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	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood House Home for the Jewish Aged	53 Walter Street Trenton, NJ 08628

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49094 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to store the resident's urinary drainage bag in a dignified manner. This deficient practice was identified for 1 of 2 residents reviewed for urinary catheter (Resident #15), and was evidenced by the following: A review of the facility's Catheter Care - Foley policy, dated revised August 2024, did not include covering the foley catheter bag with a privacy cover. On 8/5/24 at 10:45 AM, during initial tour of the facility, the surveyor observed Resident #15 in their bedroom sitting in a wheelchair. Resident #15 stated that they had a suprapubic (SP) catheter (flexible tube that is inserted into the bladder through the abdominal wall to drain urine) and wore a leg bag during the day. The resident further stated that at night, the urinary bag was switched to a foley catheter bag (drainage collection bag). On 8/6/24 at 10:13 AM, the surveyor reviewed the medical record for Resident #15. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses including but not limited to; retention of urine (when the bladder does not empty completely), type II diabetes mellitus (pancreas does not make enough insulin), and obstructive and reflux uropathy (flow of urine is blocked). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 7/8/24, indicated that the resident had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated cognitively intact cognition. A review of Section H - Bladder and Bowel, indicated that the resident had an indwelling catheter. A review of the Physician Order Summary Report revealed an order dated 3/31/23, to attach the suprapubic catheter to the leg bag when out of bed; attach foley catheter to foley bag when in bed per [facility] policy two times a day for urinary retention. On 8/7/24 at 10:30 AM, the surveyor observed Resident #15 sitting up in bed. The surveyor observed the resident's urinary catheter collection bag attached to the bed rail on the resident's left side of the bed, which was visible from the hallway. The urinary collection bag contained urine and did not have a privacy cover. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 12:10 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated the nurses were responsible for changing the foley bags and leg bags daily. The LPN further stated that a foley bag was used when a resident was in bed and should be covered with a privacy cover. On 8/8/24 at 9:10 AM, the surveyor observed Resident #15 sitting up in bed eating breakfast. The surveyor observed the resident's urinary catheter collection bag attached to the bed rail on the resident's left side of the bed, which was visible from the hallway. The foley bag contained urine and did not have a privacy cover. On 8/8/24 at 9:15 AM, the LPN in the presence of the surveyor confirmed that the foley urinary collection bag did not have a privacy cover, and it should be covered with a privacy bag. The LPN acknowledged it was important for it to be covered for the resident's privacy. On 8/8/24 at 2:13 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that a foley bag was used when the resident was in bed, and it was changed to a leg bag when they get out of bed. The RN/UM further stated that when a foley bag is used it should be covered with a privacy cover. When the surveyor asked why it was important for the foley bag to be covered, the RN/UM replied, for the resident's dignity and privacy. On 8/12/24 at 12:28 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) in the presence of the Licensed Nursing Home Administrator (LNHA), the Assistant Administrator, and the survey team who stated that a foley bag should be covered with a privacy cover and the nurse was responsible to ensure it was covered. NJAC 8:39-4.1(a)(12)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49094 Complaint NJ #: 166488 Based on interview, review of the closed medical record, and pertinent facility documents, it was determined that the facility failed to notify a resident's family after a change of condition. This deficient practice was identified for 1 of 31 sampled residents (Resident #170), and was evidenced by the following: A review of the facility's Notification of Changes policy, dated revised July 2021, included it is the policy of [the facility] to notify the resident, resident representative(s) and resident's physician (when applicable) of any changes in a manner to acknowledge and respect the resident's rights .[the facility] will immediately inform the resident, consult the resident's physician, and notify, consistent with his/her authority, the resident representative(s) when there is: A significant change in the resident's physical, mental or psychological status (i.e. a deterioration in health, mental or psychological status, skin integrity, life threatening conditions or clinical complications, etc.) . On 8/7/24 at 9:31 AM, the surveyor reviewed the closed medical record for Resident #170, which revealed the resident was admitted to the facility in 2023 and discharged from the facility in 2023. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses including but not limited to; displaced intertrochanteric fracture of right femur (hip fracture), hypertension (high blood pressure), and history of falling. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 7/29/23, indicated that the resident had a brief interview for mental status (BIMS) score of 9 out of 15, which indicated moderately impaired cognition. A review of the Progress Notes included a Nurses Note (NN) dated 8/5/23, which revealed the Certified Nurses Aid (CNA) alerted the nurse that Resident #170 had an open area to the mid back measuring two centimeters by 1.6 centimeters (2 cm x 1.6 cm) with reddening around the wound bed; no drainage or odor. The resident denied pain/discomfort to site. The nurse documented that they cleaned the area with normal saline, applied bacitracin and a bordered foam dressing. A consultation form was completed for the wound. The nurse recommended a low-pressure bed. The Nurses Note did not indicate that family notification was completed. On 8/8/24 at 9:58 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated the family should be notified when a new skin condition occurs. The surveyor asked the ADON to provide any documentation that Resident #170's family was informed of the change in condition on 8/5/23. On 8/8/24 at 1:15 PM, the surveyor re-interviewed the ADON, who stated the family notification was not completed when the new skin condition was discovered on 8/5/23. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 12:28 PM, the ADON in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Administrator, and survey team stated that the resident's family should have been notified anytime there was a change in condition. The ADON also stated that the nurse was responsible for the family notification, and there should have been documentation in the medical record. NJAC 8:39-13.1(c)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 38080 PART A NJ Complaint #: 174306 Based on interview and review of pertinent facility documents, it was determined that the facility failed to follow their abuse policies and procedures by ensuring a resident (Resident #171) was free from verbal abuse and an involuntary restraint by: a.) immediately suspending the Registered Nurse (RN #1) and Certified Nursing Aide (CNA #1) who the allegation was made against pending a thorough investigation; and b.) thoroughly investigating an allegation of verbal abuse and involuntary restraint. This deficient practice was identified for 1 of 5 residents (Resident # 171); and two staff members (RN #1 and CNA #1) who had access to all the residents in the facility on 3 of 3 nursing units, reviewed for abuse. Resident #171, who had diagnoses which included arthritis, anxiety, and depression reported to the Social Worker (SW) on 6/3/24, that two nurses were extremely rude to the resident on the 11:00 PM to 7:00 AM (11-7) shift; the nurses yelled at the resident and demanded that the resident turn the light off. The resident reported that the nurses said the resident was embarrassing the nurses, and the nurse blocked the bedside with a chair so the resident could not get to the restroom. A review of the investigation dated 6/3/24 and interview with the Director of Nursing (DON) on 8/8/24, revealed that the facility began an investigation for the allegation of abuse on 6/3/24, and determined the incident was unsubstantiated on 6/3/24. The DON obtained a statement from RN #1 dated 6/2/24, regarding the allegation made on 6/3/24, and a statement from CNA #1 on 6/7/24. Both RN #1 and CNA #1 continued to work throughout all nursing units having access to all residents with no suspension, the DON did not obtain statements from any potential witnesses who were at the facility during the time of the allegation, or from any residents who were in contact with RN #1 and CNA #1. The investigation did not include if any verbal exchange was made between RN #1 or CNA #1 with the resident; if a chair was observed at the resident's bed; or a resident assessment post allegation. The facility's failure to implement their abuse policy by immediately suspending RN #1 and CNA #1 pending a thorough investigation to ensure all residents were free from abuse. By allowing RN #1 and CNA #1 to continue to work on all three nursing units, which allowed access to all the residents without a thorough investigation to rule out verbal abuse and involuntary restraint, posed a likelihood of serious harm to all residents. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 6/3/24, after Resident #171 reported to the SW that two nurses were extremely rude and yelled at the resident, and blocked the resident in bed with a chair so the resident could not use the restroom and continued to work. RN #1 worked 73 shifts from 6/3/24 through 8/7/24, including multiple double (9-16 hours) shifts, and CNA #1 worked 52 shifts from 6/3/24 through 8/7/24, including multiple double shifts. The facility Administration was notified of the IJ on 8/8/24 at 3:52 PM. The facility submitted an acceptable Removal Plan (RP) on 8/9/24 at 12:24 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/9/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	The evidence was as follows: A review of the facility's Abuse Policy (Staff and Other Individuals) Prohibition of Photographs and Audio/Video Recordings by Staff of [facility name redacted], dated revised January 2024, included: it is the policy of the [facility] that each resident will be free from abuse, neglect, corporeal punishment, [.] Investigation: it is the policy of [facility] that reports of abuse [.] are promptly and thoroughly investigated . When an incident or suspected incident of abuse is reported, the Administration or designee will investigate the incident with the assistance of the appropriate personnel. The investigation will include: who is involved; resident's statements [.]; resident's roommate statement (if applicable); involved staff and witness statements of events; a description of the resident's behavior and environment at the time of incident; injuries including a resident assessment; observation of resident and staff behaviors during the investigation; environmental considerations .Immediately upon receiving a report of alleged abuse, the Administrator, and/or designee will coordinator [sic] delivery of appropriate medical and/or psychological care and attention . Procedures must be put in place to provide the resident with a safe, protected environment during the investigation: the alleged perpetrator will immediately be removed and resident protected. