STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 2/18/22 Census: 164 Sample: 32 (plus 2 closed records) A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to provide regular [redacted] care to a resident who required assistance with Activities of Daily Living (ADL). This deficient practice was identified for 1 of 1 resident, (Resident #80) reviewed for ADLs and was evidenced by the following: On 02/09/22 at 11:09 AM, the surveyor observed Resident #80 lying in bed on an air mattress watching television. The surveyor observed that the resident's NJ Ex.Order 26.4(b)(1) [redacted]. The surveyor further observed that the resident's [redacted] and there was a [redacted] the majority of the	F 677	F677 ADL Care Provided for Dependent Residents 1. [redacted] care was immediately completed for Resident #80 per care plan. 2. All residents have the potential to be affected. 3. An audit was immediately performed by Charge nurses on each floor, to check all residents had proper nail care. CNAs were immediately in serviced by Assistant director of nursing or nursing supervisors on proper nail care requirements.	3/11/22

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

Electronically Signed | 03/06/2022

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

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F 677	Continued From page 1 resident's [redacted]. The surveyor asked the resident if anyone at the facility had [redacted] his/her [redacted] or offered to cut his/her [redacted] and the resident stated, "no." On 02/11/22 at 10:06 AM, the surveyor observed the resident lying in bed. The surveyor observed that the resident's [redacted] on [redacted] extended approximately [redacted] his/her [redacted]. The surveyor further observed that the resident's [redacted] were [redacted] and there was a [redacted] underneath the majority of the resident's [redacted] on [redacted]. On 02/14/22 at 10:25 AM, the surveyor observed the resident in his/her room watching television. The surveyor observed that the [redacted] on the resident's [redacted] were [redacted] and had a [redacted]. The [redacted] extended approximately [redacted] above the resident's [redacted]. The surveyor asked the resident if the staff cut his/her [redacted] and the resident stated, "nope." The surveyor asked the resident if he/she would like the staff to [redacted] his/her [redacted] and the resident stated, "yes." On 02/14/22 at 12:10 PM, the resident's Certified Nursing Aide (CNA) observed the resident's [redacted] the presence of the surveyor. The CNA stated that the resident's [redacted] were [redacted] so the resident didn't [redacted] himself/herself. The CNA further stated that the resident's [redacted] on an as needed basis when it was identified that they were [redacted] On 02/14/22 at 12:13 PM, the surveyor interviewed Resident #80 in the presence of the resident's Licensed Practical Nurse (LPN) and	F 677	4. Assistant director of nursing will audit 5 residents weekly for 4 weeks, and then once monthly for 3 months to ensure that proper nail care has been completed. Director of nursing will review findings of Assistant director of nursing weekly, for the next 3 months, and bring findings to quarterly QAPI meeting.	

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F 677	Continued From page 2 asked the resident if he/she wanted his/her [redacted] cut. The resident stated, "yes." The surveyor and LPN exited the resident's room. The surveyor interviewed the LPN who stated that the resident's [redacted], [redacted] The LPN further stated that the CNAs were responsible for [redacted] the residents [redacted] as needed when they [redacted]. The surveyor asked the LPN if the facility had an accountability record for [redacted] care and the LPN stated that the nurses did not sign for [redacted] care. On 02/17/22 at 1:34 PM, the surveyor interviewed the Administrator who stated that the residents would have [redacted] care completed on their shower days. The surveyor reviewed the medical records for Resident #80. A review of the resident's Admission Record (an Admission Summary) reflected that the resident was admitted to the facility in [redacted] and had diagnoses which included, but were not limited to [redacted]. A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident had a [redacted] further review of the resident's MDS, Section G - Functional Status reflected that the resident required one-person physical assist for NJ Exec Order 26.4b1.	F 677		

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F 677	Continued From page 3 A review of the resident's Care Plan (CP) revised on [redacted], reflected that the resident had an ADL NJ Exec Order 26.4b1 related to a recent NJ Exec Order 26.4b1 The goal of the resident's CP was the resident would improve current level of NJ Exec Order 26.4b1 /ADLs through the review date. The interventions for the resident's CP included that the resident needed limited assistance with NJ Exec Order 26.4b1. A review of the facility's "Supporting Activities of Daily Living" Policy and Procedure revised 12/2021, indicated, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene." A review of the facility's "Care of Fingernails/Toenails" Policy and Procedure revised 12/2020, indicated that nail care included daily cleaning and regular trimming and the purpose of nail care was to prevent skin problems around the nail bed, infections, and scratching which could leave injury to the skin. NJAC 8:39-27.1(a)	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		3/11/22

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F 695	Continued From page 4 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to: a.) appropriately follow a Physician's Order (PO) for the use of [NJ Exec Order 26], b.) maintain [NJ Exec Order 26] equipment to prevent the spread of [NJ Exec Order 26.4], c.) appropriately perform [redacted]) care in accordance with professional standards of practice, and d.) follow facility policy and procedures for Ex Order 26.4B1 care and [NJ Exec Order 26.4b1]. This deficient practice was identified for 2 of 2 residents reviewed, (Resident #19 and Resident #139) and was evidenced by the following: 1. On 2/09/22 at 11:36 AM, the surveyor observed Resident #19 in his/her room, seated in a wheelchair. The surveyor introduced herself to the resident and the resident [NJ Exec Order 26.4b1] [redacted] The surveyor observed that the resident was wearing [redacted]) via [redacted]. The surveyor observed that the resident's Ex Order 26.4B1 was not labeled and dated. The surveyor further observed that the [Ex Ord] [NJ Ex.Order 26.4(b)(1)] went up to five (5) [Ex Order 26.4] On 2/11/22 at 10:00 AM, the surveyor entered the resident's room. The resident was not observed in his/her room at the time. The surveyor further observed that the Ex Order 26.4B1 was turned off. The [Ex Order 26.4B1] was observed not labeled and dated and was draped over the Ex Order 26.4B1 with the [NJ Exec Order 26] of the Ex Order 26.4B1 that entered	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. order for Resident #19 was immediately changed by MD, [redacted] was labeled, and put in sanitary bag when not in use. Resident #139 was immediately assessed to ensure that resident was not in [NJ Exec Order 26.4]. 2. Any residents on oxygen or trach therapy have the potential to be affected. 3. Director of nursing(DON)immediately in-serviced all nurses on oxygen and trach policy. 4. Assistant director of nursing (ADON) will audit 2 residents on oxygen therapy for proper orders, tubing dated, sanitary conditions weekly for 4 weeks, and then one resident monthly for 2 months. ADON will audit one trach care treatment weekly for 4 weeks, and then one monthly for 2 months. DON will review findings and present them at the next quarterly QAPI meeting.	

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F 695	Continued From page 5 the resident's nares in direct contact with the [redacted] At 10:09 AM, the surveyor observed Resident #19 self- propelling in his/her wheelchair into the main dining room on the unit. The resident was wearing a surgical mask and no Ex Order 26.4B1 On 2/14/22 at 9:57 AM, the surveyor observed the resident seated in his/her wheelchair in the hallway outside of their room not wearing Ex Order 2. The surveyor observed that the Ex Order 26.4B1 in the resident's room was turned off. The surveyor further observed that the part of the Ex Order 26.4B1 that went into the resident's nares was in direct contact with the Ex Order 26.4B1. The surveyor observed a piece of scotch tape with the date 2/13/22, written on it and attached to the Ex Order Ex Order 26.4B. On that same date at 10:02 AM, the surveyor interviewed the resident who stated that sometimes he/she would wear the Ex Order 26.4 Ex Order 26.4B1 Ex Order 26 and he/she would put it on themselves when he/she felt like it was needed. The resident further stated that he/she hadn't been wearing it as much anymore and hadn't been NJ Exec Order 26.4 [redacted]. The resident did not know how frequently the Ex Order 26.4B1 was change by the facility staff. On that same date at 11:06 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident wore Ex Orde, did not put it on himself/herself and the staff would put the Ex Orde on for the resident. The CNA further stated that the resident's nurse would adjust the amount of Ex Orde for the resident. The CNA stated that she made sure the residents head was elevated when she provided care, but she never	F 695		

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F 695	Continued From page 6 touched the [Ex Orde] because it was the nurse's responsibility to do so. On that same date at 11:19 AM, the surveyor entered the resident's room with the resident's Licensed Practical Nurse (LPN#1). The resident was observed wearing the [Ex Order 26.4B1] that was previously observed in direct contact with the [Ex Orde] [Ex Order 26.4B1] in his/her nares. The surveyor and the LPN#1 observed that the resident's [Ex Orde] was flowing at [NJ Exec] [Ex Order 26.4B1]. The surveyor and LPN#1 exited the resident's room. At that time, the surveyor interviewed the LPN#1 who stated that the resident would turn on the [NJ Exec Order 26] by himself/herself. The LPN#1 further stated that the Physician's Order (PO) for the [Ex Orde] should be followed when a resident was using [NJ Exec Order 26]. The LPN#1 stated that "a zip lock bag that shuts should be placed next to the [Ex Orde] [Ex Order 26.4B1] so the [NJ Exec Order 2] could be placed inside to keep the [Ex Order 26.4B1] clean." The LPN#1 further stated that the facility process was to change out the [Ex Order 26.4B1] weekly on Sunday night shift and the [Ex Order 26.4B1] should always be dated and labeled. The LPN#1 could not speak to if the there was a PO for dating and labeling the [Ex Order 26.4B1]. The surveyor reviewed the medical record for Resident #19. A review of the resident's Admission Record (an Admission Summary) reflected that the resident had resided at the facility for [NJ Ex.Order 26.4(b)(1)] and had diagnoses which included but were not limited to [Ex Order 26.4B1].	F 695		

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F 695	Continued From page 7	F 695		

A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated Ex Order 26.4B1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of Ex Orde out of 15 which indicated the resident was Ex Order 26.4B1.

A review of the resident's NJ Exec Order 26.4b1 electronic Medication Review Report (MRR) reflected a PO dated Ex Order 26.4B1, to apply Ex Orde via NJ Exec Order 26.4b1 at Ex Order 26.4B1 and to NJ Exec Orde down the Ex Orde with a Ex Order 26.4B1 as needed to maintain an NJ Exec Order 26.4b1 every shift for Ex Order 26.4B1) and Ex Order 26.4B1

A review of the resident's NJ Exec Order 26.4b1 electronic Medication Administration Record (eMAR) reflected that the nurses signed that the resident was administered the Ex Orde via NJ Exec Order 26.4b1 at Ex Order 26.4B1 and to NJ Exec Orde down the Ex Orde with a Ex Order 26.4B Ex Order 26.4B1 as needed to maintain an Ex Order 26.4B1 NJ Exec Order 26.4b1 on the night shift starting on Ex Order 26.4B1 and the day and night shifts throughout the rest of the month of Ex Order 26.4B1.

A review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses signed that the resident was administered the Ex Orde via NJ Exec Order 26.4b1 at Ex Order 26.4B1 and to NJ Exec Orde down the Ex Orde with a Ex Order 26.4 Ex Order 26.4B1 as needed to maintain an Ex Order 26.4B1 Ex Order 26.4B1NJ Exec Order 26.4b1 on the day and night shifts from NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 and on the day shift on NJ Exec Order 26.4b1.

A review of the resident's Care Plan (CP) revised on NJ Exec Order 26.4, reflected a focus area that the resident had Ex Order 26.4B1 related to Ex Order 26.4B1 NJ Exec Order 26.4 The goal of the resident's CP was the

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F 695	Continued From page 8 resident would show no signs and symptoms of [redacted] through the review date. The interventions for the resident's CP indicated to apply [redacted] via [redacted] at [redacted] and to [redacted] down the [redacted] with a [redacted] as needed to maintain an [redacted] On 2/14/22 at 12:03 PM, the surveyor conducted a follow up interview with the resident's LPN#1 who stated that the resident's [redacted] order was to [redacted] the [redacted] to [redacted] as needed. The LPN#1 looked at the [redacted] in the presence of the surveyor and stated that the [redacted] did not go up to [redacted]. On 2/14/22 at 12:47 PM, the surveyor interviewed the facility's Advanced Practitioner Nurse (APN) who stated that last month the resident had [redacted] and a [redacted]. The APN stated that the resident refused to go to the hospital, so he/she was placed on a [redacted] for [redacted] and the nursing staff was to [redacted] the resident's [redacted] to maintain an [redacted] The APN further stated that the resident would request the [redacted] for [redacted] The APN stated that the PO for the [redacted] should have been updated to reflect the residents current need for [redacted], she was unaware of how frequently resident's [redacted] should be change, and the [redacted] should be changed anytime that it was contaminated. On 2/17/22 at 1:35 PM, the surveyor interviewed the Director of Nursing (DON) who stated that there should be a PO for labeling and dating [redacted] and [redacted] should be kept in a bag when not in use to minimize the spread of infections.	F 695		

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F 695	Continued From page 9 A review of the facility's Oxygen Administration Policy and Procedure revised 12/2021 indicated, "Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." 2). On 2/14/22 9:49 AM, the surveyor observed Resident #139 lying in bed with the head of the bed elevated. The surveyor observed that the resident had a Ex Order 26.4B1 . The resident was NJ Exec O and smiled at the surveyor. On 2/15/22 at 11:00 AM, the surveyor observed the LPN #2 perform Ex Order 26.4B1 care in the presence of the Assistant Director of Nursing (ADON). The LPN#2 did not listen to the resident's NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 prior to performing Ex Order 26.4B1 care. The surveyor observed the LPN#2 place a clear trash bag on the foot of the resident's bed, gather supplies, and clean the resident's overbed table. The surveyor further observed the LPN remove the Ex Order 26.4B1 that provided Ex Order 26.4B1 and Ex Orde to the resident. At that time, Resident #139 Ex Order 26.4B1 and Ex Order 26.4B1 of Ex Order 26.4B1 . At that time, the surveyor observed the resident's Ex Order NJ Exec Order 26.4b1 The LPN#2 took her gloved hand, a NJ Exec Order 26.4b1 and pulled the Ex Order 26.4B1 Ex Order 26.4B1 out of the resident's Ex Order 26.4B1 without NJ Exec Order 26.4b1 the resident. The ADON reapplied the Ex Orde and Ex Order 26.4B1 to the resident's Ex Order 26.4B1 area and the resident's Ex Order 26.4B1 NJ Exec Order 26.4b1 At 1:30 PM, the surveyor interviewed the LPN#2	F 695		

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F 695	Continued From page 10	F 695		

who stated that she did not think the resident needed to be [redacted] prior to performing [redacted] care or listen to the resident's [redacted] sounds because "the resident was [redacted] earlier around 9 AM or 9:20 AM. I should have listened to the [redacted] sounds. If I had listened to his/her [redacted] sounds, maybe, I would have [redacted] him/her." LPN#2 further stated the resident is [redacted] on a as needed basis. The LPN#2 did not speak to what type of evaluation or care would be required when the resident presented with signs and symptoms of [redacted] during care.

