STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315215	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop a comprehensive person-centered care plan for residents who were treated with [MEDICAL CONDITION] medications. This deficient practice was identified for Resident #88 and #52, 2 of 22 residents reviewed for CPs and was evidenced by the following: 1. On 09/25/2020 at 11:53 AM, the surveyor observed Resident #88 in his/her room, lying in bed and watching television. The surveyor interviewed the resident at that time and the resident was alert and answered questions appropriately. On 09/29/2020 at 8:47 AM, the surveyor observed Resident #88 lying in bed, looking out the window and counting. The surveyor inquired about the counting. The resident stated he/she was counting birds. The surveyor looked outside the window and was unable to see the birds. Resident #88 pointed to a fence right outside the window and stated to the surveyor the birds were right there. The surveyor did not observe birds on the fence. The resident appeared upset and stated that he/she wanted to go home because he/she afraid he/she would be going to the hospital to have his/her foot cut off. Review of Resident #88's Admission Information sheet revealed the resident had [DIAGNOSES REDACTED]. Review of the Admission 5-day Interdisciplinary Summary Notes revealed one of the resident's [DIAGNOSES REDACTED].#88's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the provision of care, dated 09/07/20, revealed the resident had a Brief Interview for Mental Status (BIMS) of 14, which indicated the resident was cognitively intact. The MDS revealed an active [DIAGNOSES REDACTED]. Review of Resident #88's physician's orders [REDACTED]. Review of Resident #88's CP revealed problem areas which included activities, risk for falling, nutritional needs, risk for infection, risk for impaired gas exchanged, risk for impaired skin integrity, and risk for pain. The CP did not address the resident's antidepressants, antianxiety, [MEDICAL CONDITION] or hypnotic medications. During an interview with the surveyor on 09/30/2020 at 11:40 AM, the Registered Nurse Unit Coordinator (RN/UC #1) for Resident #88, stated the nurse who completed the admission for the resident would initiate the resident's care plan (CP) within the first 24-48 hours. The RN/UC #1 stated she would be responsible to complete the comprehensive CP. The RN/UC #1 stated things that should be included in a resident CP were fall risks, skin issues, comorbidity, oxygen, any antidepressants or [MEDICAL CONDITION] medications, nutrition, and pain. RN/UC #1 stated the CP was important so the nurses would know how to care for the resident, what the focus of care would be and what the assessments that would need to be completed. RN/UC #1 further stated she would obtain the information for the CP from things like the hospital records, medication lists and by talking to the resident if the resident was able. RN/UC #1 reviewed Resident #88's CP and acknowledged that the antidepressants, antianxiety, [MEDICAL CONDITION] and hypnotic medications were not on the CP. RN/UC #1 stated that they should have all been included. During an interview with the surveyor on 09/30/2020 at 12:05 PM, the Assistant Director of Nursing (ADON) stated the initial baseline CP would be the responsibility of the nurse who admitted the resident. The ADON stated that the comprehensive CP would be done by all disciplines involved. The ADON further added the CP should include things such as, risks, falls, safety, mood, medications, dietary, [MEDICAL CONDITION] medications, depression, and any medications that risk safety. 2. On 09/25/2020 at 11:00 AM, the surveyor observed Resident #52 seated in a wheelchair in the unit day room. The resident's eyes were closed, and an activity was being held at the time of observation. On 09/28/2020 at 10:50 AM, the surveyor observed Resident #52 seated in a wheelchair in the hallway. The wheelchair was positioned in front of a window to the unit day room. The resident's eyes were closed. On 09/28/2020 at 1:01 PM, the surveyor observed Resident #52 seated in a wheelchair in front of the nurses' station. The resident's mouth was open, and eyes were closed. Review of Resident #52's Admission Record revealed the resident had [DIAGNOSES REDACTED]. Review of Resident #52's significant change MDS, dated [DATE], included a Staff Assessment for Mental Status which revealed the resident had severely impaired cognitive skills for decision making. Review of a Psychiatric Evaluation (PE), completed by a Physician Assistant, dated 09/11/2020, revealed Resident #52 was occasionally combative with care and anxious during care which escalated into aggression. The PE further revealed the resident received the following medications: [REDACTED]. The PE recommended to discontinue Trazadone and start [MEDICATION NAME] 15 mg at hour of sleep for depression and may also help with anxiety symptoms. Review of Resident #52's CP revealed problem areas for Dementia/Alzheimer's and difficulty remembering, Activities, Falls, Skin Impairment, and Weight loss. The CP did not address