination card or their exemption (religious or medical) if applicable. On 12/6/22 at 9:20 AM, the ADON provided the surveyor with the requested COVID-19 vaccination documentation which revealed the following: Staff #1, a Certified Nursing Aide (CNA), received their completed primary series dose on 3/14/22 with no booster received. Staff #2, a Registered Nurse (RN), received their completed primary series dose on 4/19/22 with no	S 560	dose on 12/8/22 -Staff #4, a CNA, received their completed primary series dose on 1/5/21 and provided proof of receiving a booster dose on 12/8/22 -Staff #5, a CNA, received their completed primary series dose on 2/19/21 and provided proof of receiving a booster dose on 12/8/22 -Staff #6, a Housekeeper, received their completed primary series dose on 2/24/22 and provided proof of receiving a booster dose on 12/14/22 -Staff #7, a Licensed Practical Nurse (LPN), received their completed primary series dose on 2/24/22 and provided proof of receiving a booster dose on 12/14/22 -Staff #8, a LPN, received their completed primary series dose on 2/25/22 and provided proof of receiving a booster dose on Terminated due to not getting booster -Staff #9, a CNA, received their completed primary series on 2/28/22 and provided proof of receiving a booster dose on 12/7/22 No residents have been adversely affected by this deficient practice. F-560 Element Two II.IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by this situation. F-560 Element Three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031101	A. BUILDING: ____ B. WING ____	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HOUSE HOME FOR THE JEWISH AGEI	**53 WALTER STREET TRENTON, NJ 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) COMPLETE DATE
S 560	Continued From page 2 booster received. Staff #3, a CNA, received their completed primary series dose on 3/1/22 with no booster received. Staff #4, a CNA, received their completed primary series dose on 1/5/21 with no booster received. Staff #5, a CNA, received their completed primary series dose on 2/19/21 with no booster received. Staff #6, a Housekeeper, received their completed primary series dose on 2/24/22 with no booster. Staff #7, a Licensed Practical Nurse (LPN), received their completed primary series dose on 2/24/22 with no booster. Staff #8, a LPN, received their completed primary series dose on 2/25/22 with no booster. Staff #9, a CNA, received their completed primary series on 2/28/22 with no booster. A review of the National Healthcare Safety Network (NHSN) data's "Recent Facility Resident and Staff Vaccination Rates and Other Data, as reported for the week ending 11/13/22" revealed 99.2% of staff were up to date with vaccines. A review of the facility provided "Employee Health Protocol and Immunization" policy dated revised 9/14/22, included employees must have at least one dose of the COVID-19 vaccine by January 28, 2022...employees must be fully vaccinated by February 28, 2022, or have received an approved medical or religious exemption...Section III Interim Considerations for COVID-19 Vaccine Bivalent Booster (9/1/22) everyone ages 12 and older it is recommended to receive one bivalent booster dose after completion of any Food and Drug Administration [FDA] approved or FDA authorized monovalent primary series or last monovalent booster dose...primary series at least two months next dose one bivalent booster dose...The policy does not include per State	S 560	III.SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR The facility policy entitled Employee Health Protocol and Immunization" was revised to include the NJ State Regulation for COVID-19 Immunizations for Staff update on 5/11/2022; i.e., All staff have to receive one dose of a COVID-19 booster unless they qualify and has been approved for an exemption (medical or religious). All staff were in-serviced on the updated policy. All new hires will be required to comply with the NJ State Mandate for COVID-19 Immunizations for Staff as spelled out in Reference: New Jersey Executive Directive 290, dated 3/2/22, that states: 2. b. All covered workers must provide adequate proof that they are up to date with their COVID-19 vaccination by May 11, 2022; provided however, that as to having received a booster dose, covered workers must provide adequate proof that they are up to date with their COVID-19 vaccinations by May 11, 2022, or within 3 weeks of becoming eligible for a booster dose, whichever is later. F560 Element Four IV.MONITORING OF CORRECTIVE ACTIONS Infection Preventionist or designee will provide weekly reports x 3 months, then monthly x 3 months to the Administrator and Director of Nursing regarding the status of COVID-19 Immunizations of all Health Care Personnel. This is to ensure	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031101	A. BUILDING: ______ B. WING ______	C 12/12/2022

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

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S 560	Continued From page 3 regulation as of 5/11/22 all staff have to receive one dose of a COVID-19 booster or have an exemption (medical or religious). On 12/6/22 at 10:25 AM, the surveyor interviewed the IP/RN who confirmed she was in charge of the COVID-19 vaccination program and offered staff COVID-19 vaccines. The IP/RN stated that staff were eligible for the COVID-19 vaccine booster after two months of completing their primary series. The IP/RN stated the facility started offering the bivalent vaccine in October and held a COVID-19 booster clinic in both October and November. The IP/RN stated that the facility currently had ten staff who were eligible for their booster dose who had not received it and do not have an exemption. The IP/RN stated that the facility cannot "force" their staff to receive the booster vaccine. At this time, the surveyor reviewed the facility's "Employee Health Protocol Immunization" policy with the IP/RN who confirmed it was the facility's policy. When asked why the policy did not include the State booster vaccine mandate, the IP/RN stated she did not create the policy and has not read "the whole policy" to speak to it. The IP/RN confirmed the State required staff to have received at least one booster dose. On 12/8/22 at 01:31 PM, the Assistant Administrator (Assist Admin #1), in the presence of the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), Assist Admin #2, and survey team confirmed that the facility had ten staff members who have not received their booster vaccine and did not have a medical or religious exemption. NJAC 8:39-5.1(a); 19.4(a)	S 560	that facility is in compliance with the NJ State Mandate for COVID-19 Immunizations for Staff as spelled out in Reference: New Jersey Executive Directive 290, dated 3/2/2022, which states: 2. b. All covered workers must provide adequate proof that they are up to date with their COVID-19 vaccination by May 11, 2022; provided however, that as to having received a booster dose, covered workers must provide adequate proof that they are up to date with their COVID-19 vaccinations by May 11, 2022, or within 3 weeks of becoming eligible for a booster dose, whichever is later. Reports will be submitted to the QAPI Committee monthly x 6 months and will be incorporated in the facility QAPI Program for on-going compliance.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031101	A. BUILDING: ______ B. WING ______	C 12/12/2022

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315215	A. Building B. Wing	2/13/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HOUSE HOME FOR THE JEWISH AGED	53 WALTER STREET TRENTON, NJ 08628

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix F0700 Reg. # 483.25(n)(1)-(4) LSC	Correction Completed 01/04/2023	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 01/04/2023	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 01/04/2023
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/04/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/12/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
031101 (Y1)	A. Building B. Wing (Y2)	2/13/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HOUSE HOME FOR THE JEWISH AGED	53 WALTER STREET TRENTON, NJ 08628

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/04/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/12/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315215	A. BUILDING **01** B. WING ___	C **12/12/2022**

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

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/12/2022. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/12/2022 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. Greenwood House for Jewish Aged is a one-story building that was built in 1973. It is composed of Type II protected construction. The facility is divided into 7 - smoke zones.	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 01/04/2023

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.