A review of the resident's Admission Record reflected Resident #139 resided at the facility for [redacted] and had diagnoses which included but were not limited to [redacted]

A review of the quarterly MDS dated [redacted] reflected that the resident's [redacted] for [redacted] were [redacted].

A review of the resident's [redacted] electronic MRR reflected a PO dated [redacted], for [redacted] care every shift and as needed.

A review of the resident's [redacted] electronic Treatment Administration Record (eTAR) reflected that the nurses were signing on

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F 695	Continued From page 11 the day and night shifts that Ex Order 26.4B1 care was performed. A review of the residents CP dated Ex Order 26.4B1 reflected a focus area that the resident had a Ex Order 26.4B1. The goal of the resident's CP indicated the resident would have clear and equal NJ Exec Order 26.4b1 Ex Order 26.4B1 through the review date. Interventions for the resident included to NJ Exec Order 26 the resident as necessary. According to the facility's Tracheostomy Policy revised 07/2021, indicated that the need for suctioning was first to be established by evaluating the resident's breath sounds, respiratory rate and pulse oximetry (a test used to measure the oxygen level in the blood). NJAC 8:39-19.4(a);27.1(a)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by clarifying physician orders and adjusting medication times of administration to accommodate for Ex Order 26.4B1 scheduled times. This deficient practice was identified for 2 of 5 residents reviewed for	F 698	F698 Ex Order 26.4B1 1.Residents #22 and #31 medications were adjusted to reflect Ex Order 26.4B1 times. MD was notified.	3/11/22

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 698	Continued From page 12 Ex Order 26.4B1 (Resident #22 and #31), and was evidenced by the following: REFER TO F 756 Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 2/9/22 at 11:55 AM, the surveyor interviewed the RN#1 who stated that Resident #31 was out of the facility at Ex Order 26.4B1 (a Ex Order 26.4B1). The RN#1 added that the resident was NJ Exec Ord and NJ Exec Order 26.4b and was picked up for Ex Order 26.4B1 by 10 AM	F 698	2. All residents on dialysis have the potential to be affected. 3. Director of nursing(DON) immediately in-serviced all nurses on medication timing for residents on dialysis. 4. Assistant director of nursing (ADON) will audit 2 residents on dialysis re medication timing weekly for 4 weeks and then once a month for 2 months. DON will review findings, and present findings at next quarterly QAPI meeting.	

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F 698	Continued From page 13 on Monday, Wednesday and Friday and returned to the facility approximately 3 PM. The surveyor reviewed the medical record for Resident #31. A review of an admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident had an [redacted]. A review of the resident's Admission Record revealed a diagnosis of [redacted]. A review of the resident's interdisciplinary care plan (IDCP) revealed that the resident needs [redacted] due to [redacted] with an initiated and revision date of [redacted]). A review of the [redacted] Communication Forms dated [redacted] and [redacted] that were completed by the facility and [redacted] center indicated that the resident had received [redacted]. A review of the Medication Review Report reflected a physician's order (PO) dated [redacted] for "[redacted] M-W-F chair time 10:30 AM." A review of the [redacted] electronic medication administration record (eMAR) revealed three PO's for [redacted]	F 698		

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F 698	Continued From page 14 [redacted]) as follows: The first PO had a start date of [redacted] for [redacted], give [redacted] for [redacted] give with meals at specific time on [redacted] days" with a discontinuation date of [redacted] The eMAR reflected that on [redacted] at 8 AM the [redacted] was not administered. A review of the corresponding nursing electronic progress note (EPN) dated [redacted] at 9:51 AM indicated "duplicate" for the [redacted] The second PO had a start date of [redacted] for '[redacted] give one tablet by mouth three times a day every Mon, Wed, Fri for [redacted], give with meals at specific time on [redacted] days." The eMAR was blocked off so that signatures for administration were allowed on only [redacted] days. The eMAR reflected that on [redacted] (a [redacted] day) at 12 NOON a code #1 was noted for administration of [redacted] indicated that the medication was not administered because "1=Absent from home without meds." The third PO had a start date of [redacted] for [redacted], give one tablet by mouth three times a day for [redacted], give with meals three times a day on [redacted] days Tue-Thurs-Sat-Sun." The eMAR was not blocked off and allowed signatures for administration on [redacted] days as well as [redacted] days. The eMAR reflected that on [redacted] (a [redacted] day) at 12 NOON a code #9 was noted for the administration of [redacted] indicating that the medication was not administered because "9=other/see progress notes."	F 698		

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F 698	Continued From page 15 A review of the corresponding nursing electronic progress note dated [redacted] indicated that the reason the medication was not administered was '[redacted] Further review of the eMAR, revealed that on [redacted] and [redacted] ([redacted] days), the [redacted] was signed as administered at 8 AM for the [redacted] PO for [redacted] days, in addition to the [redacted] PO for [redacted] days. This reflected that [redacted] were administered at [redacted], which had not corresponded with the PO. In addition, the eMAR reflected that on [redacted] ([redacted]) the [redacted] was administered at 12 NOON (a time when the resident was out of the facility at the [redacted]) and signed by the Registered Nurse (RN#1) for the [redacted] PO for [redacted] days. On 2/14/22 at 12:26 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone who stated that she does make recommendations to adjust medications to accommodate [redacted] times. The CP stated that the nurses should know that any resident who had to go out for [redacted] had to have their medication times reviewed and adjusted to accommodate the resident being out of the facility. The CP added that the nurses would call the physician to clarify orders for the times of administration depending on the medication. The CP stated that she does a monthly drug regimen review and had entries electronically and sends a finalized report to the DON. The CP had not completed a review for February yet. A review of the CP Impact Review for Resident	F 698		

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F 698	Continued From page 16 #31 dated [redacted] reflected to administer on [redacted] days [redacted]) (another medication used to prevent [redacted] in the [redacted] for people who are on [redacted] due to [redacted]) at 8 am, 12 pm and when the resident returns from [redacted] and has dinner. On 2/15/22 at 10:40 AM, the surveyor interviewed Resident #31. The resident stated that on Monday, Wednesday, and Friday she was usually picked up by 10 AM to go to [redacted] and returned to the facility at approximately 3 PM. The resident stated that he/she has been here a couple of weeks and was familiar with the facility because he/she had been here once before but had gone home. The resident stated that the nurses brought his/her medications but was unable to say which medications he/she received. The resident stated that she thought sometimes his/her medications were late but was unable to specify which medications and at what time. On 2/15/22 at 11:19 AM, the surveyor interviewed the RN#1 who stated that Resident #31 had been on the [redacted] floor when admitted and that she had administered medications to the resident. The RN#1 added that she had [redacted] and had been working on the unit for approximately a [redacted] The surveyor with the RN#1 reviewed the [redacted] eMAR and the RN#1 acknowledged her signature on the eMAR for the administration of [redacted] for the dates of [redacted]). The RN#1 also acknowledged that she had signed for the administration of [redacted] on [redacted] and [redacted] at 8 AM for the PO for [redacted] days and for [redacted] days. The RN#1 stated that she thought on [redacted] days she was to administer two [redacted] of [redacted]. The RN#1 was unable to speak to the entry of the	F 698		

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F 698	Continued From page 17 [redacted] PO on [redacted] and [redacted] days and thought she was following the PO. In addition, the RN#1 stated that she signed for the [redacted] on [redacted] (a [redacted] day) at 12 PM because she thought the resident was possibly picked up late and administered the medication one hour before with a snack. The RN#1 could not speak to why she was signing the PO for a [redacted] when it was a [redacted] day. 02/15/22 10:54 AM, the surveyor interviewed the RN#2 who stated that she currently administered medications to Resident #31 because the resident had been transferred to her floor and that the resident was [redacted]. The RN #2 stated that she administered the resident's medications before [redacted] which included one [redacted] and then another [redacted] when the resident returned from [redacted]. The RN#2 stated that on [redacted] days the times were different because the resident was in the facility for breakfast, lunch, and dinner when the [redacted] was supposed to be administered. The RN#2 stated that the medications were supposed to be adjusted to accommodate the resident being out to [redacted]. The RN#2 could not speak to the entry of the [redacted] PO for [redacted] and [redacted] days. On 2/15/2022 at 1:27 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review the findings of the [redacted] administration for Resident #31. On 2/16/22 at 1:21 PM, the survey team met with the LNHA and DON. The DON stated that the [redacted] PO needed to be clarified and whichever	F 698		

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F 698	Continued From page 18 nurse had taken the PO should have clarified the PO. The DON acknowledged that the [redacted] PO was not clarified and inaccurately being documented for administration of the medication. The DON added that the nurses were expected to review with the physician all medication orders and accommodate for the times the resident was out to [redacted] and clarify for [redacted] days and [redacted] days. On 2/17/2022 at 1:33 PM, the survey team met with the LNHA and DON. The LNHA acknowledged that the medications were not accurately adjusted to accommodate Ex Order 26.4B1 times. The DON stated that Resident #31 when first admitted had a different medication ([redacted]) plotted correctly to allow for [redacted] times and then there was a change in the medication to [redacted] The DON stated that the nurses should follow a PO and clarify the PO if necessary. A review of the facility policy dated as revised 12/2021 for "Administering Medications" reflected that medications are to be administered in a timely manner as prescribed. Further review reflected that medications are to be administered within 1 hour of the prescribed time or at a specified prescribed time which included before a meal or after a meal. In addition, the individual administering the medication must check the label three times to verify the right time before giving a medication. 2. On 2/11/22 at 9:53 AM, the surveyor observed Resident #22 self-propel in his/her wheelchair into his/her private room. The resident stated that he/she was going to Ex Order 26.4B1 today (Friday), was usually was picked up to leave around 1:00 PM and would return to the facility around 6:00 PM.	F 698		

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F 698	Continued From page 19 The surveyor reviewed the medical record for Resident #22. A review of the resident's Admission Record (an Admission Summary) reflected that the resident was admitted to the facility in [redacted], and had diagnoses which included but were not limited to [redacted] A review of the resident's admission MDS dated [redacted] reflected that the resident's BIMS was [redacted] out of 15 which indicated the resident had [redacted]. A further review of the resident's MDS, Section O - Special Treatments indicated that the resident received [redacted] treatments. A review of the [redacted] electronic medication review report (eMRR) reflected a PO dated [redacted], give two capsules by mouth with meals for [redacted] Give at 0800 (8:00 AM), 1200 PM, 1700 (5:00 PM) on [redacted] days Tuesday, Thursday, and Sunday. Then at 8:00 AM, 12:00 PM, and 1900 (7:00 PM) on [redacted] days Monday, Wednesday, Friday. A review of the [redacted] electronic medication administration record (eMAR) indicated that the nurses were signing that the resident was receiving the [redacted] two capsules at 5:00 PM on Mondays, Wednesdays, and Fridays from [redacted] through [redacted] A further review of the [redacted]	F 698		

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F 698	Continued From page 20 eMAR did not reflect that the [redacted] was plotted to be administered to the resident at 7:00 PM as the PO specified. A review of the [NJ Exec Order 26.4b1] eMAR revealed that the nurses were signing that the resident was receiving the [redacted] two capsules at 5:00 PM on Mondays, Wednesdays, and Fridays from [NJ Exec Order 26.4] through [NJ Exec Order 26.4]. A further review of the [NJ Exec Order 26.4b1] eMAR did not reflect that the [redacted] was plotted to be administered to the resident at 7:00 PM as the PO specified. A review of the resident's Care Plan (CP) revised on [NJ Exec Order 26.4b], reflected a focus area that the resident required [redacted] related to [redacted] and received [redacted] services on Monday, Wednesday, and Friday at 2:30 PM. The goal of the resident's [redacted] CP indicated that the resident would have immediate intervention should any signs and symptoms of complications from [Ex Order 26.4B1] through the next review date. The interventions for the resident's CP included to encourage the resident to go to scheduled [Ex Order 26.4B1] appointments and to monitor labs and report to the doctor as needed. The resident's [Ex Order 26.4B1] CP did not reflect that the resident's medications should be plotted according to his/her [Ex Order 26.4B1] schedule. On 2/16/22 at 10:57 AM, the surveyor interviewed the residents Certified Nursing Aide (CNA) who stated that the resident was alert to person, place, and time, and could make his/her needs known. The CNA further stated that the resident went to [Ex Order 26.4B1] three times weekly on Monday's, Wednesday's, and Friday's and was picked up between 1:00 PM to 1:30 PM for transport to the	F 698		