the resident's use of physician prescribed [MEDICAL CONDITION] medications, anxiety/depression or behaviors. On 09/29/2020 at 11:53 AM, the surveyor interviewed a Certified Nurse Aide (CNA) #1 who stated Resident #52 sometimes nods off during the day. On 09/29/2020 at 1:02 PM, the surveyor interviewed the RN/UC #2 who stated Resident #52 had occasional tearfulness and became feisty at times. On 09/30/2020 at 9:28 PM, the surveyor observed Resident #52 seated in a wheelchair in the unit day room with eyes closed. The surveyor engaged the resident who responded to his/her name, opened his/her eyes and said hello. The resident repeated the surveyor's name during the conversation. The resident stated he/she liked the music. On 09/30/2020 at 9:58 AM, the surveyor interviewed a Licensed Practical Nurse (LPN #1) who stated Resident #52 could become combative and would swing at any staff. She stated the resident cried a lot and that the crying could last for ten minutes. She stated the resident liked music and that sometimes, if the resident didn't want to be bothered, he/she would swing at you. On 09/30/2020 at 12:03 PM, the surveyor interviewed CNA #2 who stated Resident #52 varied between happy and sad. She added the resident would pinch staff because the resident doesn't like to receive care. She stated the resident's eyes were always closed and she thought that was one of the resident's behaviors. On 09/30/2020 at 12:49 PM, the surveyor interviewed the RN/UC #2 regarding the purpose of resident care plans. The RN/UC #2 stated the care plans were for the staff, especially floaters, so they can look to see the care that the resident needs. She stated the care plan would list resident behaviors and interventions for the behaviors. On 09/30/2020 at 12:52 PM, the surveyor interviewed CNA #3 regarding Resident #52's the care needs. CNA #3 stated she was a float and she knew they had a care plan book but did not know any details related to the book, including where it was located. On 10/01/2020 at 9:31 AM, during a meeting between the survey team and the facility representatives, the Director of Nursing (DON) stated the CP was for all staff to look at regarding any problems that a resident may have. She stated a CP will have interventions and approaches. The DON acknowledged a CP for Resident #52's behaviors was not created and that it should have been done. Review of the facility's Baseline/Initial Care Plan policy and procedure, dated February 2020, revealed the purpose was to establish a guideline for providing individualized patient care that was multidisciplinary, consistent and coordinated. The objective was to ensure consistent and individualized care from the time of admission that will encompass the preferences and goals of the resident to the fullest extent. One of the procedures included, but was not limited to, that baseline care plans should be reviewed, revised and updated as needed until the comprehensive care plan was devised. Review of the facility's Care Plan Policy, dated January 2006, revealed the policy was

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

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) to develop a patient centered plan of care based on the Resident Comprehensive Assessment. Each member of the Multidisciplinary team contributed to the care plan based on the resident and/or family needs and goals. The care plan was initiated as clinically indicated and documented accordingly. The purpose was to establish guidelines for providing individualized patient care that was multidisciplinary, consistent and coordinated. The objective was to ensure consistent and individualized care to the resident in order to meet the resident's preference and desired goals to the fullest extent. The initial care plan would list priority problems which included, but was not limited to, resident specific problems based on the resident's needs and diagnoses. NJAC 8:39-11.2(e)(1-2)(f)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation in a safe, consistent manner designed to limit the potential of foodborne illness. This deficient practice was evidenced by the following: On 09/25/2020 at 8:34 AM, the surveyor entered the kitchen. The surveyor observed a person, who identified himself as a stockman, in the salad preparation area. The stockman's beard was observed past his chin and protruding below his face mask and was not wearing a beard restraint. At that time, the surveyor interviewed the cook supervisor (CS) who was in the dairy cooking area. The CS stated that a beard restraint was not needed for a beard less than two inches. On 09/25/2020 at 8:40 AM, the surveyor toured the kitchen with the night-time dietary supervisor (NDS) and observed the following: 1. A meat slicer in the food preparation area was uncovered with dried debris noted on the slicer. The NDS identified the debris on the slicer as dried meat. The NDS said the slicer was used the previous night and was not cleaned properly and the slicer should be covered after use. 2. There were 11, half-sized stainless steel pans and 7, quarter-sized stainless steel pans on a drying rack in the meat