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation . A review of the facility's Grievances/Complaints, Filing policy, dated reviewed 6/21/24, included all alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law . On 8/6/24 at 12:37 PM, the surveyor interviewed the DON and the Assistant Director of Nursing (ADON) regarding the facility's process for allegations of abuse. The DON stated that the facility obtained statements, reviewed surveillance footage from the hallways if applicable, and completed a head-to-toe assessment of the resident to try to determine what occurred. The surveyor asked if the facility removed the accused staff from the facility pending a thorough investigation, and the DON stated it depended if there was an inkling that could be true. The DON continued that some residents complain repeatedly so the facility just removed the accused staff from their care or to another wing. The surveyor asked how the facility was protecting other residents from potential abuse if the investigation was not complete and the accused staff had access to other residents. The DON responded that the nurse was instructed to keep an eye on the accused staff. The DON stated if the resident was cognitively intact with no history of delusions, then the accused staff was sent home pending an investigation. The DON stated after gathering statements, the facility contacted the New Jersey Department of Health (NJDOH) and submitted a facility reportable event (FRE) form which included the facility's investigation and the accused staff's background check, license, and abuse training. On 8/8/24 at 9:44 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON regarding the facility's process for allegations of abuse. The LNHA stated that the facility started investigating and questioning staff right away. The surveyor asked what the facility did with the accused staff member during the investigation process, and the LNHA stated the accused staff was removed from the area and many times removed from the building. The surveyor asked why the accused staff was not always removed from the building, and the LNHA stated we know these people. The LNHA further stated that the facility had known most of the staff for years and years and make personal decisions regarding the staff if they do not suspect abuse. The LNHA stated that the facility followed the regulations and reported and investigated allegations of abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 8/8/24 at 11:27 AM, the surveyor reviewed the FRE for Resident #171 that occurred on 6/2/24, and was reported on 6/3/24. The investigation revealed the following: A review of the Concern/Grievance Form completed by the SW dated received 6/3/24, indicated that the resident stated nurses were extremely rude to [the resident]; that two nurses on the 11:00 PM to 7:00 AM (11-7) shift yelled at the resident and demanded the resident turn off the light. The resident stated that the nurses said that the resident wasembarrassing the nurses, and the nurses blocked the resident's bedside with a chair so they could not get to the restroom. Actions taken included getting statements from staff and two employees at all times. A review of a timeline completed by the DON revealed that the CNA #1 entered Resident #171's room two times during the shift, at 11:55 PM, and 6:10 AM through 6:14 AM, and RN #1 entered the resident's room four times during the shift, at 12:05 AM, 12:10 AM, 2:06 AM, and 6:24 AM. The DON indicated that at no time during the entire shift did two people; either two nurses, two CNAs, or a nurse and CNA enter the room. The DON had a notation that she spoke to CNA #2 who verbally informed the DON there were no chairs blocking [the resident] from exiting bed. A review of the 11-7 Staffing sheet for 6/2/24, which included the assigned nurses and CNAs, CNA #2 was not included on that assignment sheet. A review of the Employee Statement Form for RN #1, indicated date of incident 6/2/24, revealed that RN #1 completed the form on 6/2/24, even though the incident was reported on 6/3/24, and that RN #1 stated that on the 3:00 PM to 11:00 PM (3-11) shift, the resident complained of not receiving help from the 7:00 AM to 3:00 PM (7-3) shift, the bedding was not changed and did not get the right [illegible]. RN #1 noted the resident ambulated independently with a walker to the bathroom and did not need assistance. RN #1 stated during the 11-7 shift, the resident slept well; did not put call bell on. A review of the Employee Statement Form for CNA #1, indicated date of incident 6/2/24 into 6/3/24, revealed that CNA #1 completed the form on 6/7/24, four days after the reported incident, and stated that they performed care on the resident one time during the night (surveillance footage indicated entered room on two occasions), and they did not notice anything unusual. After finishing care, CNA #1 provided the resident with the call bell and remote. A review of a typed statement from the Assistant Administrator (Assist Admin) dated 6/3/24, indicated that around 2:00 PM on 6/3/24, she knocked on Resident #171's door to inspect their room for environmental rounds. During that time, Resident #171 reported to the Assist Admin that last night two aides were rude to the resident; the aides told the resident if the resident wet their gown again, the aides will not be able to change the gown because there were no more. The aides told me I was annoying. The Assist Admin asked for a description of the aides and time of incident, the resident stated sometime in the night and two female aides. The resident stated they reported the incident that morning and the facility was investigating the matter. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	A review of the Internal Investigation Report, completed by the DON on 6/3/24, indicated the reason for investigation was that the resident complained to the SW that staff placed a chair next to the resident's bed so the resident could not get to the bathroom. Investigation included that today the SW went to interview Resident #171 and the resident stated the nurses on the 11-7 shift were extremely rude to [the resident], blocked the bedside with a chair so the resident could not get to the restroom. The resident scored a 13 out of 15 on their brief interview for mental status (BIMS) assessment, which indicated an intact cognition, but the resident was taking oxycodone (pain medication) around the clock. Conclusion was that the DON felt this may be unsubstantiated only because other statements made by the resident were untrue. The statements included the resident stated they were not at therapy (they were), and that the resident had not slept since admission. Recommendation was to send two staff members in room when needed: preferably a nurse and CNA. On 8/8/24 at 12:00 PM, the surveyor interviewed the DON who stated that the resident was very difficult and no longer resided at the facility. The surveyor reviewed the FRE dated 6/3/24, with the DON who confirmed the resident alleged staff were rude which was considered verbal abuse, and if the chair was in front of the bed, it was also considered abuse. The surveyor asked if RN #1 and CNA #1 were allowed to work during the investigation, and the DON stated yes. The surveyor reviewed the facility's abuse policy with the DON, and the DON acknowledged the policy indicated that staff were suspended pending a thorough investigation and cannot speak to why they were not suspended. The DON acknowledged that the resident specified which shift the incident occurred on and that the facility determined which two staff members entered the resident's room during that shift. The DON stated usually she had the SW speak to other residents about the shift or staff members and could not speak to why it was not done for that incident. The DON acknowledged that no other potential witnesses were interviewed who worked on that shift to determine if they saw a chair at the resident's bed or heard anything that was said to the resident. The DON stated no additional allegations have been made against RN #1 and CNA #1. On 8/8/24 at 12:13 PM, the surveyor interviewed the Director of Social Services (DSS), who stated they were the Grievance Officer, but after a grievance was obtained, the DSS provided it to the appropriate department head to investigate. The DSS stated she provided Resident #171's grievance from 6/3/24, to the DON to complete. On 8/8/24 at 12:32 PM, the surveyor interviewed the DON, in the presence of the Assist Admin, who stated the incident occurred during the night shift, and the resident complained the next day. The DON stated they reviewed the call bell system from that night and the surveillance camera footage which showed RN #1 and CNA #1 entered the resident's room, but they did not go in together. The DON stated at no time did two staff members enter the resident's room together, so the allegation was unsubstantiated. The surveyor reviewed the grievance statement with the DON and Assist Admin, who both confirmed the resident's statement did not indicate the two nurses were in the room at the same time. On 8/8/24 at 1:17 PM, the surveyor interviewed the Assist Admin, who confirmed the resident's statement was what was written on the grievance form, and that the Assist Admin did not go into the resident's room that day in response to the grievance, but to conduct environmental rounds. The Assist Admin stated during her rounds, the resident informed her of the situation and that the facility was investigating it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 8/8/24 at 1:28 PM, the surveyor interviewed the DON, who stated the facility did not conduct an assessment of the resident because it was an allegation of verbal abuse. The surveyor asked the DON if a chair was at the resident's bedside, was there a possibility injury could have occurred. The DON stated the chair could have caused injury, but the DON did not think of that because the resident's bed was not against the wall so they could have gotten out on the other side. On 8/8/24 at 1:46 PM, the surveyor interviewed the SW, who confirmed they took that statement from the resident and that was what the resident stated. The SW stated that the resident did not specify what extremely rude meant, but thought it was the yelling, demanding to turn off the light, and blocking the bed with the chair. The SW stated the resident did not know who the two staff members were, and the SW confirmed the resident never indicated that the two staff members were present at the same time, only that they worked on the 11-7 shift. The SW stated after she obtained the grievance, she provided it to the DSS who gave it to the DON to investigate. The SW stated she was conducting a social history assessment with the resident that morning in the resident's room, and the resident informed her then. The SW stated after she provided the resident's statement to the DSS, she conducted no additional interviews. On 8/8/24 at 2:00 PM, the surveyor reviewed Resident #171's closed medical record. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility for a short term stay with no admission diagnoses included. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 6/6/24, included the resident had a BIMS score of 13 out of 15, which indicated a fully intact cognition. The assessment also included that the resident required partial or moderate assistance with the helper doing less than half the effort to lift, hold or supports trunk or limbs for toileting hygiene, which included the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement and transferring to and off the toilet or commode. The resident was occasionally incontinent (less than seven episodes of incontinence) for bowel and bladder. Diagnoses included hypertension (high blood pressure), hyperlipidemia (high blood cholesterol), arthritis, anxiety, and depression. A review of the Progress Notes from 6/3/24, did not include the incident or a nursing assessment. A review of an Initial Psychiatric Evaluation dated 6/5/24, included the resident was at the facility for subacute rehabilitation and appeared tense and anxious .The resident reported having a history of anxiety and panic attacks; and the resident reported feeling anxious about their current state and seems very frustrated; much emotional support was provided . On 8/8/24 at 2:15 PM, the surveyor reviewed the timecard report for RN #1 and CNA #1 from 6/2/24, to present which revealed the following: RN #1 continued to work 73 shifts starting 6/3/24, which included 12 double shifts (9-16 hours) in June; 14 double shifts in July; and two double shifts in August with no suspension pending the completion of a thorough investigation. CNA #1 continued to work 52 shifts starting 6/3/24, which included five double shifts in June; six double shifts in July; and two double shifts in August with no suspension pending the completion of a thorough investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 8/8/24 at 3:30 PM, the ADON provided the surveyor with a copy of the nursing schedule assignment sheets from 6/2/24, until present. The ADON confirmed that between RN #1 and CNA #1, one of them had worked on all three nursing units which would have given them access to all residents. The acceptable Removal Plan (RR) on 8/9/24 at 12:24 PM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including; RN #1 and CNA #1 were immediately suspended, facility Administration including the LNHA, DON, ADON, Assist Admin, and DSS reviewed and were inserviced by the RN Nurse Consultant on the facility's abuse policy; a thorough investigation was started; and staff were inserviced on abuse. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/9/24. NJAC 8:39-4.1(a)5 PART B NJ Complaint #: 172628 Based on interviews and review of pertinent facility documents, it was determined that the facility failed to implement the facility's abuse policy to suspend a Certified Nursing Aide (CNA) after an allegation of verbal and physical abuse pending a thorough investigation. The deficient practice was identified for 1 of 5 residents reviewed for abuse (Resident #100), and was evidenced by the following: A review of the facility's Abuse Policy (Staff and Other Individuals) Prohibition of Photographs and Audio/Video Recordings by Staff of [facility name redacted] dated revised January 2024, included: it is the policy of the [facility] that each resident will be free from abuse, neglect, corporeal punishment, [.] Investigation: it is the policy of [facility] that reports of abuse [.] are promptly and thoroughly investigated . When an incident or suspected incident of abuse is reported, the Administration or designee will investigate the incident with the assistance of the appropriate personnel. The investigation will include: who is involved; resident's statements [.]; resident's roommate statement (if applicable); involved staff and witness statements of events; a description of the resident's behavior and environment at the time of incident; injuries including a resident assessment; observation of resident and staff behaviors during the investigation; environmental considerations .Immediately upon receiving a report of alleged abuse, the Administrator, and/or designee will coordinator delivery of appropriate medical and/or psychological care and attention . Procedures must be put in place to provide the resident with a safe, protected environment during the investigation: the alleged perpetrator will immediately be removed and resident protected. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation . During entrance conference on 8/5/24 at 9:54 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) a copy of the facility reported event (FRE) for Resident #100 reported to the New Jersey Department of Health (NJDOH) on 4/3/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood House Home for the Jewish Aged	53 Walter Street Trenton, NJ 08628

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 8/6/24 at 12:09 PM, the surveyor reviewed the FRE for Resident #100 reported to the NJDOH on 4/3/23, which revealed the following: A review of the Internal Investigation Report dated 3/29/24, and signed by the Director of Nursing (DON)) on 4/3/24, indicated that reason for investigation was an unsubstantiated abuse. The investigation included that last evening Resident #100 spoke to the Supervisor/Registered Nurse (RN Supervisor), and complained they were being attacked, pushed against a wall, and that their phone was taken away from them (yet they were calling on the phone). The RN Supervisor was transferring another resident to the hospital and sent their nurse (Licensed Practical Nurse; LPN) to their room. The LPN stated there were no complaints. Later that night, Resident #100 complained to the LPN that the Certified Nursing Aide (CNA #1) pushed them against the wall (they were in an opened bed, sides were not at the wall), took their phone away, and started to take pictures of their back (resident's phone has a code). Both CNAs said the resident's phone was moved while turning the resident on their side because they said they were wet (but was not), but it was given back to the resident. The resident later told the RN Supervisor that they had not spoken to the RN Supervisor that night (resident calls often), and stated they were pushed to their side hard. Resident's roommate (unsampled) had a brief interview for mental status (BIMS) score of an 11 out of 15, which indicated a moderately impaired cognition, stated that they did not hear or see any type of abuse, and that Resident #100 complains all the time. Conclusion was resident had many variations of the story; was seen by the Nurse Practitioner (NP) today, and medication changes were made. The resident could not have had their phone taken away or pushed against a wall because their alert and oriented roommate (unsampled) saw nothing. Other alert and oriented residents were interviewed and no one else had a complaint against CNA #1. Recommendations were CNA #1 will not care for the resident anymore, and a nurse will be present when the CNAs were providing care. A review of CNA #1's statement indicated date of incident 3/28/24, and signed by CNA #1 on 3/28/24, indicated that a little after 3:00 PM, Resident #100 had their light on, and stated they needed to be changed. CNA #1 stated while trying to perform care on the resident, the resident had their phone in their hand and the aide (CNA #2) that assisted me, asked the resident to remove the phone so they can be taken care of. CNA #1 stated the resident was asked to turn to their right side, and their incontinence brief was completely dry, and they informed the resident who started to say things that were not clear, so they informed the nurse what happened. A review of the LPN's statement indicated date of incident 3/28/24, and signed by the LPN on 3/28/24, indicated that between 4:30 PM and 5:00 PM, CNA #1 reported to them that they overheard Resident #100 tell a bunch of lies about them to someone on the phone. CNA #1 stated that they do not think they should take care of the resident anymore; that the resident might get someone fired. Later that shift, Resident #100 reported that CNA #1 was nasty to them and called them [redacted profanity]. The resident later stated that CNA #1 pushed them against a wall while changing them, and another CNA took their phone away from them and started taking pictures of their back. A review of CNA #2's statement indicated date of incident 3/28/24, and signed by CNA #2 on 3/28/24, indicated that around 3:00 PM to 3:30 PM, Resident #100 rang their call bell to be changed. CNA #2 stated that they went to their room with another CNA, and they informed the resident that they needed to take their phone out of their hand to perform care so the resident could hold onto the side rail. CNA #2 informed the resident that their incontinent brief was very dry, and the resident started talking nonsense that they could not understand. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 8/6/24 at 12:37 PM, the surveyor interviewed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) regarding the facility's process for allegations of abuse. The DON stated that the facility obtained statements, reviewed surveillance footage from the hallways if applicable, and completed a head-to-toe assessment of the resident to try to determine what occurred. The surveyor asked if the facility removed the accused staff from the facility pending a thorough investigation, and the DON stated it depended if there was an inkling that could be true. The DON continued that some residents complain repeatedly so the facility just removed the accused staff from their care or to another wing. The surveyor asked how the facility was protecting other residents from potential abuse if the investigation was not complete and the accused staff had access to other residents, and the DON responded that the nurse was instructed to keep an eye on the accused staff. The DON stated if the resident was cognitively intact with no history of delusions, then the accused staff was sent home pending an investigation. The DON stated after gathering statements, the facility contacted the New Jersey Department of Health (NJDOH) and submitted a facility reportable event (FRE) form which included the facility's investigation and the accused staff's background check, license, and abuse training. At that time, the surveyor asked if CNA #1 was suspended pending an investigation, and the DON stated they would need to check. On 8/8/24 at 9:44 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON regarding CNA #1, and the LNHA stated that CNA #1 was removed from Resident #100's care assignment at the time of the allegation, and they were assigned to another unit to care for the residents. The surveyor asked why the facility did not remove CNA #1 from the facility, and the LNHA stated they knew within a few minutes the allegation was unsubstantiated because the resident's roommate (unsampled) stated they did not hear or see anything. The surveyor asked how the facility protected residents from abuse or further abuse from a staff member with a pending abuse allegation, and the LNHA stated that we know these people; that the facility knew CNA #1 for many years, and made a personal decision if they do not suspect abuse. The LNHA stated the accused staff was removed from the area and many times removed from the building. The LNHA stated that the facility followed the regulations and reported and investigated allegations of abuse. On 8/8/24 at 10:00 AM, the surveyor reviewed the medical record for Resident #100. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included anxiety, hypertension (high blood pressure), depression, and need for assistance with personal care. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 6/14/24, indicated the resident had a BIMS score of 10 out of 15, which indicated a moderately impaired cognition, and they had no behaviors. A further review indicated that the resident was dependent (helper did all the effort) for toileting hygiene, which was the ability to maintain perineal hygiene, adjust clothes before or after voiding or having bowel movements, and the resident was frequently incontinent (seven or more episodes of incontinence with at least one continent episode of voiding or bowel movement) for bowel and bladder. A review of the individualized comprehensive care plan (ICCP) did not include the resident had a history of making false accusations against staff. NJAC 8:39-4.1(a)5

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40041 Based on interviews, review of facility policy, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy by completing a criminal background check prior to the start of employment. This deficient practice was identified for 1 of 10 employee files reviewed (Employee #4) and was evidenced by the following: A review of the facility's Abuse Policy dated January 2024, included . A. Screening Components Abuse Policy Requirements: It is the policy of this facility to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check . On 8/8/24 at 12:00 PM, the surveyor reviewed Employee #4's employment file which revealed the following: Employee #4, a physical therapist (PT), was hired on 9/6/23. There was no criminal background check. On 8/8/24 at 12:52 PM, the surveyor reviewed Employee #4's personnel file with the Medical Secretary (MS), who confirmed the criminal background check was not done for the employee. The MS stated they did not have a criminal background check for the employee, so it was not done. The MS also stated that the background check should have been completed when Employee #4 was interviewed and hired, so if there was a problem with their background check, the facility would have known. On 8/9/24 at 10:10 AM, the surveyor interviewed the Human Resources Manager (HRM), who stated that she was ultimately responsible for ensuring that the criminal background checks were completed, and the criminal background check should have been completed upon hire. The HRM stated a background check was completed for Employee #4 on 8/8/24 (after surveyor inquiry). On 8/9/24 at 12:35 PM, the surveyor reviewed Employee #4's timesheet. The timesheet revealed that she worked on the following days: 9/29/23, 7 hours; 10/13/23, 7 hours; 10/20/23, 6.25 hours; 10/24/23, 4.75 hours; 11/3/23, 8.5 hours; 11/13/23, 8 hours; 11/15/23, 7 hours; and 11/24/23 7.25 hours. On 8/9/24 at 12:50 PM, the surveyor interviewed the Director of Nursing (DON), who stated that a criminal background check should have been completed prior to Employee #4 working with residents. NJAC 8:39-4.1(a)5

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. 38080 NJ Complaint #: 174306 Based on interview and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate an allegation of verbal abuse and involuntary restraint for a resident (Resident #171) who informed the facility that the Registered Nurse (RN #1) and Certified Nursing Aide (CNA #1) verbally abused them and placed a chair on the side of their bed preventing the resident from using the restroom. This deficient practice was identified for 1 of 5 residents (Resident # 171); and two staff members (RN #1 and CNA #1) who had access to all the residents in the facility on 3 of 3 nursing units, reviewed for abuse. Resident #171, who had diagnoses which included arthritis, anxiety, and depression reported to the Social Worker (SW) on 6/3/24, that two nurses were extremely rude to the resident on the 11:00 PM to 7:00 AM (11-7) shift; yelled at the resident and demanded the resident turn the light off. The resident reported that the nurses said the resident was embarrassing the nurses, and the nurse blocked the bedside with a chair so the resident could not get to the restroom. A review of the investigation dated 6/3/24, and interview with the Director of Nursing (DON) on 8/8/24, revealed that the facility began an investigation for the allegation of abuse on 6/3/24, and determined the incident was unsubstantiated on 6/3/24. The DON obtained a statement from RN #1 dated 6/2/24, regarding the allegation made on 6/3/24, and a statement from CNA #1 on 6/7/24. Both RN #1 and CNA #1 continued to work throughout all nursing units having access to all residents without a thorough investigation completed which included but was not limited to; obtaining statements from any potential witnesses who were at the facility during the time of the allegation to determine if a verbal exchange was overheard or if a chair was observed at the resident's bed; obtaining any statements from any residents who were in contact with RN #1 and CNA #1; conducting a resident interview and assessment post allegation; and suspending both RN #1 and CNA #1 pending the completion of a thorough investigation. The facility failed to implement their abuse policy by immediately conducting a thorough investigation to ensure all residents were free from abuse. By allowing RN #1 and CNA #1 to continue to work on all nursing units of the facility, which allowed access to all the residents without a thorough investigation to rule out verbal abuse and involuntary restraint, posed a likelihood of serious harm to all residents. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 6/3/24, after Resident #171 reported to the SW that two nurses were extremely rude and yelled at the resident, blocked the resident in bed with a chair so the resident could not use the restroom and continued to work. RN #1 worked 73 shifts from 6/3/24 through 8/7/24, including multiple double (9-16 hours) shifts, and CNA #1 worked 52 shifts from 6/3/24 through 8/7/24, including multiple double shifts. The facility was notified of the IJ on 8/20/24 at 5:00 PM. The facility submitted an acceptable Removal Plan (RP) on 8/21/24 at 2:25 PM. The survey team verified the implementation of the Removal Plan on-site on 8/21/24. The evidence was as follows: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	A review of the facility's Abuse Policy (Staff and Other Individuals) Prohibition of Photographs and Audio/Video Recordings by Staff of [facility name redacted], dated revised January 2024, included: it is the policy of the [facility] that each resident will be free from abuse, neglect, corporeal punishment, [.] Investigation: it is the policy of [facility] that reports of abuse [.] are promptly and thoroughly investigated . When an incident or suspected incident of abuse is reported, the Administration or designee will investigate the incident with the assistance of the appropriate personnel. The investigation will include: who is involved; resident's statements [.]; resident's roommate statement (if applicable); involved staff and witness statements of events; a description of the resident's behavior and environment at the time of incident; injuries including a resident assessment; observation of resident and staff behaviors during the investigation; environmental considerations .Immediately upon receiving a report of alleged abuse, the Administrator, and/or designee will coordinator [sic] delivery of appropriate medical and/or psychological care and attention . Procedures must be put in place to provide the resident with a safe, protected environment during the investigation: the alleged perpetrator will immediately be removed and resident protected. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation . A review of the facility's Grievances/Complaints, Filing policy, dated reviewed 6/21/24, included all alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law . On 8/6/24 at 12:37 PM, the surveyor interviewed the DON and the Assistant Director of Nursing (ADON) regarding the facility's process for allegations of abuse. The DON stated that the facility obtained statements, reviewed surveillance footage from the hallways if applicable, and completed a head-to-toe assessment of the resident to try to determine what occurred. The surveyor asked if the facility removed the accused staff from the facility pending a thorough investigation, and the DON stated it depended if there was an inkling that could be true. The DON continued that some residents complain repeatedly so the facility just removed the accused staff from their care or to another wing. The surveyor asked how the facility was protecting other residents from potential abuse if the investigation was not complete and the accused staff had access to other residents. The DON responded that the nurse was instructed to keep an eye on the accused staff. The DON stated if the resident was cognitively intact with no history of delusions then the accused staff was sent home pending an investigation. The DON stated after gathering statements, the facility contacted the New Jersey Department of Health (NJDOH) and submitted a facility reportable event (FRE) form which included the facility's investigation and the accused staff's background check, license, and abuse training. On 8/8/24 at 9:44 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON regarding the facility's process for allegations of abuse. The LNHA stated that the facility started investigating and questioning staff right away. The surveyor asked what the facility did with the accused staff member during the investigation process, and the LNHA stated the accused staff was removed from the area and many times removed from the building. The surveyor asked why the accused staff was not always removed from the building, and the LNHA stated we know these people. The LNHA