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F 698	Continued From page 21 Ex Order 26.4B1 center. The CNA further stated that regardless of what time the resident was placed on the Ex Order 26.4B1 machine he/she demanded to be taken off the Ex Order 26.4B1 machine at 6:00 PM and would arrive back to the facility anywhere from 6:15 PM to 6:45 PM. On 2/16/22 at 11:06 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident went to Ex Order 26.4B1 on Monday's, Wednesday's, and Friday's and left the facility around 2:00 PM. The LPN further stated that the resident would return to the facility around 6:45 PM to 7:00 PM. The LPN stated that the resident's medications should be plotted according to the resident's Ex Order 26.4B1 schedule so the resident could receive their medications on time and when they were in the facility. The surveyor reviewed the eMAR in the presence of the LPN who stated that the Ex Order 26.4B1 medication should have been plotted according to the resident's Ex Order 26.4B1 schedule and administered with food for it to work effectively for the resident. On 2/17/22 at 1:35 PM, the Administrator stated that the resident's medications should have been plotted according to their Ex Order 26.4B1 schedule. A review of the facility's Care of Patients on Dialysis Policy and Procedure reviewed 07/21 indicated, "Ensure that medication times correspond with dialysis schedule." The facility's Care of Patients on Dialysis Policy and Procedure further revealed that medications were to be adjusted for dialysis times as ordered by the physician. NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)	F 698		

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F 755	Continued From page 22	F 755		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services to ensure that	F 755	F755Pharmacy F755 Serves/Procedures/Pharmacist/Records	3/11/22

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F 755	Continued From page 23 acceptable professional standards of clinical practice were followed for medication administration in accordance with a Physician's Order (PO) to hold a medication ([redacted] according to NJ Exec Order 26.4b1 [redacted] from [redacted] until surveyor inquiry [redacted] This deficient practice was identified for 1 of 6 residents reviewed for medication administration, (Resident #132) and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 2/11/22 at 8:25 AM, the surveyor observed the	F 755	1. MD notified regarding resident #132,new Orders implemented. 2. All residents with medication with parameters have the ability to be affected. 3. All nurses immediately in-serviced by Director of nursing (DON) on requirement of medications being administered within parameters. 4. Assistant director of nursing (ADON) will review 3 residents with parameters weekly for 4 weeks, and then once a month for 2 months. DON will review findings of ADON, audit one resident monthly for 3-month, and bring findings to next quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 755	Continued From page 24	F 755		

Licensed Practical Nurse (LPN#1) preparing to administer medications to Resident #132. The LPN#1 stated that she had already obtained the resident's [redacted] which had a result of a [redacted] of [redacted] over a [redacted] of [redacted] The LPN#1 then stated that she was not going to administer the [redacted] because the physician's order (PO) indicated to hold the [redacted] if the [redacted].

The surveyor reviewed the medical record for Resident #132.

A review of the resident's quarterly Minimum Data Set (MDS) (an assessment tool used to facilitate the management of care), dated [redacted] reflected that the resident was admitted on [redacted] and had diagnoses which include [redacted]

Further review of the MDS, reflected that a brief interview for mental status (BIMS) could not be obtained. The staff performed a [redacted] assessment which reflected that the resident had a [redacted].

A review of the [redacted] Medication Review Report reflected a PO with a start date of [redacted] for [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 755	Continued From page 25 In addition, there was another PO with a start date of [redacted] for [redacted], NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 electronic medication administration records (EMAR) for Resident #132 revealed that the [redacted] had been administered for [redacted] results that were NJ Exec Order 26.4b1. The EMAR indicated administration of a medication with a check mark and nurses initials. TheNJ Exec Order 26.4b1 EMAR revealed 14 of 90 doses that were inaccurately administered according to the PO. The following were the dates and times with the corresponding [redacted] on [redacted] at 9 AM for a [redacted]. on [redacted] at 2 PM for a [redacted]. on [redacted] at 8 AM for a [redacted]. on [redacted] at 4 PM for a [redacted]. on [redacted] at 10 PM for a [redacted]. on [redacted] at 9 PM for a [redacted]. on [redacted] at 8 AM for a [redacted]. on [redacted] at 4 PM for a [redacted]. on [redacted] at 8 AM for a [redacted]. on [redacted] at 9 PM for a [redacted]. on [redacted] at 8 AM for a [redacted]. on [redacted] at 9 PM for a [redacted]. on [redacted] at 8 AM for a [redacted]. on [redacted] at 4 PM for a [redacted]. The NJ Exec Order 26.4b1 EMAR revealed 6 of 93 doses that were inaccurately administered	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 26	F 755		

according to the PO. The following were the dates and times with the corresponding NJ Exec Or [redacted]

on NJ Exec Order 26.4b1 at 4 PM for a NJ Exec Order 26.4b1
on NJ Exec Order 26.4b1 at 4 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 8 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 4 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 10 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 10 PM for a NJ Exec Order 26.4b1.

The NJ Exec Order 26.4b1 EMAR revealed 12 of 93 doses that were inaccurately administered according to the PO. The following were the dates and times with the NJ Exec Order 26.4b1 [redacted]:

on NJ Exec Order 26.4b1 at 10 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 9AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 2 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 9 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 2 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 8AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 10 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 9 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 2 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 4 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 9 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 4 PM for a NJ Exec Order 26.4b1.

The NJ Exec Order 26.4b1 EMAR revealed 6 of 31 doses that were inaccurately administered according to the PO. The following were the dates and times with the corresponding NJ Exec Order 26.4b1 [redacted]

on NJ Exec Order 26.4b1 at 10 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 8 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 4 PM for a NJ Exec Order 26.4b1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 755	Continued From page 27 on [redacted] at 8 AM for a [redacted]. on [redacted] at 4 PM for a [redacted]. on [redacted] at 9AM for a [redacted]. On 2/15/22 at 11:12 AM, the surveyor interviewed LPN#2 who stated that a check mark on the EMAR meant that a medication was administered, and the nurse's initials were also indicated. The surveyor with the LPN#2 reviewed the EMAR for the [redacted] PO. The LPN#2 stated that according to the PO if the [redacted] was greater than 120 then the [redacted] was to be held. The LPN#2 reviewed a [redacted] on the EMAR for 136 that had a check mark indicating that the medication was administered and stated that the medication should have been held. The LPN#2 added that there was a code number instead of a check mark that the nurses would enter in the EMAR indicating that a medication was held due to being outside the parameters for administration. The LPN#2 could not speak to the dates of [redacted] and [redacted] that had her initials for corresponding [redacted] of [redacted] and [redacted] On 2/16/22 at 11:24 AM, the surveyor with the LPN#3 reviewed the EMAR for Resident #132 for the [redacted] PO. The LPN#3 stated that the check mark indicated that the medication was administered. The LPN#3 added that the nurses were to read a PO and follow the PO. The surveyor with LPN#3 reviewed the EMAR for the dates of: - [redacted] at 9 am and 2 PM that had [redacted], - [redacted] at 9 AM that had [redacted] and - [redacted] at 8 AM and 4 PM that had [redacted]	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 755	Continued From page 28 The LPN#3 acknowledged that aforementioned dates and times were her initials for the administration of [redacted]. The LPN#3 stated that she should have held the medication. Further review of the resident's EMAR revealed that all the dates listed above had a check mark and there were no code numbers entered that corresponded to the medication being held. On 2/16/22 at 1:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to review the findings of the administration of the [redacted] for Resident #132. On 2/17/22 at 10:20 AM, the surveyor interviewed the LPN#1 who stated that she had administered medications to Resident #132 on [redacted] and had followed the PO to hold the [redacted] for a [redacted] The LPN#1 could not speak to her initials for the administration of [redacted] on [redacted]. On 2/17/22 at 1:33 PM, the survey team met with the LNHA and the DON who acknowledged that the [redacted] had been administered outside of the parameters indicated in the PO. The DON stated that the nurses should follow a PO and clarify the order if necessary. The DON added that the physician was notified and the [redacted] PO was being changed. A review of the facility policy, "Administering Medications" dated as revised 12/2021 reflected that medications shall be administered as prescribed and in accordance with all orders. In addition, the individual administering the medication must check the label three times to	F 755		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 29 verify the right medication and the right method of administration before giving the medication. REFER to F756	F 755		
F 756 SS=E	NJAC 8:39- 11.2(b), 29.2(a)(d), 29.3(6) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756		3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 756	Continued From page 30 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that the Consultant Pharmacist recommendations were acted upon in a timely manner regarding a.) the use of a medication to treat NJ Exec Order 26.4b1 ( ) was identified to not be administered in accordance with the physician prescribed hold parameters for a period of four (4) months and b.) a medication for a resident who went to Ex Order 26.4B1 was plotted according to the resident's Ex Order 26.4B1 schedule. This deficient practice was identified for 2 of 5 residents reviewed for Consultant Pharmacist reviews (Resident #132 and Resident #22) and was evidenced by the following: REFER TO F 755 REFER TO F 698 1. On 2/11/22 at 8:25 AM, the surveyor observed the Licensed Practical Nurse (LPN#1) preparing to administer medications to Resident #132. The LPN#1 stated that she had already obtained the resident's NJ Exec Order 26.4b1 which had a result of a NJ Exec Order 26.4b1 over a NJ Exec Order 26.4b1	F 756	F756 Drug Regimen Review, Report Irregular, Act On 1. Pharmacy Consultant immediately audited all charts to ensure any recommendations were implemented. 2. All residents have the potential to be affected 3. DON and ADON were immediately in-serviced by regional DON on requirement of implementation of pharmacy consultant report. 4. Regional DON will audit 5 items in the monthly report for 3 months. Regional DON will review the findings, and present at next quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 31 NJ Exec Orde The LPN#1 then stated that she was not going to administer the [redacted]) because the physician's order (PO) indicated to hold the [redacted] if the NJ Exec Order 26.4b1 Ex Order 26 The surveyor reviewed the medical record for Resident #132. A review of the resident's quarterly Minimum Data Set (MDS) (an assessment tool used to facilitate the management of care), dated Ex Order 26.4B1 reflected that the resident was admitted on [redacted] and had diagnoses which included [redacted] Further review of the MDS, reflected that a brief interview for mental status (BIMS) could not be obtained. The staff performed a [redacted] assessment which reflected that the resident had a NJ Exec Order 26.4b1 [redacted] with a Ex Order 26.4B1 [redacted]. A review of the February Medication Review Report reflected a PO with a start date of [redacted] for '[redacted] give [redacted] by mouth three times a day (TID) every Monday, Wednesday, Friday for [redacted] Hold for [redacted]." In addition, there was another PO with a start date of Ex Order 26.4B1 for '[redacted], [redacted] times a day (TID) every Tuesday, Thursday, Saturday, Sunday for [redacted], NJ Exec Order 26.4b1 [redacted] Ex Order 2 ". A review of the Ex Order 26.4B1 [redacted]	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 32	F 756		

Ex Order 26.4B1 electronic medication administration records (EMAR) for Resident #132 revealed that the [redacted] had been administered for [redacted] results that were [redacted]. The EMAR indicated administration of a medication with a check mark and nurses initials.

The Ex Order 26.4B1 EMAR revealed [redacted] doses that were not administered according to the PO. The following were the dates and times with the corresponding [redacted] results that were greater than [redacted]

on [redacted] at 9 AM for a [redacted].
on [redacted] at 2 PM for a [redacted].
on [redacted] at 8 AM for a [redacted].
on [redacted] at 4 PM for a [redacted].
on [redacted] at 10 PM for a [redacted].
on [redacted] at 9 PM for a [redacted].
on [redacted] at 8 AM for a [redacted].
on [redacted] at 4 PM for a [redacted].
on [redacted] at 8 AM for a [redacted].
on [redacted] at 9 PM for a [redacted].
on [redacted] at 8 AM for a [redacted].
on [redacted] at 9 PM for a [redacted].
on [redacted] at 8 AM for a [redacted].
on [redacted] at 4 PM for a [redacted].

The Ex Order 26.4B1 EMAR revealed [redacted] doses that were not administered according to the PO. The following were the dates and times with the corresponding [redacted] results that were [redacted]

on [redacted] at 4 PM for a [redacted].
on [redacted] at 4 PM for a [redacted].
on [redacted] at 8 AM for a [redacted].
on [redacted] at 4 PM for a [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 33	F 756		

on NJ Exec Order 26.4b1 at 10 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4b1 at 10 PM for a NJ Exec Order 26.4b1.

The Ex Order 26.4B1 EMAR revealed Ex Order 26.4B1 doses that were not administered according to the PO. The following were the dates and times with the corresponding NJ Exec O results that were NJ Exec Order 26.4b1 Ex Order 26

on NJ Exec Order 2 at 10 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 2 at 9AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 2 at 2 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 2 at 9 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 2 at 2 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4 at 8AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4 at 10 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4 at 9 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4 at 2 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4 at 4 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4 at 9 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4 at 4 PM for a NJ Exec Order 26.4b1.

The Ex Order 26.4B1 EMAR revealed Ex Order 26.4B1 doses that were not administered according to the PO. The following were the dates and times with the corresponding NJ Exec O results that were NJ Exec Order 26.4b1 Ex Order 26

on NJ Exec Order 2 at 10 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 2 at 8 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 2 at 4 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 2 at 8 AM for a NJ Exec Order 26.4b1.
on NJ Exec Order 2 at 4 PM for a NJ Exec Order 26.4b1.
on NJ Exec Order 26.4 at 9AM for a NJ Exec Order 26.4b1.