area. The pans were stacked wet and nested together. The NDS stated the stainless steel pans should have been separated on the drying rack and allowed to dry. At 9:12 AM, the Director of Dietary (DOD) joined the tour: 3. There were four, 46-ounce containers of honey thickened juice past the manufacturers use by date. Three of the honey thickened juice containers were dated 09/16/2020 and one was dated 08/20/2020. The DOD stated that the stock was not rotated appropriately. On 09/30/2020 at 8:54 AM, the surveyor interviewed the Registered Dietician (RD) who stated that the facility had a policy which indicated beard guards were necessary and hair should be covered in the food preparation areas. The RD stated that food items transferred to smaller containers should be labeled and dated in covered containers. The RD further stated that the meat slicer should have been cleaned and covered when it was not in use. The RD stated that that the facility kitchen had plenty of room to dry items and the stainless-steel pans should not have been wet nested together. The RD stated that staff knew how to rotate stock. Review of the facility's Dietary Manual Policy and Procedure, revised March 2020, indicated, All foods are rotated to ensure the older items are used first. The Dietary Manual Policy and Procedure further indicated, Individuals with facial hair should cover facial hair appropriately. In addition, the manual indicated, All pots and pans will be air dried. Do not wipe dry as this will contaminate newly sanitized equipment and utensils. Make sure all pots and utensils are allowed to thoroughly dry. Utilizing drying racks and lean items on their side to avoid wet nesting. NJAC 8:39-17.2(g)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure staff follow infection control practices for appropriately donning (put on) respirator masks and for the proper storage of oxygen delivery equipment for Resident #29, 1 of 5 residents reviewed for infection control. This deficient practice was evidenced by the following: 1. On 09/25/2020 at 10:55 AM and 12:16 PM, the surveyor observed observed Resident #29 lying in bed with eyes closed. The resident was receiving humidified oxygen via a tracheal mask covering the resident's [MEDICAL CONDITION] (an artificial opening in the neck to facilitate breathing) tube. The surveyor attempted to speak to the resident, but the resident did not respond. On 09/28/2020 at 1:36 PM, the surveyor observed Resident #29 lying in bed, eyes closed. The resident was receiving humidified oxygen via a tracheal mask over the resident's [MEDICAL CONDITION]. On 09/29/2020 at 8:30 AM, the surveyor observed Resident #29's oxygen tubing connected to an oxygen delivery face mask, lying on top of a piece of respiratory equipment. The oxygen tubing and face mask were not contained in a protective covering or bag and were exposed to the environment. On 09/29/2020 at 10:27 AM, the surveyor and the Licensed Piratical Nurse (LPN) caring for Resident #29 entered the resident's room. Resident #29 was lying in bed with his/her eyes closed and was receiving humidified oxygen via a tracheal mask over the resident's [MEDICAL CONDITION]. The LPN stated she saw the oxygen tubing and oxygen delivery face mask on the respiratory equipment and moved it. The LPN showed the surveyor the tubing and face mask, that was not contained in a protective covering or bag, now on a wooden shelf. The LPN stated she had not used the tubing and mask and did not know who did or when it was last used. The LPN stated the respiratory face mask should always be in a protective bag when not in use. The LPN stated the tubing and face mask were going to be discarded because they were contaminated. During an interview with the surveyor on 09/29/2020 at 12:00 PM, the RN/IP stated a resident on oxygen should have the nasal cannula or face mask stored in a plastic bag when not in use. The surveyor reviewed Resident #29's medical record: The Admission Information sheet revealed the resident had [DIAGNOSES REDACTED].) The Admission Minimum Data Set, dated dated [DATE], revealed the resident's Brief Mental Interview Status was not determined and that the resident was rarely/never understood. The Care Plan (CP) included an intervention related to the resident's risk for infection related to a compromised status with a goal of the caregivers to be able to identify interventions to prevent and reduce the risk of infection. The physician's orders [REDACTED]. Review of the Oxygen Administration policy and procedure, dated Aug/[DATE], revealed a plastic zip-lock bag was to be attached to the side of the concentrator so the nasal cannula or oxygen mask can be stored there when not in use. 2. On 09/25/2020 at 12:07 PM, the surveyor observed a staff member in the 200-unit hall wearing a respirator type mask. The surveyor observed the bottom yellow elastic strap hanging from the front, down below the chin. At the time of the observation, the surveyor interviewed the staff member who identified herself as a Certified Nurse Aide (CNA #4) who had worked at the facility for about five years. CNA #4 stated her mask was a N95 mask