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	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood House Home for the Jewish Aged	53 Walter Street Trenton, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and policy review, the facility failed to ensure kitchen utensils were stored in a clean and sanitary manner. These failures had the potential to cause food-borne illness for 101 out of 106 residents who received meals prepared in the facility (five residents received nutrition via feeding tubes). Findings include:1. During the initial kitchen inspection, completed with the Dietary Manager (DM) and Executive Chef (EC) on 03/23/26 at 10:18 AM, the following concerns were noted: a. In a bin of serving utensils (spoons and scoops), the handle of one serving spoon was covered with a white substance on the handle. The DM stated the white substance was mayonnaise. b. On the three-compartment sink's metal counter were four out of 13 full sheet trays stacked wet. Also on the counter was a mixture of two-inch, four-inch, and six-inch hotel pans. Six of the pans were stacked wet and greasy to touch. The DM stated, They (pans) were washed last night, and the drying rack was full, so they put them over here. c. On one of four drying rack carts were five two-inch hotel pans stacked wet and greasy to touch. 2. During a follow-up inspection on 03/25/26 at 11:10 AM, the following concerns were noted: a. One two-inch hotel pan was on one of four drying rack carts. The pan had a dried crusted substance on the inside of the rim. This was confirmed by the DM. b. The three-compartment sink sanitizer was tested by the DM and registered between 700 and 848 parts per milliliter (PPM). According to Ecolab (used by the facility) recommendations for Sink and Surface Cleaner Sanitizer, the PPM should be between 272 and 700 PPM. An interview was conducted on 03/26/26 at 9:41 AM with the Administrator, Consultant Administrator, and the Dietary District Manager (DDM). The concerns of stacked wet and greasy pans, soiled spoon, and high PPM of the sanitizer in the three-compartment sink were discussed. Review of the facility's policy titled, Sanitation & Infection Control, with a revision date of 05/20/23, revealed, All clean China, dishware, and cooking wares will be stored appropriately to prevent food soil, dust or any other debris from adhering to surface of dish or cooking wares. Procedure: 1. After coming out of dish machine or the sanitizer of the 3-pot sink; dishware, utensils, and cooking wares will be air dried prior to storage. 2. Clean dishware of cooking wares will be stored in an appropriate manner with either the top dish/plate or cooking ware inverted . 4. All utensils are stored in a clean bin. NJAC 8:39-17.2(g)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy review, the facility failed to ensure staff performed appropriate hand hygiene when moving between rooms, including one with enhanced barrier precautions (EBP), creating a risk for cross-contamination. Additionally, the facility failed to process laundry in a clean and sanitary manner and did not ensure laundry staff consistently washed their hands. This failure has the potential to spread infection among the facility's 106 residents. Findings include:1. On 03/23/26 at 3:13 PM, Licensed Practical Nurse (LPN) 3 was observed entering and exiting multiple resident rooms and touching surfaces in the rooms without washing or sanitizing his/her hands between residents' rooms. LPN3 left room [ROOM NUMBER], entered room [ROOM NUMBER], left room [ROOM NUMBER], entered room [ROOM NUMBER], left room [ROOM NUMBER] and entered room [ROOM NUMBER]. The resident in room [ROOM NUMBER] was on EBP secondary to having an indwelling catheter. LPN3 was immediately interviewed upon exiting room [ROOM NUMBER] and stated regarding EBP, Staff is supposed to gown if they are providing care to residents. Regarding washing or sanitizing his/her hands between residents, LPN3 stated he/she was unsure but would wash his/her hands before and after administering medications to residents. During an interview on 03/26/26 at 11:34 AM, the Infection Preventionist (IP) stated he/she expected staff to wash and/or use hand sanitizer when going into resident rooms. If a resident is not on EPB, they do not have to wash their hands, but I expect them to sanitize their hands. During an interview on 03/26/26 at 4:45 PM, the Director of Nursing (DON) confirmed that staff should clean their hands when entering and exiting resident rooms. Observation of the EBP signs posted outside of the residents' doors (who were on EBP) revealed Wash hands when entering and exiting. Review of the facility's policy titled, Hand Washing/Hand Hygiene with revision dates of October 2023 and March 2026, revealed, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections . All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 2. During a continuous observation and interview on 03/26/26 from 10:30 AM until 11:15 AM, the Environmental Services Supervisor (ESS) demonstrated receiving dirty laundry from the utility closet on B Hall. He/she stated staff take the bagged laundry, place it in a cart, and cover it with a sheet. He/she walked down the hall and entered a small hallway with two doors, one