On 2/14/22 at 12:26 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone who stated that she does a monthly drug regimen review and had entries electronically and sends a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 34 finalized report to the Director of Nursing (DON). The CP stated that she had not completed a review for [NJ Exec Order 26.4b1] yet. A review of the Monthly Consultant Pharmacist Report provided by the DON indicated that the report included CP activities between [NJ Exec Order 26] and [NJ Exec Order 26.4b] revealed that there were no recommendations made for Resident #132. A review of the Monthly Consultant Pharmacist Report provided by the DON indicated that the report included CP activities between [NJ Exec Order 26.] and [NJ Exec Order 26.4b] revealed a recommendation for Resident #132 to nursing services [redacted] should have been held a few times for [NJ Exec Or] [redacted] [Ex Order 26.] A review of the Monthly Consultant Pharmacist Report provided by the DON indicated that the report included CP activities between [NJ Exec Order] and [NJ Exec Order 26.] revealed a recommendation for Resident #132 to nursing services [redacted] should have been held several times [NJ Exec Order 26.4b1] [Ex Order 26] please speak with nurses." On 2/15/22 at 11:12 AM, the surveyor interviewed LPN#2 who stated that a check mark on the EMAR meant that a medication was administered, and the nurse's initials were also indicated. The surveyor with the LPN#2 reviewed the EMAR for the [redacted] PO. The LPN#2 stated that according to the PO if the [NJ Exec Order 26.4b1] [redacted] then the [redacted] was to be held. The LPN#2 reviewed a [NJ Exec Order 26.4b1] on the EMAR for [NJ Exec O] that had a check mark indicating that the medication was administered and stated that the medication should have been held. The LPN#2 added that there was a code	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 35	F 756		

number instead of a check mark that the nurses would enter in the EMAR indicating that a medication was held due to being outside the parameters for administration. The LPN#2 could not speak to the dates of [NJ Exec Order 26.4b] and [NJ Exec Order 26.4] that had her initials for corresponding [NJ Exec Or] of [Ex Order 2] and [Ex Order 26]

On 2/16/22 at 11:24 AM, the surveyor with the LPN#3 reviewed the EMAR for Resident #132 for the [redacted] PO. The LPN#3 stated that the check mark indicated that the medication was administered. The LPN#3 added that the nurses were to read a PO and follow the PO. The surveyor with LPN#3 reviewed the EMAR for the dates of; [NJ Exec Order 26.4] at 9 am and 2 PM that had [NJ Exec Or] results of [Ex Order 26], [NJ Exec Order 26.4] at 9 AM that had [NJ Exec Or] results of [Ex Order 26] and [NJ Exec Order 26] at 8 AM and 4 PM that had [NJ Exec Or] results of [Ex Order]. The LPN#3 acknowledged that those dates and times were her initials for the administration of [redacted] The LPN#3 stated that she should have held the medication.

Another review of the resident's EMAR revealed that all the dates listed above had a check mark and there were no code numbers entered that corresponded to the medication being held.

On 2/16/22 at 1:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to review the findings of the administration of the [redacted] for Resident #132.

On 2/17/22 at 10:20 AM, the surveyor interviewed the LPN#1 who stated that she had administered medications to Resident #132 on [NJ Exec Order 26.] and had followed the PO to hold the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 756	Continued From page 36 [redacted] The LPN#1 could not speak to her initials for the administration of [redacted] On 2/17/22 at 1:33 PM, the survey team met with the LNHA and the DON who acknowledged that the [redacted] had been administered outside of the parameters indicated in the PO. The LNHA stated that a Quality Assurance Performance Improvement (QAPI) was started. The LNHA stated that there was no policy regarding the procedure for the CP reports. The DON stated that the nurses should follow a PO and clarify the order if necessary. The DON added that the physician was notified and the [redacted] PO was being changed. The DON stated that he was responsible for reviewing the CP reports and following up on recommendations. The DON stated that he tries to do the CP reports as soon as he gets them and complete them usually in a week. The DON added that the CP usually notifies him of a medication error and he would speak with the nurses about the error. The DON had not provided any follow up that was completed for the CP recommendations from [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1. 2. On 2/11/22 at 9:53 AM, the surveyor observed Resident #22 self-propel in his/her wheelchair into his/her private room. The resident stated that he/she was going to [redacted] Ex Order 28.4B1 today (Friday), usually was picked up to leave around 1:00 PM and would return to the facility around 6:00 PM. The surveyor reviewed the medical record for Resident #22. A review of the resident's Admission Record (an Admission Summary) reflected that the resident	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 756	Continued From page 37 was admitted to the facility in [redacted], and had diagnoses which included but were not limited to [redacted]. A review of the resident's admission MDS dated [redacted], reflected that the resident's BIMS was [redacted] out of 15 which indicated the resident had [redacted]. A further review of the resident's MDS, Section O - Special Treatments indicated that the resident received [redacted] treatments. A review of the [redacted] electronic medication review report (EMRR) reflected a PO dated [redacted], capsules by mouth with meals for [redacted] Give at [redacted] (8:00 AM), 1200 PM, 1700 (5:00 PM) on [redacted] days Tuesday, Thursday, and Sunday. Then at 8:00 AM, 12:00 PM, and 1900 (7:00 PM) on [redacted] days Monday, Wednesday, Friday. A review of the [redacted] EMAR indicated that the nurses were signing that the resident was receiving the [redacted], two capsules at 5:00 PM on Mondays, Wednesdays, and Fridays from [redacted] through [redacted]. A further review of the [redacted] EMAR did not reflect that the [redacted] was plotted to be administered to the resident at 7:00 PM as the PO specified. A review of the [redacted] EMAR revealed that the nurses were signing that the resident was	F 756		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

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756	Continued From page 38 receiving the Ex Order 26.4B1 NJ Exec, capsules at 5:00 PM on Mondays, Wednesdays, and Fridays from NJ Exec Order 26. through NJ Exec Order 26.4B.	F 756		

A review of the Ex Order 26.4B1 monthly Consultant Pharmacist Report provided by the DON indicated that the report included activities between NJ Exec Order and NJ Exec Order 26.I revealed a recommendation for Resident #22 to nursing services, Ex Order 26.4B1 give 8 12 5 Ex Order 26.4B1 days and 8 12 and when returns from Ex Order 26.4B1 on Ex Order 26.4B1 days."

On 02/17/22 at 10:26 AM, the surveyor interviewed LPN#4 who stated that the CP would come to the facility to review the resident's medications. LPN#4 was unsure of how frequently the CP came to the facility or whose responsibility it was to follow through with the CP recommendations.

On 02/17/22 at 11:00 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the CP reviewed the resident's medications monthly, made recommendations in writing and would speak to staff when irregularities were identified. The ADON stated that the DON and Administrator were responsible for completing the CP recommendations by placing a call to the resident's physician, reviewing the recommendation with the physician, and make changes to the resident's medication regimen based off the physician's order.

On 02/17/22 at 12:09 PM, the surveyor interviewed the DON who stated that the CP came monthly to the facility to review the resident's medications. The DON further stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 756	Continued From page 39	F 756		

that the CP would e-mail a report of recommendations to him and the ADON and the two of them would collaborate to complete the report. The DON stated that he and the ADON would go unit to unit, call the resident's physician, make the physician aware of the CP recommendation and make changes after receiving an order from the physician. The DON further stated that he would not document the communication between the resident's physician in the resident's medical record. The DON stated that the purpose of following through with recommendations made by the CP was to make sure the facility was compliant with medications being timed and administered appropriately.

On 02/17/22 at 1:12 PM, the surveyor interviewed the facility's CP who stated that she reviewed medications to make sure that there was no duplicate therapy and medications were administered at correct times. The CP stated that she expected a resident who went to Ex Order 26.4B1 to have their medications plotted according to their Ex Order 26.4B1 schedule. The CP stated that after she reviewed the resident's medications, she would e-mail her report to the Medical Director, DON, and ADON and once the report was submitted, the expectation would be for her recommendations to be reviewed with the resident's physicians and completed in a timely manner.

A review of the facility's Medication Therapy Policy and Procedure revised 12/21 indicated, "The Consultant Pharmacist shall review each resident's medication regimen monthly, as requested by the staff or practitioner, or when a clinically significant adverse consequence is confirmed or suspected. The facility shall review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 756	Continued From page 40 medication-related issues as part of its Quality Assurance Committee and activities. The Medical Director and Consultant Pharmacist shall collaborate to address issues of medication prescribing and monitoring." NJAC 8:39-29.3(a)(1)	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation on 2/11/22, the surveyor observed four (4) nurses administer medications to six (6) residents. There were 29 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 6.9 %. This deficient practice was identified for 1 of 6 residents, (Resident #132), that were administered medications by one (1) of four (4) nurses. The deficient practice was evidenced as follows: 1. On 2/11/22 at 8:25 AM, the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer medications to Resident #132. The LPN reviewed the electronic medication administration record (EMAR) and removed from the medication cart a bottle of NJ Exec Order 26.4b1	F 759	F759 Free of Medication Error Rts 5 Percent or More 1. Correct medication was administered to resident #132, no corrective action needed for resident. Nurse was immediately in-serviced on proper med pass, and med pass competency completed by pharmacy consultant. 2. All residents have the potential to be affected. 3. All nurses were immediately in-serviced on proper med pass. 4. Pharmacy Consultant will perform a med pass on 3 nurses monthly for 3 months. Director of nursing will review	3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 759	Continued From page 41 Ex Order 26.4B1 tablets and a bottle of Ex Order 26.4B1 . The LPN stated that both medications were house stock medications provided by the facility. On 2/11/22 at 8:34 AM, the LPN stated that she was going to administer the NJ Exec Order 26.4b1 that she had prepared, which included one tablet of Ex Order 26.4B1 and one tablet of Ex Order 26.4B1 to Resident #132. At that time, the surveyor asked the LPN to review the EMAR before administering the medications to the resident. The surveyor with the LPN reviewed the EMAR which revealed a physician's order (PO) for Ex Order 26.4B1 NJ Exec O Ex Order 26.4B1), give one tablet by mouth one time a day for NJ Exec Order 26.4b1 ." The LPN stated that she thought the Ex Order 26.4B1 and Ex Order 26 Ex Order 26 tablets were the correct medications. The LPN was unable to speak to the PO for Ex Order 26.4B1 The LPN stated, "I have only been working here NJ Exec Order 26.4b1 ." The surveyor asked the LPN to review the PO for Ex Order 26.4B1 with a supervisor. The EMAR had not reflected a PO for Ex Order 26.4B1 (ERROR#1) The surveyor reviewed the medical records for Resident #132. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26.4B , reflected that the resident was admitted on Ex Order 26.4B1 and had diagnoses which included ,	F 759	finding of medication passes done for nurses and will bring results to next quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 759	Continued From page 42 [redacted]	F 759		

Further review of the MDS, reflected that a brief interview for mental status (BIMS) could not be obtained. The staff performed a [redacted] assessment which reflected that the resident had a NJ Exec Order 26.4b1 [redacted] with a Ex Order 26.4B1 [redacted] NJ Exec Order 26.4b1 [redacted].

A review of the resident's Ex Order 26.4B1 Medication Review Report reflected a PO with a start date of [redacted], for [redacted]), give one tablet by mouth one time a day for NJ Exec Order 26.4b1." There was no PO for Ex Order 26.4B1 or Ex Order 26.4B1

A review of a list titled "Over the Counter Medications," provided by the Director of Nursing (DON) revealed that Ex Order 26.4B1 was a medication provided by the facility as a house stock medication.

On 2/11/22 at 11:47 AM, the surveyor interviewed the LPN regarding the PO for Ex Order 26.4B1. The LPN stated that she spoke with a supervisor and showed the surveyor that there was a bottle of Ex Order 26.4B1 tablets in the house stock section of the medication cart. The LPN stated, "I must have read the order wrong." The LPN again stated, "I have only been working here NJ Exec Order 26.4b1." The LPN also stated that she had completed an orientation.

On 2/14/22 at 12:26 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone. The CP stated that she routinely does medication observations and inservices on medication administration techniques at the facility. The CP added that the DON would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 759	Continued From page 43	F 759		

able to provide the documentation of medication passes and inservices that were completed and include the content of what she had inserviced.

A review of the Medication Pass Inservice dated 2/8/22, performed by the CP reflected that the LPN was inserviced on medication administration and included to check the medication three times.

On 2/15/22 at 1:27 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON to review the medication administration results.

On 2/16/22 at 1:21 PM, the survey team met with the LNHA and DON. The LNHA stated that the nurses received orientation, medication observations and inservices and were then assigned to be alone on a medication cart "when they were ready." The LNHA added that if a nurse wanted additional time before passing medications on their own, then the facility would provide additional training. The LNHA added that the LPN had received additional inservicing after 2/11/22.

A review of a Medication Pass Observation Worksheet, provided by the DON, was completed on 2/8/22 with the LPN. The worksheet reflected that the LPN was observed by a staff member and in compliance with medication administration and was aware that the label of the medication should be checked three times and the medication should be administered with the correct dose.

