

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

PRINTED: 07/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2024
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENWOOD HOUSE HOME FOR THE JEWISH AGED	STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS Complaint #: NJ00171710 Survey Dates: 03/08/2024 Census: 115 Sample Size: 4 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 COMPLAINT VISIT.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		3/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/22/2024
--	-------	--------------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2024
NAME OF PROVIDER OR SUPPLIER GREENWOOD HOUSE HOME FOR THE JEWISH AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	<p>Continued From page 1</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ00171710</p> <p>Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 03/07/24 and 03/08/2024, it was determined that the facility failed to report within the required timeframe an incident involving an alleged [redacted] allegation to the New Jersey Department of Health (NJDOH) and b.) follow the facility's "Abuse Policy". The alleged violation was reported to staff regarding an incident that involved a resident that was found to have a NJ Ex Order 26.4b1. When the resident was asked how that happened, the resident said that a staff member had NJ Ex Order 26.4b1. This deficient practice was identified for 1 of 4 sampled residents (Resident #1) and was evidenced by the following:</p> <p>During a tour of the unit on 03/07/24 at 10:36 a.m., the surveyor knocked on Resident #1's door and was granted entry by the resident. Resident #1 was observed wearing a NJ Ex Order 26.4b1 and [redacted] while seated in a wheelchair at the bedside, NJ Ex Order 26.4b1. Resident #1 stated that the resident does NJ Ex Order 26.4b1 with some of the aides and staff; the resident did not name anyone. The surveyor asked the resident if</p>	F 609	<p>GREENWOOD HOUSE HOME FOR THE JEWISH AGED PLAN OF CORRECTION Regulation: F-609 Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2024
NAME OF PROVIDER OR SUPPLIER GREENWOOD HOUSE HOME FOR THE JEWISH AGED		STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	<p>Continued From page 2</p> <p>he/she recalled an incident when a staff had NJ Ex Order 26.4b1 of the resident, the resident stated that the incident occurred NJ Ex Order 26.4b1 and that staff had entered the room to NJ Ex Order 26.4b1 and one of them NJ Ex Order 26.4b1 the resident's NJ Ex Order 26.4b1 and "NJ Ex Order 26.4b1." As the resident described the incident the surveyor observed as Resident #1 NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 to show the surveyor how the resident NJ Ex Order 26.4b1 Resident #1 further stated, "NJ Ex Order 26.4b1." When the surveyor asked how many staff members had entered the room, the resident stated that he/she NJ Ex Order 26.4b1. The resident also NJ Ex Order 26.4b1 the exact date of the incident. Resident #1 stated that this had NJ Ex Order 26.4b1. Resident #1 stated NJ Ex Order 26.4b1 at the facility.</p> <p>According to the face sheet, Resident #1 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).</p> <p>Review of Resident #1's Comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4b1 out of 15, which indicated that the resident's cognition was NJ Ex Order 26.4b1.</p> <p>Review of the Reportable Event Record provided</p>	F 609	<p>investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>¿ Resident #1 was interviewed and preventative measures were initiated on NJ Ex Order 26.4b1 when the resident reported to the facility's nursing staff NJ Ex Order 26.4b1 on the morning of NJ Ex Order 26.4b1. Assessment and evaluation of resident #1 were completed with further investigation steps implemented on NJ Ex Order 26.4b1. The US FOIA (b)(6) was notified on NJ Ex Order 26.4b1.</p> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <p>¿ All residents have the potential to be affected by the same deficient practice. Facility Nursing Administration, Supervisors, Unit Managers and Licensed nurses were educated on the importance of reporting allegations of Abuse or Neglect at the time of a suspected abuse/neglect to the Director of Nursing,</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2024
NAME OF PROVIDER OR SUPPLIER GREENWOOD HOUSE HOME FOR THE JEWISH AGED		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
F 609	<p>Continued From page 3</p> <p>by the facility revealed that the incident occurred on [redacted] at 5 A.M. and it was submitted to the NJDOH on [redacted]. The reportable revealed that Resident #1 was noted to have a [redacted] on his/her [redacted]. The reportable further revealed that the resident stated that [redacted] people came into the room to [redacted] and the resident [redacted]. " One staff member had reportedly [redacted], causing [redacted]. The reportable also revealed that an investigation was initiated, and camera footage was reviewed, at no time did [redacted] people enter the room and the incident was [redacted]. The reportable included a timeline of the camera footage and statements from staff identified on the footage. Statements from staff that had been assigned to the resident up to a few days prior to the incident were also reviewed.</p> <p>Review of Resident #1's Incident/Accident Report, dated [redacted] revealed a [redacted] that required a person to indicate where [redacted] was noted; the surveyor observed that there was an [redacted] on the [redacted] of the [redacted]. The surveyor observed that under the [redacted] section, the box checked was [redacted] with a description of [redacted].</p> <p>During an interview with the surveyor on 03/07/24 at 12:25 P.M., the [redacted] (US FOIA (b)(6)) reported that she had been informed of the incident the day after it occurred, on [redacted]. The [redacted] stated that the [redacted] (US FOIA (b)(6)) informed her. The [redacted] further stated that she was a nurse and that her title is considered "clinical support." The</p>	F 609	<p>Assistant Director of Nursing and Administrative staff timely, within two (2) hours.</p> <p>The Supervisors, Unit Managers, and Licensed nurses received education to the facility's Policy and Procedure on Abuse and Neglect with an emphasis to section "G" of the facility's policy regarding reporting and response; the importance of notification to the facility's leadership; Nursing Director, Assistant Director of Nursing and Administration at the time of the alleged allegation.