further stated the facility has known most of the staff for years and years and they will make personal decisions regarding the staff if they do not suspect abuse. The LNHA stated that the facility followed the regulations and reported and investigated allegations of abuse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 8/8/24 at 11:27 AM, the surveyor reviewed the FRE for Resident #171 that occurred on 6/2/24, and was reported on 6/3/24. The investigation revealed the following: A review of the Concern/Grievance Form completed by the SW, dated received 6/3/24, indicated that the resident stated nurses were extremely rude to [the resident]; that two nurses on the 11:00 PM to 7:00 AM (11-7) shift yelled at the resident and demanded the resident turn off the light. The resident stated the nurses said that the resident was embarrassing the nurses, and the nurses blocked the resident's bedside with a chair so they could not get to the restroom. Actions taken included getting statements from staff and provide care with two employees present at all times. A review of a timeline completed by the DON revealed that CNA #1 entered Resident #171's room two times during the shift, at 11:55 PM, and 6:10 AM through 6:14 AM, and RN #1 entered the resident's room four times during the shift, at 12:05 AM, 12:10 AM, 2:06 AM, and 6:24 AM. The DON indicated that at no time during the entire shift did two people; either two nurses, two CNAs, or a nurse and CNA enter the room. The DON had a notation that she spoke to CNA #2 who verbally informed the DON there were no chairs blocking [the resident] from exiting the bed. A review of the 11-7 Staffing sheet for 6/2/24, which included the assigned nurses and CNAs, CNA #2 was not included on that assignment sheet. A review of the Employee Statement Form for RN #1, indicated date of incident 6/2/24, revealed that RN #1 completed the form on 6/2/24, even though the incident was reported on 6/3/24, and that RN #1 stated that on the 3:00 PM to 11:00 PM (3-11) shift, the resident complained of not receiving help from the 7:00 AM to 3:00 PM (7-3) shift, the bedding was not changed and did not get the right [illegible]. RN #1 noted the resident ambulated independently with a walker to the bathroom and did not need assistance. RN #1 stated during the 11-7 shift, the resident slept well; did not put call bell on. A review of the Employee Statement Form for CNA #1, indicated date of incident 6/2/24 into 6/3/24, revealed that CNA #1 completed the form on 6/7/24, four days after the reported incident, and stated that they performed care on the resident one time during the night (surveillance footage indicated entered room on two occasions), and they did not notice anything unusual. After finishing care, CNA #1 provided the resident with the call bell and remote. A review of a typed statement from the Assistant Administrator (Assist Admin) dated 6/3/24, indicated that around 2:00 PM on 6/3/24, she knocked on Resident #171's door to inspect their room for environmental rounds. During that time, Resident #171 reported to the Assist Admin that last night two aides were rude to the resident; the aides told the resident if the resident wet their gown again, the aides will not be able to change the gown because there were no more. The aides told me I was annoying. The Assist Admin asked for a description of the aides and time of incident, the resident stated sometime in the night and two female aides. The resident stated they reported the incident that morning and the facility was investigating the matter. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	A review of the Internal Investigation Report, completed by the DON on 6/3/24, indicated the reason for investigation was that the resident complained to the SW that staff placed a chair next to the resident's bed so the resident could not get to the bathroom. Investigation included that today the SW went to interview Resident #171 and the resident stated the nurses on the 11-7 shift were extremely rude to [the resident], blocked the bedside with a chair so the resident could not get to the restroom. The resident scored a 13 out of 15 on their brief interview for mental status (BIMS) assessment, which indicated an intact cognition, but the resident was taking oxycodone (pain medication) around the clock. Conclusion was that the DON felt this may be unsubstantiated only because other statements made by the resident were untrue. The statements included the resident stated they were not at therapy (they were), and that the resident had not slept since admission. Recommendation was to send two staff members in room when needed: preferably a nurse and CNA. On 8/8/24 at 12:00 PM, the surveyor interviewed the DON who stated that the resident was very difficult and no longer resided at the facility. The surveyor reviewed the FRE dated 6/3/24 with the DON. The DON confirmed the resident alleged staff were rude which was considered verbal abuse, and if the chair was in front of the bed, it was also considered abuse. The surveyor asked if RN #1 and CNA #1 were allowed to work during the investigation, and the DON stated yes. The surveyor reviewed the facility's abuse policy with the DON. The DON acknowledged the policy indicated that staff were to be suspended pending a thorough investigation. The DON could not speak to why they were not suspended. The DON acknowledged that the resident specified which shift the incident occurred on and that the facility determined which two staff members entered the resident's room during that shift. The DON stated usually she had the SW speak to other residents about the shift or staff members and could not speak to why it was not done for this incident. The DON acknowledged that no other potential witnesses were interviewed who worked on that shift to determine if they saw a chair at the resident's bed or heard anything that was said to the resident. The DON stated no additional allegations have been made against RN #1 and CNA #1. On 8/8/24 at 12:13 PM, the surveyor interviewed the Director of Social Services (DSS), who stated they were the Grievance Officer, but after a grievance was obtained, the DSS provided it to the appropriate department head to investigate and gather statements. The DSS stated an investigation was completed within five days, and she provided Resident #171's grievance from 6/3/24, to the DON to complete. On 8/8/24 at 12:32 PM, the surveyor interviewed the DON, in the presence of the Assist Admin, who stated the incident occurred during the night shift, and the resident complained the next day. The DON stated they reviewed the call bell system from that night and the surveillance camera footage which showed RN #1 and CNA #1 entered the resident's room, but they did not go in together. The DON stated at no time did two staff members enter the resident's room together, so the allegation was unsubstantiated. The surveyor reviewed the grievance statement with the DON and Assist Admin, who both confirmed the resident's statement did not indicate the two nurses were in the room at the same time. On 8/8/24 at 1:17 PM, the surveyor interviewed the Assist Admin, who confirmed the resident's statement was what was written on the grievance form, and that the Assist Admin did not go into the resident's room that day in response to the grievance, but to conduct environmental rounds. The Assist Admin stated during her rounds, the resident informed her of the situation and that the facility was investigating it. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 8/8/24 at 1:28 PM, the surveyor interviewed the DON, who stated the facility did not conduct an assessment of the resident because it was an allegation of verbal abuse. The surveyor asked the DON if a chair was at the resident's bedside, was there a possibility injury could have occurred. The DON stated the chair could have caused injury, but the DON did not think of that because the resident's bed was not against the wall so they could have gotten out on the other side. On 8/8/24 at 1:46 PM, the surveyor interviewed the SW, who confirmed they took the statement from the resident and that was what the resident stated. The SW stated that the resident did not specify what extremely rude meant, but thought it was the yelling, demanding to turn off the light, and blocking the bed with the chair. The SW stated the resident did not know who the two staff members were, and the SW confirmed the resident never indicated that the two staff members were present at the same time, only that they worked on the 11-7 shift. The SW stated after she obtained the grievance, she provided it to the DSS who gave it to the DON to investigate. The SW stated she was conducting a social history assessment with the resident that morning in the resident's room, and the resident informed her then. The SW stated after she provided the resident's statement to the DSS, she conducted no additional interviews. On 8/8/24 at 2:00 PM, the surveyor reviewed Resident #171's closed medical record. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility for a short term stay with no admission diagnoses included. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 6/6/24, included the resident had a BIMS score of 13 out of 15, which indicated a fully intact cognition. The assessment also included that the resident required partial or moderate assistance with the helper doing less than half the effort to lift, hold or supports trunk or limbs for toileting hygiene, which included the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement and transferring to and off the toilet or commode. The resident was occasionally incontinent (less than seven episodes of incontinence) for bowel and bladder. Diagnoses included hypertension (high blood pressure), hyperlipidemia (high blood cholesterol), arthritis, anxiety, and depression. A review of the Progress Notes from 6/3/24, did not include the incident or a nursing assessment. On 8/8/24 at 2:15 PM, the surveyor reviewed the timecard report for RN #1 and CNA #1 from 6/2/24, to present which revealed the following: RN #1 continued to work 73 shifts starting 6/3/24, which included 12 double shifts (9-16 hours) in June; 14 double shifts in July; and two double shifts in August with no suspension pending the completion of a thorough investigation. CNA #1 continued to work 52 shifts starting 6/3/24, which included five double shifts in June; six double shifts in July; and two double shifts in August with no suspension pending the completion of a thorough investigation. On 8/8/24 at 3:30 PM, the ADON provided the surveyor with a copy of the nursing schedule assignment sheets from 6/2/24 until present. The ADON confirmed that between RN #1 and CNA #1, one of them had worked on all three nursing units which would have given them access to all residents in the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood House Home for the Jewish Aged	53 Walter Street Trenton, NJ 08628