On 2/17/22 at 1:33 PM, the surveyor team met with the LNHA and the DON. The DON stated that the nurses were expected to follow a PO and

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F 759	Continued From page 44 clarify a PO if necessary. A review of the manufacturer's specifications for Ex Order 26.4B1 reflected that the medication is a combination of NJ Exec Order 26.4b1. 2. On 2/11/22 at 8:25 AM, the surveyor observed the LPN preparing to administer NJ Exec Order 26.4b1 medications to Resident #132 which included Ex Order 26 capsule of Ex Order 26.4B1 NJ Exec Ord . The LPN stated that according to the EMAR the resident had to have the medications crushed. The surveyor observed the LPN crush the NJ Exec Order 26.4b1 which included the Ex Order 26.4B1 . On 2/11/22 at 8:34 AM, the LPN stated that she was going to administer the NJ Exec Order 26.4b1 medications which included the Ex Order 26.4B1 that she had crushed to Resident #132. At that time, the surveyor asked the LPN to review the EMAR before administering the medications to the resident. The surveyor with the LPN reviewed the EMAR which revealed a physician's order (PO) for Ex Order 26.4B1 Ex Order 26.4B1 Ex Order 26.4B1), give one capsule by mouth two times a day for NJ Exec Order 26.4b1, may open capsule." In addition, the surveyor with the LPN reviewed the label of the Ex Order 26.4B1 Ex Order 26.4B1 for the resident. The label from the provider pharmacy revealed cautionary instructions to swallow whole or sprinkle on a small amount of food. The LPN stated, "I have only been working here NJ Exec Order 26.4b1." The LPN added that she thought maybe she was supposed	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 759	Continued From page 45 to open the capsule, but she was unsure how the Ex Order 26.4B1 should be administered. The surveyor asked the LPN to review how the Ex Order 26.4B1 should be administered with a supervisor. (ERROR#2) The surveyor reviewed the medical records for Resident #132. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26.4B1 reflected that the resident was admitted on [redacted] and had diagnoses which included [redacted] Further review of the MDS, reflected that a brief interview for mental status (BIMS) could not be obtained. The staff performed a NJ Exec Order 26.4b1 assessment which reflected that the resident had a Ex Order 26.4B1 with a Ex Order 26.4B1 NJ Exec Order 26.4b1 . A review of the resident's Ex Order 26.4B1 Medication Review Report reflected a PO start date of [redacted], for [redacted] give Ex Order 26 capsule by mouth Ex Order 26.4B1 , may open capsule." On 2/11/22 at 11:47 AM, the surveyor interviewed the LPN regarding the cautionary instructions for the [redacted] capsule. The LPN stated that she spoke with a supervisor and should not have crushed the capsule. The LPN added that she should have opened the capsule and put the contents of the capsule in the applesauce. The	F 759		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 46 LPN again stated, "I have only been working here [NJ Exec Order 26 4b]." The LPN also stated that she had completed an orientation. On 2/14/22 at 12:46 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone. The CP stated that she routinely does medication observations and inservices on medication administration techniques at the facility. The CP added that the DON would be able to provide the documentation of medication passes and inservices that were completed and include the content of what she had inserviced. A review of the Medication Pass Inservice dated 2/8/22 performed by the CP reflected that the LPN was inserviced on medication administration and included to check the medication three times. On 2/15/22 at 1:27 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON to review the medication administration results. On 2/16/22 at 1:21 PM, the survey team met with the LNHA and DON. The LNHA stated that the nurses received orientation, medication observations and inservices and were then assigned to be alone on a medication cart when they were ready. The LNHA added that if a nurse wanted additional time before passing medications on their own, then the facility would provide additional training. The LNHA added that the LPN had received additional inservicing on 2/11/22. A review of a Medication Pass Observation Worksheet, provided by the DON, was completed on 2/8/22 with the LPN. The worksheet reflected	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 759	Continued From page 47 that the LPN was observed by a staff member and in compliance with medication administration. In addition, the worksheet reflected that the LPN was aware that medications were to be administered in compliance with cautionary statements and to review if a medication can be crushed before crushing. On 2/17/22 at 1:33 PM, the surveyor team met with the LNHA and the DON. The DON stated that the nurses were expected to follow a PO and clarify a PO if necessary. A review of the manufacturer's specifications for Ex Order 26.4B1 capsule revealed that if the capsule cannot be swallowed whole, open it, and sprinkle the medication into pudding or applesauce. A review of the facility policy, "Administering Medications" dated as revised 12/2021 reflected that medications shall be administered as prescribed and in accordance with all orders. In addition, the individual administering the medication must check the label three times to verify the right medication and the right method of administration before giving the medication. NJAC 8:39-11.2(b), 29.2(d)	F 759		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documents it was determined that the	F 814	F814Dispose Garbage and Refuse Properly	3/11/22

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F 814	Continued From page 48 facility failed to dispose of trash in a sanitary manner. This deficient practice was evidenced by the following: When the surveyors entered the facility parking lot on 2/9/22, at approximately 9:00 AM, all surveyors observed that the dumpster's in the lot were uncovered and overflowing with debris. There were used surgical masks, disposable gloves, plastic silverware, Styrofoam containers and food waste strewn on the ground surrounding the dumpster's. On 2/9/22 at 9:38 AM, during the initial tour of the kitchen, the surveyor asked to see the dumpster area used by the food service department. The Food Service Director (FSD) stated that the dumpster's in the parking lot across the street were used by the whole facility. When asked who was responsible for keeping that area clean, the FSD stated that Dietary and Housekeeping were responsible. The FSD also mentioned that the facility planned to get a trash compactor. On 2/10/22 at 09:19 AM, the surveyor observed three green dumpster's in the parking lot for trash and two blue dumpster's for recyclables. One of the blue dumpster's contained food items. Once again, all of the dumpster's were uncovered, and surrounded by litter on the ground. None of these dumpster's had covers attached to them, so facility personnel were unable to seal them. The surveyor observed birds flying into the open dumpster's. This same condition was observed in the morning and afternoon on 2/14 and 2/15/22. On 2/15/22, the surveyors observed an additional waste management company taking care of the trash.	F 814	1. All trash receptacles were immediately fitted with lids and area cleaned. 2. No residents have the potential to be affected. 3. Director of HK and Dietary Director immediately in-serviced their staff on the requirement of garbage bins being covered and area clean. Housekeeping staff will ensure area is clean and bins covered daily. 4. HK director or dietary director will audit bins once weekly for 4 weeks and then once a month for 2 months for proper covers. All findings will be brought to LNHA, LNHA will audit once a month for 3 months., and all findings will be brought to next quarterly QAPI meeting.	

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F 814	Continued From page 49 On 2/16/22 at 11:35 AM, the surveyor interviewed the Housekeeping Director (HD). He stated that all departments would take their trash to the dumpster's. Housekeeping would take their trash in the morning and the afternoon. The HD stated, "first thing we do is take it out and clean the area." He explained that the main problem was that there were no lids provided for the dumpster's. "They should have a lid. Every day the wind comes. I'd have to have a guy there steadily to keep that area clean. We are going to get a compactor. Ask the Administrator." On 2/16/22 at 1:53 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) about the dumpster's in the parking lot. The LNHA stated, "It's got to be cleaned. I plan to order a compactor. I tried to get a different type of dumpster, but it wouldn't fit in our parking lot. The lids on the dumpster's went missing." The LNHA further stated that he didn't know how long ago the dumpster covers disappeared. He added that the company that provided the dumpster's was going to send covers for them now, "but I was trying to get a larger dumpster." The LNHA also explained that the facility added additional times to pick up the garbage. He employed another trash hauling company on 2/15/22 because he saw the condition of the parking lot and new that he had to do more... "with disposable gloves and other medical waste" on the grounds. On 2/17/2022 at 9:05 AM, the LNHA provided additional information which included estimates for a trash compactor, dated August 2020. The LNHA also provided a copy of an email, dated 2/15/22, indicating that the waste management	F 814		

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F 814	Continued From page 50 company was working on getting lids for the five dumpster's as soon as possible. This email was written after the surveyors arrived and began inquiring about the unsanitary conditions involving the uncovered dumpster's.	F 814		
F 880 SS=E	NJAC 8:39-19.7 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		3/29/22

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F 880	Continued From page 51 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it	F 880	F880 Infection Prevention & Control	

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F 880	Continued From page 52 was determined that the facility failed to a.) appropriately don (put on) and doff (remove) Personal Protective Equipment (PPE), in accordance with Centers for Disease Control and Prevention (CDC) guidelines, before entering and after exiting a resident's room who was on NJ Exec Order 26.4b1 due to being a NJ Exec Order 26.4b1) and perform hand hygiene for 2 of 3 certified nursing aides (CNA) for 3 of 9 resident rooms on [redacted], b.) appropriately don and doff PPE, in accordance with CDC guidelines, before and after exiting a resident's room who was on [redacted] due to being [redacted] and appropriately perform hand hygiene after doffing PPE while performing housekeeping services, for 1 of 9 residents on [redacted], c.) maintain a social distanced hallway for the transportation to and from the NJ Exec Order 26.4b1 on the [redacted] floor with [redacted] residents non-compliant with [redacted], and d.) consistently monitor 3 out of 32 residents (Resident #94, #64 and #130) reviewed for signs and symptoms of [redacted] during an outbreak in the facility. These deficient practices were evidenced by the following: According to the U.S. CDC COVID-19 Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated 9/10/2021, "Managing Residents with Suspected or Confirmed SARS-CoV-2 Infection" reflects that healthcare personnel caring for residents with suspected SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and NIOSH approved N 95 or equivalent higher-level respirator). In addition, the healthcare personnel are to remove gloves, gown, and dispose into a	F 880	1. ADON immediately re-in-serviced identified staff re PPE doffing and donning and hand hygiene. Rehab staff immediately in-serviced by rehab director on requirements to ensure proper social distance when transporting residents to rehab gym. Orders were immediately updated on monitoring for [redacted] signs and symptoms for residents # 94, # 64, # 130. Missing PPE disposable bins immediately placed in al[redacted] rooms. DPOC required Root cause analysis and in-services completed. PROBLEMS IDENTIFIED: a) The facility failed to follow acceptable standards of practice to minimize the risk of the spread of infection. ¿ Employees from two departments could not demonstrate proper donning and doffing of PPE. ¿ Employees did not maintain social distance hallway for transport to and from rehab gym. ¿ Employees did not consistently monitor residents for signs and symptoms of [redacted] during an outbreak. CONTRIBUTING FACTORS: ¿ Employees did not don PPE before entering a room with residents on [redacted], and properly doff after exiting. ¿ Employees did not ensure that no	

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F 880	Continued From page 53 trash receptacle. Then the healthcare provider may exit the patient room and then perform hand hygiene. According to the U.S. CDC guidelines for Hand Hygiene in Healthcare Settings Hand Hygiene Guidance, updated 1/30/20, included Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: * Immediately before touching a patient * After touching a patient or the patient's immediate environment * After contact with blood, body fluids, or contaminated surfaces * Immediately after glove removal Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands. According to the U.S. CDC guidelines for Transmission-Based Precautions dated 1/7/2016, indicated to "Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens." According to the U.S. CDC COVID-19 Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2	F 880	residents on [NJ Exec] were in the hallway before transporting other residents. ¿ Nurses did not perform daily monitoring of vitals for all residents. ROOT CAUSES: ¿ Facility failed to provide sufficient education to all departments Infection Control. ¿ Lack of signage on appropriate PPE procedures. ¿ Insufficient oversight by facility leadership on Infection Control. CORRECTIVE ACTIONS: ¿ Staff Noted with deficient practice were counseled and educated ¿ Facility wide staff were re-educated on proper PPE donning and doffing. ¿ Facility staff were re-educated on proper social distancing. ¿ Charge nurses were reeducated on daily monitoring for signs and symptoms of covid-19 ¿ Facility also initiated CDC approved video training to all front-line staff titled, *Keep COVID out (https://youtu.be/7srwrF9MGdw)	

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F 880	Continued From page 54 Spread in Nursing Homes updated 9/10/2021, "Evaluate and Managing Personnel and Residents" indicates that healthcare personnel should, "Actively monitor all residents upon admission and at least daily for fever...and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry..." This document also reflects that for "New Infection in Healthcare Personnel or Resident... -Consider increasing monitoring of all residents from daily to every shift, to more rapidly detect those with new symptoms." 1. On 2/9/22 at 9:00 AM, the Licensed Nursing Home Administrator (LNHA) provided a list of residents who were considered persons [redacted] due to [redacted] and were placed on [redacted] The LNHA stated that they were [redacted] due to being a [redacted] A review of the floor plan indicated that the [redacted] floor was the only floor with the [redacted] residents. On 2/9/22 at 10:21 AM, the surveyor, in the presence of another surveyor, interviewed the Assistant Director of Nursing/Licensed Practical Nurse (ADON/LPN) on the [redacted] floor who informed the surveyors that the [redacted] floor had residents that were [redacted] for the [redacted] because they were new admissions placed on [redacted]. The ADON/LPN added that there were bins in front of the doorways in the hall which contained PPE for the designated [redacted] rooms along with signage. The ADON/LPN also stated that the staff working on	F 880	*Clean Hands (https://youtu.be/t7OH8Or5lg) *Closely Monitor residents (https://youtu.be1ZbT1Njv6xA) *Use PPE correctly for COVID□19 (https://youtu.be/YYTATw9yav4 Inservice conducted for staff on : Module 7 - Hand Hygiene https://www.train.org/main/course/1081806/ Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ Module 6D - Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ In addition for Topline Staff and Infection Preventionist: Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/1081802/ Module 5 - Outbreaks https://www.train.org/cdctrain/course/1081	

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F 880	Continued From page 55 the [NJ Exec O] floor were required to wear a N95 mask, face shield/goggles at all times on the floor and when going to enter a [NJ Exec O] room had to don gloves and a gown. In addition, upon exiting a [NJ Exec O] room the staff were to doff the gown and gloves and perform hand hygiene. The surveyors were able to observe bins with PPE at the doorways of the [NJ Exec O] rooms and signage indicating "STOP, [NJ Exec Order 26.4b1] Entry to room requires gown, gloves, N95 respirator mask and goggle/face shield." The designated [NJ Exec O] rooms were as follows: Ex Order 26.4B1 On 2/9/22 at 10:56 AM, the surveyor, in the presence of another surveyor, observed a CNA#1 walking with Resident #245 back to his/her room [Ex Order 26]. The surveyors observed from the hallway the CNA#1 enter the room with the resident and discussed clothing that was in a box and then the CNA#1 exited the room. The surveyors observed a bin in the hallway with PPE and signage on the outside of the room. The surveyors had not observed the CNA#1 don or doff PPE or perform hand hygiene. On 2/9/22 at 11:01 AM, the surveyor interviewed the CNA#1 who stated that she should have donned and doffed a gown and gloves because the resident was a [NJ Exec O] and was on [NJ Exec O]. The CNA#1 stated that she had to redirect the resident back to his/her room because they were NJ Exec Order 26.4b1, but the clothing was in the original package. The CNA#1 stated that she was going to get a plastic bag for the resident to separate the clothing that the resident thought was not	F 880	803/ MONITORING/EVALUATIONS: The DON or designee will audit one employee performing Donning and doffing weekly for 6 weeks, then monthly for three months, to ensure that proper infection control protocols are in place. Results of the audit will be reviewed by the administrator quarterly at the QA meeting X 2. The administrator or designee will observe one individual being transported to the rehab gym per week for six weeks, then monthly for three months, to ensure that proper infection control protocols are in place. Results of the audit will be reviewed by the administrator quarterly at the QA meeting x 2. Results will be reported to the QA Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. 2. All residents have the potential to be affected. 3. DON or nursing supervisor immediately re- in-service all staff on PUI unit regarding proper PPE doffing and donning and hand hygiene. Signage with instructions for proper donning and doffing were hung through out the unit. Regional DON did competency on staff for proper donning and doffing of PPE. Monitoring	