and that she had received a PPE (personal protective equipment) in-service which included the proper donning of masks. CNA #4 stated that both yellow elastic straps should have been around the back of her head and that she left the bottom strap off because it was too hard to breath. Review of CNA #4's Competency Evaluation for Donning and Doffing PPE, dated 06/24/2020, revealed CNA #4 was competent in applying a mask/respirator: secure ties/elastic bands at middle of head and neck. On 09/28/2020 at 11:26 AM, the surveyor observed a staff member wearing a respirator mask as he/she walked in the hall toward the A Wing 100-unit. The surveyor observed the bottom yellow elastic strap of the mask was hanging from the front, down below the chin. During an interview with the surveyor at that time, the staff member identified herself as a housekeeper. The housekeeper stated her N95 mask was worn to protect her and the residents from infection. The housekeeper stated she had been in-serviced on wearing PPE, including masks. The housekeeper stated she had just come from her locker and would only wear the mask on the PUI (person under investigation for COVID) units. Review of the housekeeper's Competency Evaluation Donning and Doffing PPE for the housekeeper, dated 07/06/2020, revealed the housekeeper was competent in applying a mask/respirator: secure ties/elastic bands at middle of head and neck. On 09/29/2020 at 9:27 AM, the surveyor observed a staff member in front of the North Unit nurses' station wearing a respirator mask. The surveyor observed the bottom yellow elastic strap of the mask was hanging from the front, down below the chin. During an interview with the surveyor at that time, the staff member was identified as a CNA (CNA #5). CNA #5 stated the reason the bottom strap was not secured was that the N95 mask hurts her. The CNA stated the N95 masks were a precaution for infection to protect herself and the residents she cared for. The CNA stated she had been in-serviced how to wear PPE, including masks. Review of CNA #5's Competency Evaluation Donning and Doffing PPE, dated 06/24/2020, revealed CNA #5 was not competent in applying a mask/respirator: secure ties/elastic bands at middle of head and neck. The Competency Evaluation included a handwritten note, Explained proper way of don/doff PPE. Had return demonstration. Given a pamphlet. There was no documentation of an evaluator signature noted on the competency form. On 09/29/2020 at 11:49 AM, the surveyor, in the presence of the Director of Nursing (DON) and Assistant Director of Nursing (ADON) who were at the nurses' desk, observed a person sitting with a

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) resident on the 300-unit Long Term Care. The person was observed wearing a N95 mask with the bottom white strap in front of her chin and tucked under the top strap. During an interview with the surveyor at that time, the person identified herself as the resident's private companion (PC). The PC stated she was hired by the resident's family and worked with the resident at the facility for two years. The PC stated the facility provided her with the N95 mask and instructed her on the proper way to wear the mask. The PC stated she was aware both of the straps should go behind her head and could not say why she did not secure both straps of the mask behind her head. The PC stated the purpose of the mask was to protect herself and the resident from germs. At that time, both the DON and ADON stated that the PC should have been wearing both straps behind her head for the mask to be effective. During an interview with the surveyor on 09/29/2020 at 11:55 AM, the Registered Nurse/Infection Preventionist (RN/IP) stated she had thought the PC was from an agency and that she had been in-serviced by the agency on PPE. The RN/IP stated that the facility instructs non-staff, who come to the facility, on PPE and how to wear it. The RN/IP stated it was important to wear the respirator masks the right way to prevent the spread of infection. On 09/30/2020 at 9:44 AM, the RN/IP informed the surveyors she had educated the four staff members the surveyor had observed and two additional staff that she had observed wearing their PPE masks incorrectly. The facility provided a written statement from a facility LPN that the PC had been in-serviced on donning and doffing the N95 mask. The statement was dated 10/01/2020. Review of the facility's information posting, How to Properly Put on and Take off a Disposable Respirator revealed the top strap goes over and rests at the top back of your head and the bottom strap was positioned around the neck and below the ears. The posting included a picture of the straps around the back of the head and neck. Review of the facility's information posting, Sequence for Putting on Personal PPE revealed that the ties or elastic bands of the mask or respirator were to be secured at the middle of the head and neck. The posting included a picture of the ties/bands around the back of the head and neck. The surveyor observed these informational postings located throughout the facility. NJAC-8:39 19.4(a)(1,2,6), 27.1(a)