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	The acceptable Removal Plan (RR) on 8/21/24 at 2:25 PM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including; RN #1 and CNA #1 were suspended on 8/8/23, facility Administration including the LNHA, DON, ADON, Assist Admin, and DSS reviewed and were inserviced by the RN Nurse Consultant on the facility's abuse policy on 8/8/23, and that upper management which included the DON, ADON, and RN Supervisor were re-educated on the facility's abuse policy on 8/20/24 and 8/21/24; a thorough investigation was started; and staff were inserviced on abuse. The survey team verified the implementation of the Removal Plan on-site on 8/21/24. NJAC 8:39-4.1(a)5

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40744 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure the plan of care was updated and interventions were implemented to reduce hazards and risks for a resident with a high risk of injury during dining who burned themself with soup (Resident #37); and b.) implement the facility's smoking policy and procedure for a resident who smoked (Resident #84). This deficient practice was identified for 2 of 5 residents reviewed for accidents and hazards (Resident #37 and Resident #84), and was evidenced by the following: 1. A review of the facility's Incident/Accident Report Investigation (Resident) policy, dated revised January 2024, included when an accident or incident occurs to a resident, an investigation is conducted followed by documentation of the incident, cause and effect and the recommendation and intervention that were implemented to prevent or minimize future incidents .initiate interventions/recommendations to minimize or prevent future occurrences . A review of the facility's Care Plan policy, dated revised January 2024, included the purpose was to establish guidelines for providing individualized patient care that is multidisciplinary, consistent, and coordinated and to facilitate communication among the members of the multidisciplinary team providing care to the resident . On 8/5/24 at 10:52 AM, during the initial tour of the facility, the surveyor observed Resident #37 resting in bed with the bed in the lowest position. On 8/6/24 at 9:30 AM, the surveyor reviewed the medical record for Resident #37. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, hypertension (high blood pressure), and major depressive disorder. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 4/19/24, reflected that the resident had a brief interview for mental status (BIMS) score of 3out of 15, which indicated the resident had severe cognitive impairment. On 8/7/24 at 10:36 AM, the resident was observed in the sitting in a wheelchair in the day room during activities with their eyes closed. On 8/8/24 at 8:46 AM, the surveyor reviewed the incidents/accidents for Resident #37. On 5/30/24, it was documented that the resident was eating dinner and spilled soup on their chest. The nurse assessed the resident, and it was noted that there was redness to the chest, and a cool compress was applied to the area. The soup was described by the nursing staff as warm to touch. On 8/8/24 at 12:03 PM, the resident was observed in the day room having lunch with no clothing protector. At that time, the surveyor then interviewed the Licensed Practical Nurse (LPN #1) regarding the resident and history of the incident. LPN #1 stated that they were a travel nurse, and they were unfamiliar with the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 12:27 PM, the surveyor reviewed the resident's individualized comprehensive care plan (ICCP) which did not include the incident on 5/30/24, or any interventions that were implemented as a result to prevent the resident from burning themself again during meals. On 8/8/24 at 12:36 PM, the surveyor reviewed the Progress Notes dated 5/30/24, which included around dinner time, while resident started to have dinner, the Certified Nursing Aide (CNA #1) had already set up resident's dinner tray, and the resident accidentally spilled soup on their chest area. Some redness was noted to left chest, and a cool compress was applied as a nursing measure. The family was made aware. On 8/9/24 at 11:58 PM, the resident was observed sitting with a visitor in the unit day room having lunch. Resident #37 did not have on a clothing protector at the time of the observation. On 8/12/24 at 10:47 AM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN #1) for the [NAME] nursing unit regarding residents and clothing protectors. UM/RN #1 stated if a clothing protector was available from laundry, the resident received one, or staff just used a napkin if unavailable. UM/RN #1 stated clothing protectors were not included in a resident's ICCP because all residents would need it. On 8/12/24 at 12:06 PM, the surveyor interviewed UM/RN #2 for the North nursing unit regarding clothing protectors, and how a CNA would know if a resident needed a clothing protector during meals for safety or dignity. UM/RN #2 replied, the information was included on the CNA's assignment, and it could be included on a sign that was kept behind a resident's door. The surveyor asked if a resident needed a protector for safety, should it be included on the ICCP, and the UM/RN #2 confirmed yes. On 8/12/24 at 12:40 PM, during a meeting with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator, Assistant Director of Nursing (ADON), and survey team, the surveyor asked if a resident should be care planned for a clothing protector, and the ADON responded yes, it should be included on the ICCP. 49094 2. A review of the facility's Smoking Policy - Residents, dated revised December 2023, included .residents will not be permitted to hold their smoking devices or lighters/matches. The facility will keep the items in a safe and secure location . On 8/5/24 at 11:45 AM, during initial tour of the facility, the surveyor observed Resident #84 sitting in his/her room. The resident stated that they used to smoke cigarettes, but now they smoked an electronic cigarette (e-cigarette; a vape). The resident stated that they held their own vape. On 8/6/24 at 12:25 PM, the surveyor observed the resident independently ambulating via wheelchair towards their bedroom. Resident #84 stated that they just finished vaping outside. At that time, the surveyor observed the e-cigarette in the resident's right hand. On 8/6/24 at 1:01 PM, the surveyor reviewed the medical record for Resident #84. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses including but not limited to; multiple sclerosis (neurological condition, meaning it affects your nerves) and anxiety disorder (mental health condition). A review of the Minimum Data Set (MDS), an assessment tool dated 7/18/24, indicated that the resident had a brief interview for mental status (BIMS) score of 11 out of 15, which indicated moderately impaired cognition. A review of the admission Smoking Safety Evaluation dated 2/16/23, indicated that Resident #84 was a current tobacco user. A review of the individualized comprehensive care plan (ICCP) initiated on 2/16/23, and revised on 12/20/23, indicated that the resident smoked an electronic cigarette. Interventions included that the resident received their e-cigarette from the nurse when they wanted to smoke; and the resident could not keep their e-cigarette in their room. A further review of Resident #84's medical records did not indicate a history of having smoked in their room. On 8/7/24 at 10:24 AM, the surveyor observed Resident #84 in lying in their bed. Resident #84 stated that once they were dressed, they would go outside to smoking area to vape. The surveyor observed the e-cigarette in the resident's right hand. On 8/7/24 at 12:15 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #2), who stated that residents who smoked had a smoking assessment completed. LPN #2 further stated that Resident #84 held on to their e-cigarette and when the resident wanted to vape, staff escorted them to the designated smoking area. On 8/8/24 at 2:13 PM, the surveyor interviewed Unit Manager/Registered Nurse (UM/RN #3) and the Unit Manager/Licensed Practical Nurse (UM/LPN). UM/RN #3 stated that smoking assessments were completed annually and quarterly for any resident that smoked or used an e-cigarette. UM/RN #3 further stated that Resident #84 was allowed to hold on to their e-cigarette, and staff took the resident to the smoking area when they wanted to vape. UM/RN #3 also stated that there had been no incidents of the resident vaping in their room or inside the facility. The surveyor asked the UM/LPN to review Resident #84's ICCP, and the UM/LPN confirmed that the resident's ICCP indicated that they were to receive their e-cigarette from the nurse when they wanted to smoke and could not keep their e-cigarette in their room. On 8/12/24 at 12:28 PM, the Assistant Director of Nursing (ADON) in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA) and the survey team stated that a smoking assessment was completed upon admission, quarterly, and annually to determine if a resident was deemed appropriate to smoke. The ADON further stated that she thought Resident #84's representative held onto the e-cigarette. When asked who was responsible for holding onto the smoking device, the AA replied the staff were responsible to hold onto them. The AA stated that she was under the impression that the resident's represetative held on to the e-cigarette and charged it. The LNHA stated that Resident #84 was alert and oriented and went outside to smoke. LNHA further stated that it was explained to Resident #84 that they could not smoke in the facility. (continued on next page)

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Greenwood House Home for the Jewish Aged	53 Walter Street Trenton, NJ 08628