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F 880	Continued From page 56 clean. The CNA#1 stated that the bin in the hallway and signage was because the resident was on [NJ Exec Order 26 4b]. The CNA#1 acknowledged that she should have donned and doffed a gown and gloves because the resident was a [NJ Exec O] and was on [NJ Exec O]. The CNA#1 also stated that she was supposed to perform hand hygiene upon exiting the room. On 2/9/22 at 11:34 AM, from the hallway, the surveyor observed two (2) CNA's delivering lunch trays to rooms. The surveyor observed CNA#2 coming out of room #[Ex Order] wearing a N95 mask, goggles, gown, and gloves and spoke with CNA#3. Then, CNA#2 doffed the gown and gloves in the hallway and waited until CNA#3 brought a red covered garbage pail and placed it in the hallway outside room #[Ex Order 2] and CNA#2 placed the gown and gloves in the red pail. The CNA#2 continued down the hallway. There was no observation of hand hygiene performed. The surveyor observed a bin with PPE in the hallway and signage in front of room #[Ex Order 2]. On 2/9/22 at 11:43 AM, the surveyor observed, from the hallway, CNA#2 come out of room #[Ex Order] at the door in the hallway wearing a N95, goggles, gown and gloves and then walked back into room #[Ex Order]. The surveyor observed a bin with PPE and signage in the hallway for room [Ex Order 2]. At that time, the surveyors also observed a CNA#3 in room #[Ex Order] wearing a N95 mask, goggles, gown, and gloves and before exiting doffed the gown and gloves and placed them in a small garbage pail in the room and performed appropriate hand washing technique and exited the room. The surveyor observed a bin with PPE and signage in the hallway for room #[Ex Order 2]	F 880	order was added to monthly resident chart review. 4. Infection preventionist will audit 5 staff donning/doffing weekly for 4 weeks, and then 5 staff a month for 2 months.DON will review all findings and present at next quarterly QAPI meeting.	

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F 880	Continued From page 57 On 2/9/22 at 11:46 AM, the CNA#2 walked out of room #[Ex Order] wearing a N95, goggles gown and gloves and doffed the gown and gloves at the door in the hall and rolled the gown and gloves into a ball and proceeded to walk to room #[Ex Order] and threw the balled gown and gloves in a small garbage pail in room [Ex Order]. The surveyor had not observed hand hygiene performed. The surveyor observed that the resident residing in room #[Ex Order 2] was not in the room and there was no bin with PPE or signage for room #[Ex Order 26] On 2/9/22 at 11:48 AM, the surveyor interviewed CNA#2 who stated that she has worked in the facility for approximately [NJ Ex.Order 26.] and floats to different floors and has worked on the [NJ Exec O] floor before. The CNA#2 stated that she was supposed to wash her hands after exiting a [NJ Exec O] room. The CNA#2 acknowledged that she had not performed hand hygiene and should have. The CNA#2 stated that she did not think she could use alcohol-based hand rub (AHBR) after exiting a [NJ Exec O] room and could only wash her hands with soap and water. The CNA#2 stated that she usually doffed her gown and gloves and put them in a red garbage pail in the hallway but today had not seen any of the red garbage pails except for the one CNA#3 got for her. The CNA#3 acknowledged that she walked out of room [Ex Order] with the gown and gloves and threw them in room #[Ex Order 26.] garbage because she said that room [Ex Order 26] did not have a garbage pail and she used the garbage pail in room [Ex Order 26] because she knew that no one was in that room at the moment. The CNA#2 stated that she had been inserviced on infection control procedures but was unable to identify who had done the inservicing.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 58 On 2/9/22 at 11:52 AM, the surveyor interviewed CNA#3 who stated that there had been red garbage pails to place the gown and gloves in after he removed them but today, he had not seen any. The CNA#3 acknowledged that he had to get one for CNA#2 and was unsure why there was no garbage pails. The CNA#3 thought the red pails were either placed in the PUI rooms or in the hallway. The CNA#3 acknowledged that there were only small garbage pails in the rooms which was used for regular garbage and had to use those garbage pails today to doff his PPE in the [NJ Exec D] rooms. The CNA#3 stated that every time he entered a [NJ Exec C] room he had to don and before exiting had to doff PPE and wash his hands before leaving the room. On 2/10/22 at 10:11 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing/Infection Preventionist (DON/IP). The DON/IP stated that inservices on infection control were completed face to face as well as online inservicing. The DON stated that all staff should be aware of how to don and doff appropriately. The LNHA stated that there had been a full staff inservice program done for infection control recently. The LNHA stated that upon exiting a [NJ Exec C] room the staff was to remove their gown and gloves and place them in the large black garbage pails and the pails were placed inside the designated [NJ Exec D] rooms. The LNHA stated that each [NJ Exec D] room should have a dedicated large black garbage pail. The LNHA explained that the large red garbage pails were being used when there was [NJ Exec Order 26.4b1] residents. The LNHA also stated that there were [NJ Exec Order 26.4b1] residents that were [NJ Exec C] and because they were physically	F 880		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 59 able to [NJ Exec Order 26.4b] sometimes left their rooms and the staff was trained to encourage the residents to return to their rooms. On 2/15/22 at 1:27 PM, the survey team met with the LNHA and DON and discussed the findings of the infection control on the [NJ Exec Orde] floor. On 2/16/22 at 1:21 PM, the survey team met with the LNHA and DON. The LNHA stated that training and inservices were completed on 2/8/22 and that the facility provides hands on training competencies for hand hygiene for all staff. A review of inservices on infection control procedures and hand washing competencies that were performed with staff in different departments was provided by the LNHA. A review of inservices dated 11/10/21 and 12/28/21 provided by the LNHA reflected that CNA#1 was in attendance and had instructions regarding wearing appropriate PPE before entering a [NJ Exec O] room and before exiting a [NJ Exec O] room to doff PPE. In addition, CNA#1 performed a Hand Washing Competency Validation on 12/14/21 and passed. There were no signatures found for CNA#2 for attendance at inservices or a hand washing competency. A review of a facility policy dated as revised 12/2021 for Personal Protective Equipment-Using Gowns provided on entrance by the LNHA indicated that gowns must be disposed in appropriate containers located in the room. A review of a facility policy dated as revised	F 880		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 60 12/2021 for Personal Protective Equipment-Using Gloves provided on entrance by the LNHA indicated that gloves were to be discarded in designated waste receptacles located in the room and to wash hands after the removal of gloves. A review of the facility policy Categories of Transmission-Based Precautions dated as revised 12/2021 reflected COVID-19 Transmission-Based Precautions included for staff entering the resident's room or providing care the use of N95 ask, eye protection, gown, and gloves. A review of the facility policy Handwashing/Hand Hygiene dated as revised 12/2021 reflected that hand hygiene was the primary means to prevent the spread of infections and all personnel were to follow the hand hygiene procedures. In addition, the policy reflected that hand hygiene was the final step after removing and disposing of PPE and gloves was not a replacement for hand hygiene. The policy also indicated that hand hygiene was to be performed before and after applying gloves and ABHR could be used before and after entering isolation precaution settings. 2. On 2/10/22 at 10:02 AM, the surveyor observed, from the hallway, a housekeeper (HK) in room #[redacted] near the first bed, where Resident #31 resided in the second bed. The HK was wearing gloves, a N95 mask and face shield. The surveyor observed a bin with PPE and signage in the hallway. At that time, the HK came out of the room and removed her gloves and placed them in her housekeeping cart. Then, the HK proceeded to don a gown and new gloves. The surveyor had	F 880		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 61 not observed hand hygiene be performed. The surveyor interviewed the HK who stated that she was the usual HK for the [NJ Exec O] floor and had been working for approximately [NJ Exec Order 26.4b1]. The surveyor asked the HK why she was inside a [NJ Exec O] room without a gown and the HK stated, "I had to have a look at my surroundings." The HK stated that every time she entered a [NJ Exec O] room she donned and upon exiting she doffed. The HK stated that she was unsure where the nurses placed the PPE when they removed them, but she put her gowns and gloves in her housekeeping cart garbage. The HK acknowledged that she was to perform hand hygiene upon exiting a [NJ Exec O] room. On 2/10/22 at 10:11 AM, the survey team met with the LNHA and DON /IP. The DON/IP stated that inservices on infection control were completed face to face as well as online inservicing. The DON stated that all staff should be aware of how to don and doff appropriately. The LNHA stated that there had been a full staff inservice program done for infection control recently. The LNHA stated that upon exiting a [NJ Exec O] room the staff was to remove their gown and gloves and place them in the large black garbage pails and the pails were placed inside the designated [NJ Exec O] rooms. The LNHA stated that each [NJ Exec O] room should have a dedicated large black garbage pail. The LNHA explained that the large red garbage pails were being used when there was [NJ Exec Order 26.4b1] residents. The LNHA also stated that there were [NJ Exec Order 26.4b1] residents that were [NJ Exec Order 26.4b1] and because they were physically able to [NJ Exec Order 26.4b1] sometimes left their rooms and the staff was trained to encourage the residents to return to their rooms.	F 880		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

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GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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F 880	Continued From page 62 On 2/15/22 at 1:27 PM, the survey team met with the LNHA and DON and discussed the findings of the infection control on the first floor. On 2/16/22 at 1:21 PM, the survey team met with the LNHA and DON. The LNHA stated that training and inservices were completed on 2/8/22 and that the facility provides hands on training competencies for hand hygiene for all staff. A review of a "Self Learning Packet for Mandatory Orientation and Annual Inservice Program" was signed by the HK and dated 2/8/22. The program included infection control inservicing regarding TBP, how to put on and take off PPE and hand washing. A review of a facility policy dated as revised 12/2021 for Personal Protective Equipment-Using Gowns provided on entrance by the LNHA indicated that gowns must be disposed in appropriate containers located in the room. A review of a facility policy dated as revised 12/2021 for Personal Protective Equipment-Using Gloves provided on entrance by the LNHA indicated that gloves were to be discarded in designated waste receptacles located in the room and to wash hands after the removal of gloves. A review of the facility policy Categories of Transmission-Based Precautions dated as revised 12/2021 reflected COVID-19 Transmission-Based Precautions included for staff entering the resident's room or providing care the use of N95 ask, eye protection, gown, and gloves.	F 880		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 63 A review of the facility policy Handwashing/Hand Hygiene dated as revised 12/2021 reflected that hand hygiene was the primary means to prevent the spread of infections and all personnel were to follow the hand hygiene procedures. In addition, the policy reflected that hand hygiene was the final step after removing and disposing of PPE and gloves was not a replacement for hand hygiene. The policy also indicated that hand hygiene was to be performed before and after applying gloves and ABHR could be used before and after entering isolation precaution settings. 3. On 2/9/22 at 10:56 AM, the surveyor in the presence of another surveyor observed a CNA#1 walking with Resident #245 back to his/her room #[redacted]. The resident was wearing a surgical mask. The surveyors observed a bin in the hallway with PPE and signage on the outside of the room. At that time, the surveyors observed the Rehabilitation (REHAB) gym for physical therapy (PT) at the end of the hallway with doors open and rooms #[redacted], #[redacted], and #[redacted] the same hallway. All three (3) rooms had bins with PPE and signage for [redacted]. On 2/9/22 at 10:45 AM, the surveyor, in the presence of another surveyor, observed Resident #247 walking with a walker down the hall past the nursing station with a CNA#3 following the resident. The CNA#3 helped the resident fix a chair to sit in in the hallway. The resident was wearing a surgical mask. On 2/9/22 at 10:49 AM the surveyor, in the presence of another surveyor interviewed Resident #247 who stated that he/she was not	F 880		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 64 staying long and wanted to speak to someone about a discharge plan. A review of the [NJ Exec O] resident room list revealed that Resident #247 was in room #[Ex Order] and was on [NJ Exec Ord] On 2/9/22 at 11:01 AM, the surveyor interviewed the CNA#1 who was unable to speak to whether the residents in the [NJ Exec] rooms were allowed to come out of their room. On 2/9/22 at 11:21 AM, the surveyor, in the presence of another surveyor, observed an unsampled resident from room #[Ex Order2] exit the room and sit in a chair across the hall from the room. The surveyors observed a bin in the hallway with PPE and signage for room [Ex Order 26]. The resident was wearing a surgical mask. On 2/9/22 at 11:22 AM, the surveyor interviewed the ADON/LPN who stated that he was aware that Resident #245 was [NJ Exec Order 26.4b1] with staying in his/her room and was on [NJ Exec O] and was currently having a [NJ Exec Order 26.4b1] and was going to be transferred from the facility. The ADON/LPN stated that he was also aware of the unsampled resident being [NJ Exec Order 26.4b1] with staying in the room and he/she was on [NJ Exec O] and that was due to [NJ Exec Order 26.4b1]. The ADON/LPN added that the CNAs would encourage and redirect the residents that were [NJ Exec O] to return to their rooms. The ADON/LPN stated that Resident #247 was a [NJ Exec Order 26.4b1] with supervision and was [NJ Exec Order 26.4b] that he/she was being [NJ Exec Order 26.4b1] regarding staying in the room. The ADON/LPN stated that the [NJ Exec O] floor had the REHAB gym for any resident in the facility that required PT at the end of the hallway.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 65 The ADON/LPN acknowledged that residents being transferred to the REHAB gym would have to pass through the hallway where the unsampled resident resided in room [Ex Order 26], Resident #245 resided in room #[Ex Order 2] and Resident #247 resided in room #[Ex Order] and the residents were on [NJ Exec O] and came out of their rooms. On 2/9/22 at 11:30 AM, the surveyor observed CNA#3 redirect the unsampled resident to return to their room#[Ex Order]. On 2/9/22 at 11:32 AM, the surveyors observed Resident #247 walking with a walker returning to his/her room and stopped at the doorway of room [Ex Order] and had a conversation with Resident #246 who resided in the room. The surveyors observed that there was no bin with PPE or signage for room #[Ex Order] and Resident #246 was not a [NJ Exec O]. On 2/9/22 at 11:34 AM, the CNA#3 asked Resident #247 to not stop at other rooms and return to his/her room for lunch. During the times between 10:21 AM and 11:52 AM, the surveyors were able to observe residents from different floors being transported from the elevators to the Rehab gym and from the Rehab gym back to the elevators. The surveyors observed the doors to the Rehab gym open at the end of the hallway with rooms #[Ex Order 2], #[Ex Order] and #[Ex Order] also near the end of the hall where the Rehab gym opening was located. On 2/10/22 at 10:11 AM, the survey team met with the LNHA and DON /IP. The LNHA stated that there were [NJ Exec Order 26.4b1] residents that were [NJ Exec Order 26.4b1] and because they were [NJ Exec Order 26.4b1] sometimes left their	F 880		