</p> <p>The Director of Nursing, Assistant Director of Nursing and Administration are to follow the facility Policy and Procedure especially regarding notification of any allegation of abuse during an active investigation of alleged abuse to New Jersey Department of Health and the Office of the Ombudsman within two (2) hours.</p> <p>III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>↳ All staff were re-educated on the regulations governing F-609 and the facility policy and procedure for "Abuse". Emphasis was placed on section "G" of the facility policy and procedure; Reporting and Response. This section of the facility policy is to ensure that all alleged violations that involve abuse and neglect would be reported to the facility's leadership; Nursing Director, Assistant Director of Nursing and Administration at</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2024
NAME OF PROVIDER OR SUPPLIER GREENWOOD HOUSE HOME FOR THE JEWISH AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	<p>Continued From page 4</p> <p>[US FOIA] stated that she completed a Nursing Assessment on Resident #1, on [NJ Ex Order 26.4b1] at 3:30 P.M., "I saw [NJ Ex Order 26.4b1]." She stated that when she asked Resident #1 what happened, Resident #1 told her that the resident [NJ Ex Order 26.4b1], "I got the impression that the [Resident #1] [NJ Ex Order 26.4b1] [US FOIA (b)(6)]." The [US FOIA (b)(6)] further stated that the resident stated to her, "[NJ Ex Order 26.4b1]," while care was attempting to be provided. The [US FOIA (b)(6)] said that the resident did not state how many staff had entered the room or who had [NJ Ex Order 26.4b1] the resident.</p> <p>During an interview with the surveyor on 03/07/24 at 1:06 P.M., the [US FOIA (b)(6)] stated that she had participated in in-services on [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1] recently. The [US FOIA (b)(6)] recalled working the day after the incident on [NJ Ex Order 26.4b1]. She stated that she was walking in the hallway of the unit and she saw the assigned nurse walk into the room, as the [US FOIA (b)(6)] was walking past the door the nurse had called her into the room as the resident said [NJ Ex Order 26.4b1]. The [US FOIA (b)(6)] further stated, "I walked in behind the nurse and saw a [NJ Ex Order 26.4b1] on her [NJ Ex Order 26.4b1]. She stated that Resident #1 said that [NJ Ex Order 26.4b1] s came into her room and [NJ Ex Order 26.4b1] [US FOIA (b)(6)]." The [US FOIA (b)(6)] stated that she was asked to provide a statement the next day, which she did. The [US FOIA (b)(6)] further stated that she had worked the day before the incident [7 A.M. - 3 P.M on [NJ Ex Order 26.4b1]] and that her assignment involved providing daily care for residents that included getting them up and dressed for the day. The [US FOIA (b)(6)] stated, "[Resident #1] did not have the [NJ Ex Order 26.4b1] the day before." The [US FOIA (b)(6)] further added that this is the first time that she is aware that Resident #1 had made this type of allegation.</p>	F 609	<p>the time of the incident or within two (2) hours of the incident.</p> <p>When an allegation of abuse or an incident result in serious bodily injury, the administrator and nursing administration of the facility is to be notified immediately. All Unit Managers, Supervisor and Licensed nurses received education on section "G" of the facility policy with emphasis on the necessary steps of investigation and notification to the resident involved responsible representative, the physician and the facility's leadership; Nursing Director, Assistant Director of Nursing and Administration at the time of the incident. Notification to the New Jersey State agencies is to be within two (2) hours after the allegation is made, if the incident that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the incident that caused the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>IV. Monitoring of Corrective Action</p> <p>¿ The Assistant Administrative or Designee will review allegations of Abuse for reporting and response, ensuring the facility's policy on Abuse is followed accordingly. Finding will be reported to Administrator 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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2024
NAME OF PROVIDER OR SUPPLIER GREENWOOD HOUSE HOME FOR THE JEWISH AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 5 During an interview with the surveyor on 03/07/24 at 2:40 P.M., the US FOIA (b)(6) stated that if US FOIA (b)(6) and/or US FOIA (b)(6) were reported to a staff member on the floor, staff was to notify the chain of command. The US FOIA (b)(6) stated that once notified, an investigation was to begin, and statements were to be obtained. She further stated that the resident's representative was to be contacted along with the physician, the Ombudsman, and the NJDOH who were to be contacted immediately. The surveyor asked the US FOIA (b)(6) when this incident had been reported, to which the US FOIA (b)(6) asked to see the Reportable that had been provided to the surveyor. After reviewing the documentation in the presence of the surveyor the US FOIA (b)(6) stated that it was reported by her on US FOIA (b)(6) . The surveyor then asked the US FOIA (b)(6) why it was reported on US FOIA (b)(6) when the incident occurred on US FOIA (b)(6) , to which the US FOIA (b)(6) stated, "I was on vacation US FOIA (b)(6) - US FOIA (b)(6)] during that time and I called it in as soon as I returned, when it was brought to my attention on US FOIA (b)(6) ." The surveyor asked the US FOIA (b)(6) if the US FOIA (b)(6) was the only person in the facility that was responsible for calling in a reportable to the NJDOH? The US FOIA (b)(6) stated, "No." During a follow-up interview with the surveyor on 03/08/24 at 2:57 P.M., the US FOIA (b)(6) stated that reports of US FOIA (b)(6) and/or US FOIA (b)(6) were to be immediately reported to the NJDOH. When asked who was responsible for notifying the NJDOH the US FOIA (b)(6) stated that Nursing Administration is tasked with calling the NJDOH. The US FOIA (b)(6) said that Nursing Administration is composed of the US FOIA (b)(6) and the US FOIA (b)(6) . The US FOIA (b)(6) further stated, "The US FOIA (b)(6) was on vacation, so I	F 609	Completion Date: March 30, 2024	