to access the dumbwaiter and the next door to enter the kitchen. Laundry staff placed dirty laundry in the dumbwaiter for it to go to the basement. Upon entering the basement there were two doors. The first door was opened and entered to retrieve the dirty laundry from the dumb waiter. The second door was closed, which was the entry to the clean linen. The ESS stated he would wheel the dirty laundry through the area where the clean laundry would pass, then go towards the room where the dirty laundry was washed. Upon entry into the dirty laundry side, the ESS wore a mask, gown, and gloves. He/she pushed the cart through the dirty laundry room door and began to sort the laundry. He/she threw a towel and sheet into the dirty laundry bin, which he/she confirmed had feces on the side of it. The ESS stated laundry often received towels and wash clothes that had feces on them. The ESS sorted all the laundry and removed his/her gloves. Without washing his/her hands, the ESS opened the door to leave the dirty laundry room. Continuing not to wash his/her hands, the ESS returned to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the dirty laundry room without gloves and entered the clean laundry room. At 11:10 AM, Laundry Aide (LA) 1 was observed putting gloves on and taking a clean linen cart into the dirty laundry room. LA1 retrieved washed laundry and took it back into the clean laundry room to place into the dryer. LA1 was then observed putting on gloves, a mask, and a gown and stated he/she was going in the dirty laundry area to place dirty linen in the washers. LA1 stated he/she would put gloves and a mask on if he/she was retrieving clean linen from the washer to take back to the clean laundry room and would place a gown, gloves, and mask if he/she was returning to the dirty laundry room to sort dirty laundry. During an observation on 03/26/26 at 11:25 AM, LA1 wore gloves and entered the dirty laundry room with a cart. LA1 removed the gloves at the door of the clean linen room and opened the door with bare hands before returning to the dirty laundry room and washing his/her hands in the sink. LA1 returned to the clean laundry room after touching the door to enter the laundry room. During an interview and observation on 03/26/26 at 5:31 PM, the ESS opened the dumbwaiter revealing visible white and black crumbs in the corners between the wall and the floor. The kitchen door was open. The ESS stated it was open frequently, and to avoid cross contamination it should be closed. The ESS stated the dumbwaiter was currently cleaned weekly but agreed it should be cleaned more frequently. The ESS stated hands should be washed after leaving the dirty linen room and before entering the clean laundry room. During an interview on 03/26/26 at 5:45 PM, the DON stated that he/she expected laundry not to be cross-contaminated and all staff should wash their hands in between handling clean and dirty linen. Review of the facility's policy titled, Isolation Laundry, dated 07/01/25, indicated, . Procedure: Any employee transporting soiled linen, be it isolation or not, should follow all safety precautions and procedures . 12. Wash hands thoroughly following proper hand-washing techniques.'' Review of the undated facility's policy titled, Personal Protective Equipment (PPE) Donning and Doffing Guide, Proper Order Prevents Infection Transmission,'' indicated, Putting on PPE (Donning) 1. Perform hand hygiene. Wash hands or use alcohol sanitizer before touching PPE . 5. Put on gloves. Removing PPE (Doffing) 1. Remove gloves. Gloves are most contaminated. Remove carefully. 2. Perform hand hygiene. Clean hands immediately . '' NJAC 8:39-19.4

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that food was served at the correct temperature for two residents who received hamburgers (Residents (R) 19 and 90) and food served was palatable in taste for two residents (R 70 and R135). Specifically, the facility did not ensure that dietary staff followed appropriate processes to prepare and serve food palatable for 101 out of census of 106 residents during meal service. This failure had the potential to place residents at increased risk for meal dissatisfaction and the service of potentially unsafe food. Findings include: 1. Review of R70's undated Face Sheet provided by the facility indicated R70 was admitted to the facility on [DATE]. Review of R70's quarterly Minimum Data Set (MDS), located under the MDS tab in the electronic medical record (EMR), with an Assessment Reference Date (ARD) of 01/24/26 indicated R70 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R70 had moderate cognitive impairment. During an interview on 03/23/26 at 3:26 PM, R70 stated he/she does not like the food. They don't salt the food. 2. Review of R135's undated Face Sheet provided by the facility indicated R135 was admitted to the facility on [DATE]. Review of R135's admission MDS, located under the MDS tab in the EMR, with an ARD of 03/16/26 indicated R135 had a BIMS score of 15 out of 15, which indicated R135 was cognitively intact. During an interview on 03/24/26 at 10:05 AM, R135 stated the food is edible, they don't put salt or seasoning in the food. R135 stated his/her spouse and daughter bring in food for him/her that he/she likes. 