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	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 66 rooms and the staff was trained to encourage the residents to return to their rooms. The surveyor reviewed the medical record for Resident #247. A review of the Admission Record revealed that the resident was admitted on [redacted] A review of the resident's interdisciplinary care plan (IDCP) revealed that the resident was under observation for [redacted] with an end date of [redacted] and had an intervention to provide resident with PPE and education on its use. The IDCP had no mention of the resident being NJ Exec Order 26.4b1 . A review of the electronic progress notes indicated that the resident had signed out of the facility NJ Ex.Order 26.4(b)(1) on NJ Exec Order 26 . On 2/15/22 at 1:27 PM, the survey team met with the LNHA and DON and discussed the findings of the infection control on the first floor. On 2/16/22 at 1:21 PM, the survey team met with the LNHA and DON. The LNHA stated that training and inservices were completed on 2/8/22, and that the facility provides hands on training competencies for hand hygiene for all staff. On 2/17/22 at 1:33 PM, the survey team met with the LNHA and DON. The LNHA stated that there was no policy for a procedure when a resident was NJ Exec Order 26.4b1 . The LNHA stated that the Rehab gym had been closed when the facility had NJ Exec Order 26.4b1 residents. A review of an inservice dated 12/28/21, on	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 67 Infection Control provided by the LNHA revealed that CNA#1 and CNA#3 were in attendance and the inservice included that if a [NJ Exec O] resident comes out of their room then the staff member was to educate the resident and if the resident refuses to comply then the staff member should report to a supervisor. A review of the facility policy Categories of Transmission-Based Precautions dated as revised 12/2021 reflected COVID-19 Transmission-Based Precautions included restricting the resident to his/her room and if the resident under COVID-19 TBP required movement outside the room due to medical necessity then information about the residents' suspected coronavirus would be communicated to other departments. 4. During the entrance conference on 2/9/2022, the LNHA stated that the facility had been in a [NJ Exec Order 26.4b1] outbreak that began on [NJ Exec Order 26.4b1]. On 2/14/22 at 9:33 AM, the surveyor reviewed medical records to ensure that residents were being monitored for signs and symptoms of [NJ Exec Order 26.4b1] with the following findings: The surveyor reviewed the medical record for Resident # 94: According to the Face Sheet (an admission summary), Resident #94 was admitted with diagnoses that included but not limited to personal history of [redacted]	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 68	F 880		

[redacted]

Review of the resident's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident had an [redacted]

Review of the resident's immunization records revealed that Resident #94 was [redacted], and [redacted], and a booster was provided on Ex Order 26.4B1

Review of the electronic Medication Review Report (MRR) for Resident #94 revealed physician orders (PO) dated Ex Order 26.4B1, to test for NJ Exec Order 26.4b1 in the event of symptom presentation or facility outbreak per public health guidance and a PO dated Ex Order 26.4B1 for vital signs every shift for monitoring.

There was no specific physician order to monitor for signs/symptoms of NJ Exec Order 26.4b1.

A review of the resident's electronic Medication Administration Record (eMAR) and Weights and Vitals Summary (WVS) for Ex Order 26.4B1 revealed that vital signs were only recorded once a day, instead of every shift, on the following days in [redacted] and [redacted]. Vital signs were not recorded at all for Resident #94 for the following days in [redacted] and [redacted]

Review of the Ex Order 26.4B1 eMAR and WVS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 69	F 880		

revealed that the resident's vital signs were only documented for one shift on each of the following days in NJ Exec Order 26.4b1: [redacted] and NJ Exec Order 26.4b1.

Further review of the Ex Order 26.4B1 eMAR and WVS revealed that the resident's vital signs were not documented on [redacted] and NJ Exec Order 26.4b1

Review of the facility's NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 outbreak revealed that Resident #94 was not involved in NJ Exec Order 26.4b1 due to the resident was not exposed to the [redacted] during the outbreak. The facility provided evidence that Resident # 94 was tested twice a week for NJ Exec Order 26.4b1 during the outbreak, and tested NJ Exec Order 26.4b1.

On 2/16/22 at 10:58 AM, the surveyor interviewed Resident #94, who stated that he/she had NJ Exec Order 26.4b1 " The surveyor asked the resident how often the staff checked his/her NJ Exec Order 26.4b1 [redacted] The resident replied, "When I ask for it or every couple of days. They were doing it every day but... it's been a while. They did it today. They don't do it every day." The resident claimed to have no NJ Exec Order 26.4b1 symptoms today...NJ Exec Order 26.4b1 [redacted]

The surveyor reviewed the medical record for Resident # 64:

According to the Face Sheet, Resident #64 was admitted with diagnoses that included but not limited to a [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 70 [redacted].	F 880		

Review of the resident's most recent MDS dated [redacted], reflected that Resident #64 had a BIMS score of [redacted] out of 15, indicating that the resident had an [redacted].

Review of the resident's immunization records revealed that Resident #64 was [redacted]

A review of the resident's electronic MRR revealed a PO dated [redacted], to test for [redacted] in the event of symptom presentation or facility outbreak per public health guidance and a PO dated [redacted] to monitor for signs/symptoms o[redacted] including [redacted]. Notify MD and document in progress notes if resident presents with any symptoms and a PO dated [redacted], for vital signs every shift for monitoring.

Review of the [redacted] eMAR and WVS indicated that the resident's vital signs were not documented for one shift on each of the following days: [redacted] and [redacted].

Review of the [redacted] eMAR and WVS revealed that the resident's vital signs were not documented for one shift on each of the following days: [redacted] and [redacted].

Further review of the [redacted] eMAR and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 71 WVS indicated that the resident's vital signs were not documented on [redacted] and [redacted]. Review of the facility's [redacted] for the [redacted] outbreak revealed that Resident #64 was not involved in [redacted] due to the resident was not exposed to the [redacted] during the outbreak. The facility provided evidence that Resident #64 was tested twice a week for [redacted] during the outbreak, and tested [redacted] On 2/16/22 at 10:19 AM, the surveyor interviewed Resident #64. The resident claimed to have no symptoms of [redacted] including [redacted]. The resident [redacted] Resident #64 stated that the staff tested him/her with a [redacted] twice a week. The resident stated that the staff would "sometimes" take his/her [redacted], but not often. "They don't do it every day." When the surveyor described the [redacted], Resident #64 indicated familiarity with the device. In regards to checking [redacted], Resident #64 stated, "they check that, but not too often either. Not once a day." The surveyor reviewed the medical record for Resident # 130: According to the Face sheet, Resident #130 was admitted with diagnoses that included but not limited to [redacted].	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 72 Review of the resident's most recent MDS dated [redacted], reflected that the resident had a BIMS score of [redacted] out of 15, indicating that the resident had [redacted]. Review of the resident's immunization records revealed that Resident #130 was [redacted] A review of the resident's electronic MRR revealed a PO dated [redacted], for vital signs every shift for monitoring, and a PO dated [redacted], to monitor for signs/symptoms of [redacted] including [redacted] control Notify MD and document in progress notes if resident presents with any symptoms. Review of the [redacted] eMAR and WVS indicated that vital signs were only documented for one shift per day on the following days: [redacted], and [redacted]. Vital signs were not documented on the following days: [redacted]. Review of the [redacted] eMAR and WVS revealed that the resident's vital signs were not documented for one shift on each of the following days: [redacted] and [redacted] Vital signs were not documented on the following days: [redacted]. Review of the facility's [redacted] for the [redacted] outbreak revealed that Resident # 130 was not involved in [redacted] due to the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 73 resident was not exposed to the [NJ Exec Or] during the outbreak. The facility provided evidence that Resident #130 was tested twice a week for [NJ Exec Order 26.4b1] during the outbreak, and tested [NJ Exec Order 26.4b1]. On 2/16/22 at 9:47 AM, the surveyor interviewed the Registered Nurse (RN) who was the charge nurse on the floor where Residents #94, #64 and #130 resided. The surveyor asked why the RN frequently documented "NA" (Not Applicable) on the eMAR, where [NJ Exec Order 26.4b1] and [Ex Orde] [NJ Exec Order 26.4b1] were meant to be recorded. The RN stated that if the resident "didn't complain of [redacted] or any symptoms, I put NA. People with [NJ Exec Order 26] signs, I notified the Nurse Practitioner or Doctor." She further stated that she was not sure why some residents (such as Resident #94) didn't have the order for monitoring for signs and symptoms of [NJ Exec Order 26.4] The RN further stated that she had no explanation for why the vital signs for resident #94 were not documented consistently. "I don't know why they don't do them." The surveyor asked if the CNAs checked the resident's vital signs. The RN replied, "the CNAs have been trained to take vital signs, but haven't been doing them." On 2/16/22 at 1:56 PM, the surveyor interviewed the LNHA who stated that Resident #94 did have physician's orders to monitor for signs and symptoms of [redacted], but they were not carried over to the current month. On 2/17/22 at 9:00 AM, in the presence of the survey team, the LNHA stated that the facility	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	**101 NORTH GROVE STREET EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 74 planned to train the CNAs to take vital signs of residents through [redacted] He stated that he expected the staff "not just do a visual, but to check vital signs." A review of the facility's policy for "Coronavirus, Prevention and Control" revised 2/7/22, indicated "The facility will actively monitor every resident for signs and symptoms of COVID-19. This includes monitoring all vital signs and other symptoms (e.g. cough, SOB, muscle aches, diarrhea, sore throat, headache, fatigue, etc.). Frequency of monitoring will be determined based on guidance from the CDC, CMS, and DOH." NJAC 8:39 -19.3(b), 19.4(a)(b)(n)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060704	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITA	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Part A: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the state of New Jersey. This was evidenced for 7 of 14 day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH), dated 01/28/2021, "Compliance with	S 560	S560 A. 1. staffing coordinator was immediately re in-serviced on staffing ratio requirements. 2. All residents have the potential to be affected 3. LNHA will review staffing schedules weekly for 3 months. 4. DON or LNHA will review open positions and applications plus results of any	3/11/22

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

Electronically Signed — 03/06/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060704	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 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 at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 1/23/22 through 1/29/22 and 1/30/22 through 2/5/22, revealed the staffing to residents' ratios did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: - 01/23/22 had 14 CNAs for 161 residents on the day shift, required 21 CNAs. - 01/24/22 had 20 CNAs for 161 residents on the day shift, required 21 CNAs. - 01/27/22 had 19 CNAs for 164 residents on the day shift, required 21 CNAs. - 01/30/22 had 15 CNAs for 163 residents on the day shift, required 21 CNAs. - 01/31/22 had 18 CNAs for 163 residents on the	S 560	interview weekly to look for opportunities to hire. Findings of review will be presented by LNHA at next quarterly QAPI meeting. S560 B. 1. LNHA was immediately in- serviced by regional administrator on the requirements for IP. LNHA continues to post ads and review job applicants to hire a qualified IP. 2. All residents have the potential to be affected 3. regional administrator will review credentials of IP to ensure they fulfill required training. 4. LNHA will review findings and present to next quarterly QAPI meeting.	

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	060704	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2	S 560		

day shift, required 21 CNAs.
- 02/04/22 had 20 CNAs for 165 residents on the day shift, required 21 CNAs.
- 02/05/22 had 16 CNAs for 165 residents on the day shift, required 21 CNAs.

On 2/17/22 at 9:25 AM, the surveyor interviewed the Staffing Coordinator/Human Resources (SC/HR) who stated her "job is make sure the facility has enough staffing on each shift for the nurses and CNAs." She further stated that the required ratio is one CNA to eight residents for the day shift, one CNA to 10 residents on the evening shift, and one CNA to 16 residents on the night shift. "If there is a call out, the staff person will call me directly during working hours. After working hours, the staff nurse or CNA calling out is to call the supervisor or the front desk receptionist. The nursing supervisor will send an email to me, regarding who called out so that I can re-adjust the schedule. I have a work phone that has all nurses and CNAs names and phone contacts and my email." The SC/HR further stated that she feels the facility is meeting the new ratio requirements and stated, "we are well-staffed with CNAs and we are still hiring and using agency nurses that come faithfully. We offer incentive bonuses for overtime or will give an extra two hour PTO [paid time off] or an extra one to two days off." In addition, the SC/HR stated she "keeps in constant communication with administration regarding staffing."

