| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/05/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GROVE PARK HEALTHCARE AND REHABILITATION CENTER | 101 NORTH GROVE STREET , EAST ORANGE, New Jersey, 07017 |

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| F0000 | INITIAL COMMENTS<br><br>COMPLAINT #: 2598536, 2569577, 00185424<br><br>CENSUS: 171<br><br>SAMPLE SIZE: 4<br><br>THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. | F0000 | | 12/22/2025 |
| F0689<br>SS = D | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, and record review, and review of pertinent documentation it was determined that the facility failed to fully investigate and implement measures to address an NJ Exec Order 26.4 that a visitor provided NJ Exec Order 26.4b1 to a resident with history of NJ Exec Order 26.4b1, which the resident NJ Exec Order 26 and reported it to the facility. This deficient practice was identified for 1 of 4 resident reviewed (Resident #1).<br><br>The evident is as followed:<br><br>A review of the Admission Record (AR) revealed that | F0689 | Immediately on 12/15/2025 upon identification of the concern, the facility conducted a comprehensive investigation of Resident #1's incident.<br><br>All the residents with a history of substance use disorders (SUD) have the potential to be affected.<br><br>Systemic Changes to prevent recurrence:<br><br>The Director of Nursing (DON) and/or designee re-educated all staff immediately on 12/15/2025 regarding prompt reporting and documentation of alleged allegations and Investigation process as per policy.<br><br>A standardized investigation checklist was implemented immediately on 12/15/2025 to ensure all allegations are thoroughly investigated.<br><br>Monitoring and Quality Assurance:<br><br>The DON or designee will conduct weekly audits for four (4) weeks, then monthly audits for the next three (3) months to ensure compliance with all alleged allegations are thoroughly investigated and reveiwed. Findings will be reviewed and reported to the Quality | 01/27/2026 |

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 reverse for further 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 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/05/2025 |
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| F0689 SS = D | Continued from page 1<br>Resident #1 was admitted to the facility with diagnoses that included but not limited to NJ Exec Order 26.4b1 [redacted]<br><br>A review of Resident #1's quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that the resident had a Brief Interview Mental Status (BIMS) score of [redacted] out of 15, indicating that the resident's NJ Exec Order 26.4b1 [redacted]<br><br>A review of Resdient#1's Medication Administration Record (MAR), revealed a physician order initiated on NJ Exec Order 26.4b1 [redacted] give 1 NJ Exec Order 26.4b1 every morning and at bedtime for NJ Exec Order 26.4b1.<br><br>A review of the resident's care plan initiated on [redacted], revealed in the focus area that Resident #1 has a history of NJ Exec Order 26.4b1 and received [redacted]<br><br>On 12/4/25 at 10:21AM, the surveyor conducted an interview with Resident #1 who stated that a "[redacted] who worked for a NJ Exec Order 26.4b1, was in the facility to [redacted] their roommate, and that the [redacted] gave them a [redacted] that contained [redacted]<br><br>On 12/4/25 at 2:07PM, the surveyor conducted an interview with the [redacted] who stated that Resident #1 was given NJ Exec Order 26.4b1 by a NJ Exec Order 26.4b1. The [redacted] further stated that the NJ Exec Order 26.4b1 was contacted, and that the company indicated that no [redacted] assigned to the facility had name that matched the name provided by the resident. The [redacted] stated that since the NJ Exec Order 26.4b1 denied having a [redacted] by the name Resident #1 provided, the facility ended the investigation.<br><br>A review of the facility's policy "Accident and Incident-Investigating and Reporting" with a revised date of 1/2025, revealed in the Policy Interpretation and Implementation #1 the "The Nurse Supervisor/ Charge Nurse and /or the department director or supervisor shall promptly initiate and document investigation of the accident or incident."<br><br>NJAC 8:39-33.1(c) | F0689 | Continued from page 1<br>Assurance and Performance Improvement (QAPI) committee for ongoing oversight. The Licensed Nursing Home Administrator will implement additional corrective actions as needed to maintain ongoing compliance. The audit findings will be reviewed during quarterly QAPI meetings. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060704 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/05/2025 |
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| S0000 | Initial Comments<br><br>COMPLAINT #: 2569577<br><br>CENSUS: 171<br><br>SAMPLE SIZE: 4<br><br>The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations. | S0000 | | 02/11/2026 |
| S0560 | Mandatory Access to Care<br><br>CFR(s): 8:39-5.1(a)<br><br>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on review of facility documents on 12/5/25, it was determined that the facility failed to ensure staffing rations were met for 5 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents.<br><br>Findings include:<br><br>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing | S0560 | 1. Administrator in-serviced Staffing Coordinator, 1/5/2026, in regard to requirement to staff in accordance with NJDOH mandated minimum staffing ratios.<br><br>2. All residents have the potential to be affected.<br><br>3. Weekly meetings starting on 1/5/2026 with Administrator and Staffing Coordinator to review numbers of staff available to schedule and scheduling have been instituted.<br><br>4. Administrator or designee will review new hires and numbers of staff scheduled weekly for two months starting on 1/5/2026. Results will be brought to the next quarterly Quality Assurance Performance Improvement meeting. Based on results, decision will be made on how much longer or if to continue reviews. | 01/27/2026 |



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| S0560 | Continued from page 1<br>homes. The following ratio (s) were effective on 02/01/2021:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.<br><br>For the 2 weeks of staffing prior to survey from 11/16/25-11/29/25, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows:<br><br>On 11/16/25 had 19 CNAs for 172 residents on the day shift, required at least 21 CNAs.<br><br>On 11/18/25 had 20 CNAs for 172 residents on the day shift, required at least 21 CNAs.<br><br>On 11/21/25 had 20 CNAs for 174 residents on the day shift, required at least 22 CNAs.<br><br>On 11/28/25 had 20 CNAs for 173 residents on the day shift, required at least 22 CNAs.<br><br>On 11/29/25 had 18 CNAs for 172 residents on the day shift, required at least 21 CNAs. | S0560 | | |

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| F0000 | INITIAL COMMENTS<br><br>An offsite/desk review of the facility's Plan of Correction was conducted on 02/11/2026 in relation to the 12/05/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. | F0000 | | |

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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New Jersey State Department of Health

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| S0000 | Initial Comments<br><br>An offsite/desk review of the facility's Plan of Correction was conducted on 02/11/2026 in relation to the 12/05/2025 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities | S0000 | | |

Office of Primary Care and Health Systems Management

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