3. During lunch observation on 03/25/26 at 11:10 AM, lunch was observed being plated from the steam table in the kitchen. The food was plated directly onto individual plates, then covered with plastic lids before being placed onto a wheeled cart. Hamburger patties were plated for two residents (R19 and 90). The Executive Chef (EC) took the temperature of the hamburger patties as they were being plated from the oven warmer. The temperature of the hamburger patties was 132 degrees Fahrenheit. According to the FDA [U.S Food and Drug Administration] Food Code, dated 03/07/22, All foods will be held at appropriate temperatures, greater than 135 F [Fahrenheit] for hot foods. 4. Further observation of the steam table revealed for Regular diets, the residents received beef stew, noodles, and the mixed steamed vegetables contained carrots. For residents on Minced and Moist diets, they received ground beef, mashed potatoes, and their steamed minced vegetables did not contain carrots. Review of the menu extensions revealed beef stew and noodles with mixed vegetables scheduled for both Regular and Minced and Moist diets. During an interview with the [NAME] on 03/25/26 at 11:15 AM, he/she confirmed the Minced and Moist steamed vegetables did not contain carrots but could not explain why. During an interview on 03/25/26 at 12:15 PM, the Dietary Manager (DM) stated the vegetables should have been the same for all three diet consistencies and contained carrots. During an interview on 03/26/26 at 10:39 AM, the Registered Dietician (RD) reviewed the menu and confirmed the residents who received the Minced and Moist diets should have received a variation of the beef stew, not ground beef, and chopped noodles, not mashed potatoes. 5. On 03/25/26 at 12:15 PM, tasting of a Minced and Moist test tray was conducted by two surveyors, the Dietary Manager (DM), and the Dietary Area Manager (DAM) revealed the following: The ground beef was not seasoned; mashed potatoes were bland, not seasoned; and the steamed vegetables were bland, not seasoned, and the appearance was not appealing. An interview was conducted on 03/26/26 at 9:41 AM with the Administrator, Consultant Administrator, and the Dietary District Manager (DDM). The lack of seasoning with the food was discussed. On 03/26/26 at 12:30 PM, the RD stated the facility did not have a policy that addressed the palatability of food. We address the concerns individually. NJAC 8:39-17.4(a)2

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and document review, the facility failed to provide residents and their resident representatives (RR) with the required written transfer notice following emergent hospital transfers for two of three residents (Resident (R) 129, and R138) reviewed for hospitalization out of 27 sampled residents. This failure created a risk that residents and their RRs would be uninformed about the reason and location of the transfer and their right to appeal it, if desired. Findings include:1. Review of R129's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R129 was admitted to the facility on [DATE]. Review of R129's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/26 revealed a Brief Interview for Mental Status (BIMS) was unable to be completed due to R129 rarely being understood. Review of R129's Progress Notes, dated 12/16/25 and located under the Progress Notes tab of the EMR, revealed R129 was, extremely agitated physically and verbally abusive towards staff, prn [as needed] medication given not effective. Writer spoke with daughter and [spouse] due to physical aggression towards staff and to [himself/herself] [he/she] was transferred to [hospital name] for eval [evaluation], [spouse] and daughter present for transfer to hospital. Further review revealed that R129 was admitted to the hospital. 2. Review of R138's admission Record, located under the Profile tab in the EMR, revealed R12 was admitted to the facility on [DATE]. Review of R138's admission MDS, with an ARD of 01/31/26 and located under the MDS tab of the EMR, revealed a BIMS score of seven out of 15, indicating R128 was severely cognitively impaired. Review of R138's Progress Notes, dated 02/19/26 and located under the Progress Notes tab of the EMR, revealed, called to resident room, resident sitting on [his/her] wheelchair with family at bedside. Noted lethargic, blood pressure 53/46 arousable with sternal rub. Resident transferred back to bed. Put on Trendelenburg position. physician made aware, new order to transfer to ER [emergency room] for further evaluation and treatment. blood pressure rechecked 97/52.Resident more alert than [he/she] was. Called 911 resident transferred to ED [emergency department] at 7:45PM. Report given to ER nurse. Further review revealed that R138 was admitted to the hospital. During an interview on 03/25/26 at 2:13 PM, the Consultant Admin said they were not sending or providing transfer notice forms to residents or their families when a resident was transferred. The Consultant Admin stated the Administrator confirmed this was not happening. During an interview on 03/26/26 at 2:08 PM, the Director of Nursing (DON) stated the transfer notice should be provided to the resident or representative when a discharge occurred. Review of the facility's