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 10:32 AM, the AA in the presence of the LNHA, ADON, and the survey team stated that they had a care conference with Resident #84 and their representative to discuss that the resident's e-cigarette had to be turned into staff, and that the resident could not hold onto it. The AA confirmed that per facility policy, Resident #84 was not supposed to hold onto their e-cigarette. NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure respiratory equipment was stored and dated in accordance with professional standards when not in use, and b.) ensure an individualized comprehensive care plan included oxygen therapy. This deficient practice was identified for 2 of 2 residents reviewed for respiratory care (Resident #101 and #319), and the evidence was as follows: A review of the facility's Oxygen Administration policy dated revised January 2024, included date the humidifier when put into use .a plastic zip-lock bag is to be attached to the side of the concentrator so the nasal cannula or oxygen mask can be stored there when not in use . A review of the facility's Care Plan Policy dated revised August 2024, included the Multidisciplinary Care team shall review the comprehensive care plan no less than every three months (more often if there is a significant change); the assessments will be updated and revised as necessary to assure continued accuracy, progress in meeting goals and changing goals, when appropriate . 1. On 8/5/24 at 10:16 AM, during initial tour of the facility, the surveyor observed Resident #319 resting in bed, awake and alert. The surveyor observed the resident's nightstand had a bilevel positive airway pressure (BiPAP) machine (a type of device that helps with breathing and deliver oxygen while you sleep) and face mask on top. The BiPAP mask was placed on top of the nightstand without being stored in a plastic bag. The oxygen tubing which connected the mask to the oxygen concentrator, was not stored in a plastic bag and was lying on the floor next to a partially opened trash receptacle. The oxygen tubing also was not labeled or dated when in use. On 8/6/24 at 11:36 AM, the surveyor reviewed the medical record for Resident #319. A review of the Admission Record face sheet (an admission record) which reflected the resident was admitted to the facility with diagnosis which included but was not limited to; chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and morbid (severe) obesity. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 5/21/24, indicated the resident had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated a fully intact cognition. A further review reflected the resident used a non-invasive mechanical ventilator (BiPAP). A review of the Order Summary Report reflected the following physician orders (PO): A PO dated 6/1/24, to administer oxygen per nasal cannula at 2 liters per minute as needed for pulse oxygen (blood oxygen level) less than 91% (may titrate oxygen flow rate to keep saturation above 91%). A PO dated 6/1/24, to change oxygen tubing and humidifier bottle every day shift every Thursday. A PO dated 6/6/24, to date and initial tubing and humidifier bottle. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO dated 6/1/24, to change oxygen tubing and humidifier bottle as needed; date and time tubing and humidifier bottle when changed. A PO dated 6/1/24, for BIPAP set-up: BIPAP to be used on programmed settings oxygen 2 liters per minute bled in at bedtime and removed per schedule. A review of the corresponding June, July, and August 2024 Medication Administration Record (MAR) reflected that the resident was administered oxygen and BiPAP therapy as ordered. A review of the individualized comprehensive care plan (ICCP) included a focus area dated revised on 6/2/24, for increased risk of impaired oxygenation. Interventions included to administer BIPAP and oxygen as ordered. On 8/8/24 at 10:08 AM, the surveyor observed Resident #319 in their room resting in bed. Alongside the resident's bed was the BIPAP machine with a mask on top of the nightstand. The mask was not stored in plastic bag, and the oxygen tubing that connected the BIPAP to the concentrator, the tubing was lying on the floor not in a protective plastic bag while not in use. On 8/8/24 at 10:24 AM, the surveyor interviewed the Certified Nursing Aide (CNA #1), who stated the facility's nurses were responsible for maintenance and care of oxygen equipment for the residents. On 8/8/24 at 10:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated oxygen tubing and other respiratory equipment were stored in a plastic bag and hung when not in use to keep clean and maximize infection control. LPN #1 acknowledged that if not stored properly, it could be considered contaminated and could cause illness. LPN #1 stated that the oxygen tubing was changed weekly, and it should be dated. At that time, the surveyor and LPN #1 entered Resident #319's room, and the LPN confirmed that the oxygen tubing was not dated, not stored properly, and should not be on the floor. LPN #1 acknowledged that the BIPAP mask should have been cleaned, in a protective bag, and stored inside the nightstand drawer. On 8/8/24 at 11:06 AM, the surveyor interviewed the Infection Preventionist/LPN (IP/LPN), who stated no equipment should be stored on the floor since that could cause unnecessary infection. The IP/LPN stated that oxygen equipment and tubing should be stored in a bag off the floor when not in use, and it should be labeled with the date it was changed. The surveyor showed the IP/LPN photos of how the oxygen tubing was stored to which she stated it absolutely should not be stored that way. On 8/8/24 at 11:24 AM, the surveyor interviewed the Director of Nursing (DON) and the Assistant DON (ADON), who both confirmed that oxygen tubing and equipment should be stored in clean plastic bags when not in use to prevent contamination for infection control purposes. They also confirmed that oxygen tubing should be labeled and dated once opened for use. 2. During initial tour of the facility on 8/5/24 at 10:22 AM, the surveyor observed Resident #101 in bed with their eyes closed. The surveyor observed next to the resident's bed an oxygen concentrator which had nasal cannula tubing attached to it, that was lying on the floor not in use. The oxygen tubing was not stored in a plastic bag or labeled and dated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 11:45 AM, the surveyor reviewed the medical record for Resident #101. A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnosis which included but was not limited to; dementia and history of pneumonia. A review of the most recent comprehensive MDS dated [DATE], reflected the resident had a BIMS score of 3 out of 15, indicating severe cognitive impairment. A review of the Order Summary Report included the following physician orders (PO): A PO dated 7/16/24, to administer oxygen per nasal cannula at 2 liters per minute as needed for comfort. A PO dated 6/16/24, to change oxygen tubing and humidifier bottle as needed; date the humidifier bottle when changed. A review of the corresponding June, July, and August 2024, MAR reflected the resident was administered oxygen as ordered. A review of the ICCP did not include a focus area for oxygen. On 8/8/24 at 10:24 AM, the surveyor interviewed the CNA #1 who stated the facility's nurses were responsible for maintenance and care of oxygen equipment for the residents. On 8/8/24 at 10:30 AM, the surveyor interviewed LPN #1, who stated oxygen tubing and other respiratory equipment were stored in a plastic bag and hung when not in use to keep clean and maximize infection control. LPN #1 acknowledged that if not stored properly, it could be considered contaminated and could cause illness. LPN #1 stated that the oxygen tubing was changed weekly, and it should be dated. At that time, the surveyor and LPN #1 entered Resident #319's room, and the LPN confirmed that the oxygen tubing was not dated, not stored properly, and should not be on the floor. LPN #1 acknowledged that the BIPAP mask should have been cleaned, in a protective bag, and stored inside the nightstand drawer. On 8/8/24 at 11:06 AM, the surveyor interviewed the IP/LPN, who stated no equipment should be stored on the floor since that could cause unnecessary infection. The IP/LPN stated that oxygen equipment and tubing should be stored in a bag off the floor when not in use, and it should be labeled with the date it was changed. The surveyor showed the IP/LPN photos of how the oxygen tubing was stored to which she stated it absolutely should not be stored that way. On 8/8/24 at 11:24 AM, the surveyor interviewed the DON and the ADON, who both confirmed that oxygen tubing and equipment should be stored in clean plastic bags when not in use to prevent contamination and for infection control purposes. They also confirmed that oxygen tubing should be labeled and dated once opened for use. On 8/8/24 at 12:09 AM, the surveyor and ADON reviewed Resident #101's ICCP. The ADON confirmed the resident was not care planned for oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 10:32 AM, the ADON, in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), and survey team stated that Resident #101's ICCP had been updated to include oxygen therapy after surveyor inquiry. NJAC 8:39 - 11.2(e)2, 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40041 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a system of record keeping that ensures an accurate inventory of controlled medications. This deficient practice was identified on 3 of 7 medication carts reviewed and was evidenced by the following: A review of facility's Controlled Substances policy dated January 2024, included all scheduled II, II, IV and V controlled substances are to be stored under double locks, separate from all other medications. Schedule II through V are counted by incoming and outgoing nurses each shift and signatures documented . On 8/7/24 at 10:28 AM, during medication storage observation, the surveyor, in the of the Licensed Practical Nurse (LPN #1), observed the controlled substances inventory and count logs for the B Wing North nursing unit's medication. A review of the Record of Narcotic Count log (a log used track the count of controlled medications) for August 2024, revealed the following nurses' signatures were missing: On 8/1/24, the 7:00 AM to 3:00 PM (7-1) shift, the outgoing nurse. On 8/2/24, the 11:00 PM to 7:00 AM (11-7) shift, outgoing nurse. On 8/6/24, the 7-3 shift, the outgoing nurse. On 8/6/24, the 11-7 shift, outgoing nurse. At that time, LPN #1 confirmed that the signatures were missing, and that there should not have been any missing signatures on the Record of Narcotic Count log. On 8/7/24 at 10:57 AM, during a medication storage observation, the surveyor, in the presence of the Registered Nurse (RN), observed the controlled substances inventory and count logs for the A Wing North nursing unit's medication. A review of the Record of Narcotic Count log for August 2024, revealed the following nurses' signatures were missing: On 8/6/24, the 11-7 shift, the outgoing nurse. On 8/7/24, the 7-3 shift, incoming nurse. At that time, the RN stated, I didn't count this morning because they had already counted when I asked. The RN also confirmed that signatures were missing, and there should not be any missing signatures. (continued on next page)

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	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood House Home for the Jewish Aged	53 Walter Street Trenton, NJ 08628