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

PRINTED: 07/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2024
NAME OF PROVIDER OR SUPPLIER GREENWOOD HOUSE HOME FOR THE JEWISH AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	<p>Continued From page 6</p> <p>reported it to the [US FOIA (b)(6)] on [NJ Ex Order 26.4b1] around 3:30 P.M."</p> <p>During an interview with the surveyor on 03/07/24 at 3:05 P.M., the [US FOIA (b)(6)] stated that reports of [NJ Ex Order 26.4b1] and/or [NJ Ex Order 26.4b1] were to be immediately reported to the NJDOH. The [US FOIA (b)(6)] stated that she was made aware of the incident around 3:30 P.M. on [NJ Ex Order 26.4b1], but she was not sure who informed her. The [US FOIA (b)(6)] stated that she was told that Resident #1 had reported that [NJ Ex Order 26.4b1] people [staff] entered the room, [NJ Ex Order 26.4b1] Resident #1's [NJ Ex Order 26.4b1], and [NJ Ex Order 26.4b1]. When asked if the [US FOIA (b)(6)] thought that this incident qualified as a report of [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1] the [US FOIA (b)(6)] stated, "Yes". The [US FOIA (b)(6)] further stated that the investigation was started immediately. The surveyor asked if the [US FOIA (b)(6)] had called the NJDOH, to which the [US FOIA (b)(6)] stated, "I did not call." The [US FOIA (b)(6)] further added that she was unsure if the [US FOIA (b)(6)] was going to call. When asked if she had a conversation with the [US FOIA (b)(6)] on the day of the incident, the [US FOIA (b)(6)] stated, "No."</p> <p>During an interview with the surveyor on 03/07/24 at 3:20 P.M., the [US FOIA (b)(6)] stated that it was the responsibility of the [US FOIA (b)(6)] or the [US FOIA (b)(6)] to call in the reportable.</p> <p>Review of the facility's "Abuse Policy", revised January 2024, revealed under the "G. Reporting and Response" section that the facility was to ensure that all alleged violations that involve abuse and neglect were to be reported " ... immediately, but not later than two hours after the allegation is made ..."</p>	F 609			

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

PRINTED: 07/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2024
NAME OF PROVIDER OR SUPPLIER GREENWOOD HOUSE HOME FOR THE JEWISH AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 7 NJAC 8:39-9.4(f)	F 609			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315215	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 3/31/2024	Y3
NAME OF FACILITY GREENWOOD HOUSE HOME FOR THE JEWISH AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 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 F0609	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c) (1)(4)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	03/30/2024	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/7/2024

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO