

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

PRINTED: 08/12/2022
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 06/05/2021
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 #: NJ136645, NJ143632 Census: 89 Sample Size: 5 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		7/5/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/22/2021

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 580	<p>Continued From page 1</p> <p>resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint Intake NJ136645</p> <p>Based on record review and interviews, it was determined that the facility failed to notify the physician (MD) and responsible party (RP) of a pressure wound for [redacted] (Resident # [redacted]) of [redacted] residents reviewed for [redacted] Executive Order 26, 4.b.</p> <p>Findings include:</p> <p>1. Resident [redacted] was admitted with diagnoses including [redacted] Executive Order 26, 4.b.</p> <p>Resident [redacted]'s care plan, dated [redacted] Executive Order 26, 4.b. included a problem of [redacted] Executive Order 26, 4.b., and a history of [redacted] Executive Order 26, 4.b.</p>	F 580	<p>This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully disagrees with this deficiency, notwithstanding the following actions have been taken:</p> <p>Element One F580</p>	

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F 580	<p>Continued From page 2</p> <p>Executive Order 26, 4.b. Executive Order 26, 4.b. _____ and treatments as ordered.</p> <p>The quarterly Minimum Data Set, dated Executive Order 26, 4.b., revealed Resident Executive Order 26, 4.b., Executive Order 26, 4.b., and was not usually understood. The resident required total assistance from staff for activities of daily living and had Executive Order 26, 4.b..</p> <p>A physician's order, dated Executive Order 26, 4.b. for Executive Order 26, 4.b. (Executive Order 26, 4.b.) to the Executive Order 26, 4.b. was noted as a verbal order by the physician, written and signed off by Licensed Practical Nurse (LPN) #2.</p> <p>A review of a Executive Order 26, 4.b. Record for Resident Executive Order 26, 4.b. and signed by LPN #2, indicated on Executive Order 26, 4.b. of Executive Order 26, 4.b. or Executive Order 26, 4.b. e, and appeared as Executive Order 26, 4.b.. Treatment was Executive Order 26, 4.b. and this was the initial treatment.</p> <p>A progress note dated Executive Order 26, 4.b., by LPN #2, indicated Resident Executive Order 26, 4.b. had an Executive Order 26, 4.b., treatment was started, and monitoring would continue.</p> <p>A review of Resident Executive Order 26, 4.b.'s treatment administration record (IAR) for Executive Order 26, 4.b. revealed Executive Order 26, 4.b. treatment to the Executive Order 26, 4.b. occurred Executive Order 26, 4.b. on Executive Order 26, 4.b..</p> <p>A review of progress notes by the Nurse Practitioner (NP) dated Executive Order 26, 4.b. did not</p>	F 580	<p>Resident Executive Order 26, 4.b., Executive Order 26, 4.b. However, all nursing supervisors were made aware of the alleged deficiency and immediately reviewed their unit's residents and ensured that any change in condition had been reported to both the physician and the residents primary contact.</p> <p>Element Two F580 All residents have the potential to be affected.</p> <p>Element Three F580 The Director of Nursing(DON)and her designees reeducated and in-serviced all nurses both via verbal instruction and a written memo dated 6/7/21 on 'Notification of Change in Condition'. In addition, a Policy & Procedure(P&P) will be created re: Notification of Change in Condition of non-critical residents. (A P&P already exists re: notification for critical and emergent residents.)</p> <p>Element Four F580 The DON or her designee will review all charts on those residents reported to have a change in condition to ensure the physician and the residents primary contact have been notified. This will be ongoing for three (3) months. The data collected from the review will be reported to the Quality Assurance Committee for three (3) months or until compliance is achieved.</p>	

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F 580	<p>Continued From page 3 address the Executive Order 26, 4.b.</p> <p>On 06/05/2021 at 9:06 AM, an interview was conducted with the Director of Nursing (DON). The DON verified there was no documentation of physician (MD) or responsible party/family (RP) notification in the notes, but a physician was onsite at the facility four days per week. The DON stated Resident Executive Order 26, 4.b. family member was at the facility daily and continued to come after COVID-19 started as the family member fed the cats outside the facility.</p> <p>On 06/05/2021 at 10:20 AM, an interview was conducted with LPN #2, who stated she did not recall the Executive Order 26, 4.b., or writing the note for the Executive Order 26, 4.b. The nurse stated she did not remember if the physician or family were notified. The nurse stated if she wrote for Executive Order 26, 4.b. then that was the treatment she thought was needed at the time, but she could not recall the appearance of the Executive Order 26, 4.b.</p> <p>On 06/05/2021 at 10:46 AM, an interview was conducted with the MD. The MD stated he was the medical director, so his signature was usually used first for resident orders. The MD stated he was not familiar with the resident and could not remember the Executive Order 26, 4.b., as the resident was under the care of his partner. The MD stated if the Executive Order 26, 4.b. was an Executive Order 26, 4.b. Executive Order 26, 4.b. would be appropriate. The MD stated Resident Executive Order 26, 4.b. had contracted Executive Order 26, 4.b. and had become Executive Order 26, 4.b. because of it, so Executive Order 26, 4.b. would have been a Executive Order 26, 4.b.</p> <p>On 06/05/2021 at 2:23 PM, an interview was conducted with the NP who cared for Resident Executive Order 26, 4.b. on Executive Order 26, 4.b. The NP stated she was at the Executive Order 26, 4.b.</p>	F 580		

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F 580	<p>Continued From page 4</p> <p>facility to care for residents who had come down with ^{Executive Order 26, 4.b} and that was why she saw Resident [REDACTED]. The NP stated she was not familiar with the resident and was not at the facility to treat the ^{Executive Order 26, 4.b}, so could not remember anything pertaining to wounds.</p> <p>On 06/05/2021 at 2:55 PM, a follow up interview was conducted with the DON. The DON stated she expected staff to notify the MD and RP when new ^{Executive Order 26} were found.</p> <p>The DON was unable to find the facility policy for notification for change of condition.</p> <p>New Jersey Administrative Code 8:39-13.1(d)</p>	F 580			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315215	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 7/5/2021	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 F0580	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	07/05/2021	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 6/5/2021		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		