policy titled, Emergency Transfer Forms for Long-Term Care Residents, revised 03/26/26, revealed, [NAME] House works to ensure the Emergency Transfer Forms for long-term care residents are completed accurately, submitted timely to the Long-Term Care Ombudsman, and properly filed in accordance with regulatory requirements. NJAC 8:39-4.1(a)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure that one resident of 60 residents (Resident (R) 18) reviewed for missing Minimum Data Set (MDS) assessments over 120 days old had a tracking discharge assessment completed and transmitted in a timely manner. Failure to complete and transmit MDS data timely can lead to inaccurate federal reimbursement and quality measures. Findings include: Review of R18's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R18 was admitted to the facility on [DATE] and discharged on 08/24/25. Review of R18's discharge return anticipated MDS with an Assessment Reference Date (ARD) of 08/24/25, located under the MDS tab in the EMR, indicated that the assessment was batched and accepted on 02/04/26. During an interview on 03/26/26 at 5:00 PM, the MDS Coordinator confirmed that the tracking assessment was late, but he/she was unsure why it was late. The MDS Coordinator confirmed that the Director of Nursing (DON) pulls the missing assessment report every Friday and lets her know of any residents in the report. She stated that she transmits the assessments on a weekly basis. During an interview on 03/26/26 at 5:10 PM, the DON confirmed that R18 was on the January 2026 missing assessment report. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, revised October 2025, revealed for a Discharge Assessment, . MDS completion date (Item Z0500B) no later than discharge date + [plus] 14 calendar days . transmission date no later than MDS completion + 14 calendar days. NJAC 8:39-11.2

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure that a comprehensive Minimum Data Set (MDS) assessment was submitted accurately for one resident (Resident (R) 83) reviewed for MDS assessments out of a total sample of 27 residents. This had the potential to affect quality measures and the resident's care planning process. Findings include:Review of R83's admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE]. Review of R83's Physician Orders located under the Orders, tab in the EMR revealed hospice services were ordered on 07/16/24. Review of R83's quarterly MDS under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 10/21/25, revealed the Brief Interview for Mental Status (BIMS), was unable to be completed due to R83 rarely being understood. Further review revealed the resident was documented not to be receiving hospice care. Review of R83's Physician Orders located under the Orders tab in the EMR revealed hospice services were discontinued on 11/19/25. Review of R83's quarterly MDS under the MDS tab of the EMR, with an ARD of 02/19/26, revealed the BIMS was unable to be completed due to R83 rarely being understood. Further review revealed the resident was documented to be receiving hospice services. During an interview on 03/26/26 at 10:06 AM, the MDS Coordinator stated both assessments were completed inaccurately. He/She said it was an error on his/her part. During an interview on 03/26/26 at 2:08 PM, the Director of Nursing (DON) said he/she expected MDS assessments to be completed accurately before they were submitted. Review of the facility's policy titled, Leisre Chateau, revised 10/2025, revealed, It is our policy to complete the RAI process according to the requirements and standards of the latest published RAI [Resident Assessment Instrument] manual. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025 and located at www.cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf, revealed, Check all of the following treatments, procedures, or programs that were performed . while a resident of this facility and within the last 14 days . Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. NJAC 8:39-33.2(d)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure residents did not have side rails on beds when they had not been assessed for their use for one of four residents (Resident (R) 139) reviewed for side rails out of a total of 27 sampled residents. The lack of appropriate assessment placed residents at risk for unintended restraint and potential side rail entrapment. Findings include:Review of R139's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R139 admitted to the facility on [DATE] with a diagnosis of weakness. Review of R139's Admission/readmission Evaluation Section-Siderail, completed by Licensed Practical Nurse (LPN) 2, dated 03/05/26 and located under the Assessments tab in the EMR, revealed side rails were not being considered at the time. Further review revealed no discussion of risks versus benefits and informed consent. Review of R139's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/11/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Review of R139's Care Plan, dated 03/17/26 and located under the Care Plan tab of the EMR, revealed R139 was not care planned for half side rails on both sides of the bed. Review of R139's Physician Orders, located under the Orders tab in the EMR, dated 