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 11:40 AM, during a medication storage observation, the surveyor, in the presence of LPN #2, observed the controlled substances inventory and count logs for the E Wing South nursing unit's medication. A review of the Record of Narcotic Count log for August 2024, revealed the following nurses' signatures were missing: On 8/1/24, the 7-3 shift, outgoing nurse. On 8/2/24, the 3:00 PM to 11:00 PM (3-11) shift, incoming and outgoing nurses. On 8/9/24 at 12:01 PM, the surveyor interviewed the Director of Nursing (DON), who stated the incoming and outgoing nurses counted the narcotic inventory together, and signed that the count was completed and correct. NJAC 8:39-29.7(c)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to serve all residents a nourishing snack when there was more than a fourteen-hour span of time between the dinner and breakfast mealtimes. This deficient practice was identified for 3 of 3 residents sampled for bedtime snacks (Resident #29, Resident #46, and Resident #65), and was evidenced by the following: A review of the facility's Nourishment Between Meals policy dated reviewed/revised August 2024, included nursing staff are responsible for offering each resident and afternoon and evening snack to the extent medically possible . During initial tour of the kitchen on 8/5/24 at 9:31 AM, the surveyor accompanied by the Dietary General Manager (DGM) observed half sandwiches on a tray in the walk-in refrigerator. The DGM stated the sandwiches were for hour of sleep (HS) snacks. The surveyor asked if all residents received HS snacks, and the DGM stated no, that some residents had physician ordered snacks. On 8/5/24 at 9:50 AM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) who stated the facility had in the back crackers, pretzels, and ice cream. The UM/RN stated staff asked residents if they wanted a snack, but snacks were not provided unless requested. During entrance conference on 8/5/24 at 9:54 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to provide a copy of the facility's mealtime schedule. On 8/7/24 at 9:00 AM, the surveyor reviewed the facility provided Tray Line Schedule - Cart Order dated updated 12/18/23, which indicated dinner tray line began at 4:45 PM, and C [NAME] Unit was the first to receive the dinner meal and 100 Hall received dinner last. The schedule indicated that breakfast tray line began at 7:30 AM, with 100 Hall was the first to receive the breakfast meal, and C [NAME] Unit received the meal last. This indicated that there was a fourteen hour and forty-five-minute (14.75) gap between dinner and breakfast meal service. On 8/8/24 at 10:38 AM, the surveyor conducted a Resident Council meeting which included three residents (Resident #29, #45, and #65). All three residents informed the surveyor during the meeting that bedtime (HS) snacks were not offered; that snacks were only offered during the day. On 8/8/24 at 11:02 AM, the surveyor interviewed the DGM who confirmed there were afternoon snacks of chips cookies, ice cream, pudding, peanut butter jelly sandwiches, tuna fish sandwiches, and egg salad sandwiches in the pantries on the North, South, and C [NAME] nursing units. The DGM stated certain residents had HS snacks that were labeled with their name because there was a physician order. The DGM stated if anyone else wanted a snack or asked staff for a snack, staff could provide them one from the pantry. At that time the surveyor requested a list of residents who received HS snacks. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/8/24 at 1:00 PM, the surveyor reviewed the HS snack list provided by the DGM, which indicated out of the facility's 114 residents, 41 residents received HS snacks. The three residents from Resident Council were not included on the list. On 8/12/24 at 10:18 AM, the surveyor interviewed the Certified Nursing Aide (CNA), who confirmed they occasionally worked the 3:00 PM to 11:00 PM (3-11) shift. The CNA stated that HS snacks usually had the resident's name on it that they handed out. The CNA stated if a resident requested a snack, the staff provided them with one. On 8/12/24 at 10:39 AM, the surveyor interviewed the Registered Dietitian (RD), who stated HS snacks were sent out with labels to residents who requested a snack be provided or have a medical condition such as diabetes where the resident benefited from the snack. There were additional snacks that if an alert and oriented resident asked for a snack, staff provided. The surveyor asked what was considered a nourishing snack, and the RD stated a piece of fruit, milk with a half a sandwich, milk with graham crackers, and cottage cheese with fruit. The RD stated the snack should have two to three macronutrients which were carbohydrates, fat, and protein. The surveyor asked if there was a certain time span that should be between dinner and breakfast, and the RD stated less than fourteen hours, or the residents needed a snack. The surveyor informed the RD that the reported mealtimes provided by the facility was a 14.75-hour time span, and the RD stated that residents usually received their dinner starting at 5:00 PM. On 8/12/24 at 10:48 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated the dietary department usually sent out HS snacks on a tray with dinner service, and the nurse and CNAs offered the snacks. The ADON stated unsure if the facility had a policy; the facility used to have someone who passed out snacks. On 8/13/24 at 10:32 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the ADON, Assistant Administrator (Assist Admin), and survey team stated the facility had HS snacks for any resident who wanted a snack. The LNHA stated the mealtimes were not accurately provided on entrance, and he would check the mealtimes. No additional information was provided. NJAC 8:39-17.2 (f)(1)(i-ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833 Based on observation, interview, and review of pertinent facility records, it was determined that the facility failed to implement infection control protocols for residents on enhanced barrier precautions to prevent the spread of infection. This practice was identified for 1 of 3 residents observed on enhanced barrier precautions (Resident# 87), and was evidenced by the following: A review of the facility's Enhanced Barrier Precautions (EBP) policy dated revised August 2024, included enhanced barrier precautions (EBP) will be used in conjunction with standard precautions by implementing the expanded use of personal protective equipment [PPE] to the donning of gowns and gloves during high contact resident care activities for residents who have an indwelling medical device (urinary catheter, feeding tube etc.) wound or known to be colonized (no active infection) with an organism. EBP is a transmission-based precaution measure focusing on the use of gown and gloves during high contact resident care activities that have been demonstrated to result in the transfer of multi-drug resistant organisms [MDRO] to the hands and clothing of health care personnel, even if blood and body fluid exposure is not anticipated .postage signage on the door or wall outside of the resident's room Enhanced Barrier Precaution. An orange dot will be applied next to the resident's name indicating he/she is on EBP . there are no special precautions for visiting except for hand hygiene that we emphasis for you to practice during all resident visits. Hand hygiene is the number one way to prevent spread of infection . A review of the facility's Hand Hygiene policy dated revised March 2023, included glove use .wearing gloves is not a substitute for hand hygiene. Dirty gloves can soil hands. Always use hand hygiene after removing gloves . On 8/5/24 at 10:53 AM, during initial tour of the facility, the surveyor observed Resident #87's room having an EBP signage on the door frame with an orange dot next to the names of both residents occupying the room. At that time, the surveyor observed the Certified Nursing Aide (CNA #1) exit Resident #87's room, and she doffed (took off) her disposable gloves, and disposed of them. Then CNA #1, without performing hand hygiene, walked to Resident room [ROOM NUMBER], knocked on the door, and entered. CNA #1 was observed to have spent approximately one minute in the room as she spoke to another staff member. CNA #1 the exited the room and without performing hand hygiene entered Resident room [ROOM NUMBER], and quickly exited with no observed hand hygiene as she went directly into Resident room [ROOM NUMBER] and obtained a handful of clean disposable gloves that she placed in her scrub top pocket (shirt). CNA #1 then exited the room with no observed hand hygiene, and entered Resident room [ROOM NUMBER]. At that time, the surveyor interviewed CNA #1, who stated EBP meant that you had to put on gloves, wash your hands, and use a gown when performing resident care because the resident might have an infection. The surveyor asked about about hand hygiene, and CNA #1 stated that she had removed her gloves, but I'm not done yet. The CNA confirmed she entered other residents' rooms, and she stated that she did not perform resident care in other rooms so she did not need to perform hand hygiene. The CNA then excused herself, donned (put on) gloves and a disposable gown from the PPE bin hanging from the resident's door, and entered the resident room to perform care on Resident #87. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 1:01 PM, the surveyor interviewed CNA #2 who stated EBP signs indicated the need to use PPE which included gown and gloves to care for a resident, as well as, the proper way to dispose of the PPE. CNA #2 stated upon exiting a resident's room, you disposed of the PPE at the exit of the room, and performed hand hygiene. CNA #2 stated hand hygiene was also performed using alcohol-based hand rub (ABHR) upon entering the resident's room, removing gloves, and exiting the resident's room to prevent the spread of germs. On 8/8/24 at 1:14 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who confirmed hand hygiene was required and indicated on the EBP signage upon entering and exiting the resident's room. LPN #1 stated it was not appropriate to enter a resident's room without performing hand hygiene with ABHR for infection control purposes. On 8/8/24 at 1:27 PM, the surveyor reviewed the medical record for Resident #87. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnosis which included but was not limited to; pressure ulcer (bed sore) of the sacral region, need for assistance with personal care, and neuromuscular dysfunction of the bladder. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 6/21/24, reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating a fully intact cognition. The MDS further indicated that the resident had an indwelling urinary catheter and a stage four (full tissue thickness) pressure ulcer. A review of the Order Summary Report included the following physician orders (PO): A PO dated 7/8/24, for EBP; wear PPE (gown, gloves) when providing high contact activities at bedside including dressing, bathing/showering, transferring, changing bed linens, providing hygiene, changing briefs/assisting with toileting, device care and/or use, or wound care. May additionally wear face protection (goggles, face shield, face mask) if there is a risk of splash or spray or circulating respiratory viruses in the community every shift for EBP. On 8/8/24 at 2:30 PM, the surveyor interviewed the Director of Nursing (DON) and Assistant DON (ADON), who stated to prevent spread of infection, staff were expected to perform hand hygiene after doffing gloves. The DON and ADON further stated that it was not acceptable for CNA #1 to doff gloves and not perform any hand hygiene, even if she was expecting to return to the same resident upon exiting the resident's room. On 8/12/24 at 12:33 PM, the ADON in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), and survey team, confirmed that CNA #1 should have performed hand hygiene upon doffing gloves and exiting an EBP room. NJAC 8:39-19.4