03/17/26, revealed no current order for side rails. During observations on 03/23/26, 03/24/26, and 03/26/26, side rails were observed on both sides of R139's bed in the up/raised position. During an interview on 03/23/26 at 10:53 AM, R139 was sitting in a wheelchair at bedside eating. R139 said he/she was a new resident and had been there a few weeks. R139 stated the bed rails had been on the bed since he/she was admitted . R139 stated he/she did not recall signing anything related to the risks and benefits of bedrail use. During an interview on 03/26/26 at 10:17 AM, LPN2 said he/she was not the nurse who normally completed admission assessments related to bed rail use. He/She said there must not have been a supervisor working at the time of R139's admission, and therefore he/she completed R139's. He/She said when a resident has bed rails there should be an assessment, a physician's order, and it should be care planned. LPN2 was unsure of the facility's policy on bed rail use. He/She stated that bed rails were already on R139's bed, and initially R139 did not want them but then decided he/she did. LPN2 agreed that another bed rail assessment should have been complete on bed rail use prior to implementing bed rails for R139. He/She agreed that a resident should not have bed rails if not assessed to have them. During an interview on 03/26/26 at 2:08 PM, the Director of Nursing (DON) stated a resident should not have bed rails unless they were assessed to require them. He/She also stated residents with bed rails should be assessed prior to use, there should be an order, and it should be care planned. Review of the facility's undated policy titled Side Rails revealed, It is the policy of the facility to ensure the safety and psychosocial well-being of its residents while avoiding the use of side rails a restraint. NJAC 8:39-27.1(a)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to maintain accurate resident medical records, including physician orders and medication administration records (MARs), for one (Resident (R) 132) of five residents reviewed for medication administration and accuracy of medical records. R132 had a duplicate physician order for the same medication, which was transcribed as two separate entries on the resident's MAR. This documentation error created the potential for the medication to be administered more than once as prescribed, placing the resident at risk for medication errors and possible adverse health effects. Findings include:A review of R132's admission Record found under the Profile tab in the electronic medical record (EMR) revealed R132 was admitted to the facility on [DATE] with diagnoses of heart failure, chronic obstructive pulmonary disease, hypertension, type 2 diabetes mellitus, and atrial fibrillation. The resident was discharged from the facility on 07/23/25 to an assisted living facility. A review of R132's July 2025 Physician Orders, located under the Orders tab in the EMR, revealed a duplicate order for potassium chloride extended release 20 milliequivalents (mEq) to be administered once daily for low potassium, which was entered by Registered Nurse/Unit Manager (RN/UM) on 06/30/25 to start on 07/01/25. The duplicate order was removed on 07/06/25 by the Assistant Director of Nursing (ADON). A review of R132's July 2025 Medication Administration Record (MAR), located under the Orders tab in the EMR, revealed that the order for potassium chloride extended release 20 mEq appeared twice on the MAR for the dates of 07/01/25, 07/02/25, 07/03/25, 07/04/25, and 07/05/25. Licensed Practical Nurse (LPN) 1 documented on the MAR that both orders were administered on those dates. An interview on 03/25/26 at 12:00 PM with the ADON revealed the order for potassium chloride extended release 20 mEq, to be administered as one tablet by mouth once daily for low potassium, was inadvertently transcribed twice on the Physician Orders and MAR from 07/01/25 through 07/05/25. The ADON stated RN/UM entered the duplicate order and is no longer employed at the facility. The ADON stated LPN1 signed off on both orders on the MAR during this period. The ADON further stated that the medication was verified on the medication cart at the time and administered only once each day. Additionally, the ADON stated LPN1 received a verbal warning regarding accurate documentation during medication administration. An interview on 03/25/26 at 12:33 PM with LPN 1 revealed he/she recalled being counseled by the ADON regarding the duplicate potassium order and its duplicate entry on the MAR. LPN 1 stated he/she accidentally signed off on both duplicate MAR entries. LPN 1 further stated he/she did not administer any additional potassium to the resident. An interview with the Director of Nursing (DON) on 03/25/26 at 1:30 PM revealed he/she was not working at the facility in July of 2025. The DON stated he/she has the expectation that all documentation, including physician orders and MARs, must always be correct and that the nursing staff need to be aware of everything they document and sign off. A review of the facility policy titled, Charting and Documentation, with a revision date of March 2026, revealed all documentation in the medical record must be objective, complete, and accurate. NJAC 8:39-4.1(a)