On 2/17/22 at 9:40 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The LNHA stated that the new minimum staffing ratios were one CNA to eight residents for the day shift, one CNA to 10 residents for the evening shift, and one CNA to 14 residents for the night shift. He further

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	060704	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITA	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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S 560	Continued From page 3 stated that the facility "is very close to meeting the staffing requirements. There are some lags due to callouts, but do the best we can and that most days are good with staffing, but with a census increase it had been more challenging." The DON stated "care of the residents comes first, but have to balance because want to avoid burn-out with staff." The LNHA further stated that the facility is affiliated with CNA schools and are offering to pay the CNA tuition." Review of the facility's "Staffing" policy revised 12/2021, indicated "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment... Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services, staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter." Part B: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that the Infection Preventionist who was assigned to oversee their infection preventionist and control program met the minimum qualifications as mandated by the State of New Jersey. This deficient practice was	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060704	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITA	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

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S 560	Continued From page 4 identified and the findings are as followed: Reference: New Jersey Executive Directive 20-026 "Directive for the Resumption of Services in all Long-Term Care Facilities" dated 1/6/21, directs the following: "In addition to the requirements in N.J.A.C. 8:39-20, the following practices shall remain in place even as LTCF's (Long-Term Care Facilities) resume normal activities, regardless of the facility's current reopening phase;... ii. All facilities except for facilities with ventilator-dependent residents, are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; b. A physician who has completed and infectious disease fellowship; c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of infection control experience." Reference: N.J.A.C. 8:39- Standards for Licensure of Long-Term Care Facilities Subchapter 20. Advisory Infection Control and Sanitation 8:39-20.2 Advisory staff qualification dated 11/17: "a. The infection control coordinator is certified in Infection Control (CIC) by the National Board of	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 5 Infection Control... b. The infection control coordinator is an active member of the National Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)... c. The infection coordinator has completed an APIC Basic Training Course or has received at least 25 hours of training in infection control, and receives additional six hours of training annually." During the entrance conference on 2/9/22 at 10:24 AM, the Licensed Nursing Home Administrator (LNHA) informed the Team Coordinator that the Director of Nursing (DON) was also the facility's infection prevention coordinator and performed that role on a part-time basis. On 2/16/22 at 12:02 PM, the surveyor interviewed the DON who confirmed that he did not have five years experience in the Infection Preventionist/Registered Nurse (IP/RN) role. In addition, he stated this was his first position as the infection control coordinator since [redacted]. He stated he started the DON position on [redacted] and was the facility's infection control coordinator since [redacted]. He stated he had seven years of general nursing experience which included supervisory positions but not specific to the role of infection control and prevention. On 2/17/22 at 1:28 PM, both the LNHA and DON acknowledged the surveyor's findings.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315147 Y1	A. Building B. Wing Y2	5/24/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0677	Correction	ID Prefix F0695	Correction	ID Prefix F0698	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed
LSC	03/11/2022	LSC	03/11/2022	LSC	03/11/2022
ID Prefix F0755	Correction	ID Prefix F0756	Correction	ID Prefix F0759	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	03/11/2022	LSC	03/11/2022	LSC	03/11/2022
ID Prefix F0814	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	03/11/2022	LSC	03/29/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/18/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060704 Y1	A. Building B. Wing Y2	5/24/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/11/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING **01** B. WING _____	**02/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	**101 NORTH GROVE STREET** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/16/22 and 02/17/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 6-story building, that was built in 70's. It is composed of Type II protected construction. The facility is divided into 10- smoke zones. The generator does approximately 30% of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

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

Electronically Signed | 03/06/2022

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

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K 000	Continued From page 1 The facility has 185 certified beds. At the time of the survey the census was 164.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING	K 222		3/11/22

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K 222	Continued From page 2 ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/17/21, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that the 15-second delayed egress feature on 1 of 10 exit discharge doors (with this feature) observed would activate when tested. This deficient practice was evidenced by the following: At 12:22 PM, the Surveyor and Maintenance Director, observed the 4th floor south egress door. The door indicated that they were equipped with a delayed 15-second egress feature which	K 222	K222 Egress Doors 1. 4th floor door was immediately repaired to have 15 second egress. 2. All residents have the ability to be affected. 3. Maintenance director was immediately in-serviced by Licensed nursing home administrator (LNHA) on requirement for egress door to have 15 second egress. Maintenance director will audit 5 egress	

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K 222	Continued From page 3 was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's egress feature did not function. The door was provided with a key pad that opened the door, and according to the Maintenance Director, the fire alarm would release the device if activated. In an interview with the Maintenance Director who stated and confirmed the finding during the observation. The Administrator was notified of the findings at the Life Safety Code exit conference on 02/17/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222	doors weekly for 4 weeks, then monthly for 2 months and submit findings to LNHA. 4. LNHA will audit 2 doors monthly for 3 months, and will bring findings to next quarterly QAPI meeting.	
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/17/22, the facility failed to provide and maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1.	K 271	K271 Discharge from Exit 1. Handrail at south stairwell exit was repaired, vines removed, concrete slab repaired. 2. All residents have the potential to be affected.	3/11/22

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K 271	Continued From page 4 This deficient condition was evidenced for 1 of 2 exit stairwell discharge's by the following finding: During an exterior tour of the south stairwell egress/exit, the Surveyor and Maintenance Director observed that the iron handrail was loose and rusted, exterior vines were growing up the wall on the left-side of the exit/egress stairs, garbage and unattended landscaping was blocking half of the bottom concrete stair and concrete slabs to the public way were cracked and unleveled. An interview was conducted with the Maintenance Director, during the observation's, who stated and confirmed the findings. The Administrator was informed of this finding during the Life Safety Code Surveyor exit conference on 02/17/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7, 19.2.7	K 271	3. Licensed nursing home administrator (LNHA) immediately in-serviced Maintenance Director on requirement of clear egress. Egress was checked and clear of any impediments. 4. Maintenance director will audit egress once a week for 4 weeks, and then monthly for 2 months, and submit findings to LNHA. LNHA will review findings, audit egress once a month for 3 months, and bring findings to next quarterly QAPI meeting.	
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/17/22, the facility failed to provide automatic emergency	K 281	K281 Illumination of Means of Egress	3/11/22

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	315147	A. BUILDING **01** B. WING _____	**02/18/2022**

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K 281	Continued From page 5 illumination, that would operate automatically along the means of egress, and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.8, 7.8.1.1, 7.8.1.2, 7.8.1.4. The deficient practice was evidenced for 1 of 2 exit/egress areas by the following: At 10:38 AM, the surveyor and Maintenance Director observed outside the south exit/egress area, that the wall mounted exterior fixture did not illuminate. The Maintenance Director was unsure how the light operated at the time of the observation. The findings were verified by the Maintenance Director at the times of the observation. The Administrator was informed of the findings at the Life Safety Code exit conference on 02/17/22. NJAC 8:39-31.2(e)	K 281	1. Light at south exit was repaired 2. All residents have the potential to be affected. 3. Maintenance director was immediately in-serviced by Licensed nursing home administrator (LNHA) on requirement for proper illumination at exits at all times. 4. Maintenance Director will audit egress for lighting once a week for 4 weeks, then monthly for 2 months, and submit findings to LNHA. LNHA will review findings, audit one egress once a month for 3 months for proper illumination, and bring findings to next quarterly QAPI meeting.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation in the presence of the Maintenance Director, it was determined that the facility failed to maintain emergency lighting in exit ways. This deficient practice was evidenced	K 291	K291 Emergency Lighting 1. 5th floor south stairwell emergency lighting was repaired.	3/11/22

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K 291	Continued From page 6 for 1 of 2 exit stairwells, by the following: On 02/17/22 at 10:38 AM, the Surveyor and Maintenance Director observed that the facility's 5th floor south stairwell emergency light, when tested did not function. The Maintenance Director attempted to activate the test button, but the button did not activate the 2-bulb fixture. An interview was conducted during the observation with the Maintenance Director, where he stated and confirmed the testing of the emergency lighting did not work when tested. The Administrator was informed of the finding at the Life Safety Code exit conference. NJAC 8:39 - 31.1(c), 31.2(e)	K 291	2. All residents have the potential to be affected. 3. All emergency lighting was checked to ensure it is in working order. Maintenance Director was immediately in-serviced by Licensed nursing home administrator (LNHA) on requirement for emergency lighting at stairwells to be operational. 4. Maintenance director will audit stairwell emergency lighting once a week for 4 weeks, then monthly for 2 months and submit findings to LNHA. LNHA will review findings, audit one stairwell emergency lighting once a month for 3 months, and bring findings to next quarterly QAPI meeting.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		3/11/22

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K 321	Continued From page 7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing and shall be separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 3 of 8 observed fire-rated doors and was evidenced by the following: 1. During the tour of the building on 02/17/22 at 12:51 PM, in the presence of the facility's Maintenance Director (MD), an inspection of the first floor dining room revealed that hazardous storage was being stored (25 plus cardboard boxes). The door requires an auto-close device installed. 2. The main kitchen door did not fully close into its frame, due to the #1 door rubbing onto the floor, remaining open approximately 2' from closing into its frame.	K 321	K321 Hazardous Areas □Enclosure 1. First floor day room closer was installed, kitchen and laundry doors were replaced. 2. All residents can be affected. 3. Licensed nursing home administrator (LNHA) immediately in-serviced Maintenance Director on requirement for doors to close properly. 3. Maintenance director will audit 3 hazardous areas once a week for 4 weeks, and then monthly for 2 months and submit findings to LNHA. LNHA will review findings, audit one hazardous area once a month for 3 months, and bring findings to the next quarterly QAPI meeting.	

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K 321	Continued From page 8 3. The Laundry room door on floor #3 did not fully close into its frame due to the door rubbing onto the floor, remaining open approximately 3' from closing into its frame. An interview was conducted with the Maintenance Director who stated and confirmed the finding's during the observations. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference on 02/17/22. NJAC 8:39-31.2 (e)	K 321		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		3/11/22

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K 353	Continued From page 9 Based on observation and interview on 02/17/22, it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. During a building tour from 09:30 AM to 02:25 PM, the Surveyor and Maintenance Director, observed drop ceiling tiles missing and/or holes in the ceiling tiles (sheetrock) and bad cuts around the fire sprinkler heads including missing escutcheon plates in the following areas of the facility: 1. floor #5 central supply missing escutcheon plate. 2. floor #5 central supply missing ceiling tiles and tiles with bad cuts. 3. resident room 505 missing escutcheon plate. 4. kitchen walk-in freezer above open ceiling area. 5. kitchen utility closet escutcheon plate not in the proper position. 6. kitchen utility closet broken ceiling tile. 7. maintenance shop holes in the ceiling tiles. 8. floor # 3 janitors closet escutcheon plate missing. 9. floor # 3 shower room holes in the ceiling tiles. 10. floor # 3 chute room missing escutcheon plate. 11. main oxygen storage room missing ceiling tiles. 12. main oxygen storage room missing escutcheon plate. 13. resident room 209 drop ceiling tile opening approximately 1"x 8" by the resident sink.	K 353	K353 Sprinkler System - Maintenance and Testing 1. Missing and damaged ceiling tiles and escutcheons were immediately repaired. The following was repaired: 1. Floor #5 central supply missing escutcheon plate. 2. Floor #5 central supply missing ceiling tiles and tiles with bad cuts. 3. Resident room 505 missing escutcheon plate. 4. Kitchen walk-in freezer above open ceiling area. 5. Kitchen utility closet escutcheon plate not in the proper position. 6. Kitchen utility closet broken ceiling tile. 7. Maintenance shop holes in the ceiling tiles. 8. Floor # 3 janitors closet escutcheon plate missing. 9. Floor # 3 shower room holes in the ceiling tiles. 10. Floor # 3 chute room missing escutcheon plate. 11. Main oxygen storage room missing ceiling tiles. 12. Main oxygen storage room missing escutcheon plate. 13.Resident room 209 drop ceiling tile opening approximately 1"x 8" by the resident sink. 14. Kitchen ceiling 4 of 11 escutcheon plates not in place and 2 missing. 2. All residents can be affected 3. Maintenance director was immediately in-serviced by Licensed nursing home administrator (LNHA) on the requirement of ceiling tiles not being damaged or missing and missing escutcheons. 4. Maintenance Director will check 5 areas weekly for 4 weeks for proper ceiling tiles and escutcheons, then 5	

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K 353	Continued From page 10 14. kitchen ceiling 4 of 11 escutcheon plates not in place and 2 missing. The Maintenance Director stated and confirmed the above findings during the building tour on 02/17/22. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 02/17/22.	K 353	areas monthly for 2 months, and submit findings to LNHA. LNHA will review findings, audit 5 areas monthly for 3 months and bring findings to next quarterly QAPI meeting.	
K 363 SS=E	NJAC 8:39-31.2(e) Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363		3/11/22

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	315147	A. BUILDING **01** B. WING _____	**02/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	**101 NORTH GROVE STREET EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 11 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview from 02/16/22 to 02/17/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 6 of 40 resident room door's and was evidenced by the following: From 02/16/22 to 02/17/22, during the building tour from 9:00 AM to 1:00 PM, the Surveyor and Maintenance Director, observed that the doors to resident rooms, did not latch into the door frame in the following room numbers: # 213 hardware malfunction.	K 363	K363 Corridor - Doors K363 CFR(s): NFPA 101 1. The following were immediately repaired or corrected: 1. Room 213 hardware malfunction. 2. Room 308 curtain blocked door from closing. 3. Room 310 hardware malfunction. 4. Room 405 hardware malfunction.5. Room 412 hardware malfunction. 6. Room 508 resident room curtain blocked door from closing. 2. All residents have the potential to be affected 3. Director of nursing (DON) or nursing supervisor immediately in-serviced certified nursing assistants (CNAs) to the requirement that curtains do not block doors from closing properly. Licensed nursing home administrator (LNHA) immediately in-serviced the Maintenance	

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K 363	Continued From page 12 # 308 resident room curtain blocked door from closing. # 310 hardware malfunction. # 405 hardware malfunction. # 412 hardware malfunction. # 508 resident room curtain blocked door from closing. An interview was conducted with the Maintenance Director, who stated and confirmed that the above resident room doors, had hardware issues that prevented the doors from latching into there frame's properly and resident room curtains installed to close to the doors preventing the door from closing properly. The Administrator was informed of the finding at the Life Safety Code exit conference on 02/17/22. NJAC 8:39-31.1(c), 31.2(e)	K 363	Director on the requirement of doors closing properly. 4. The maintenance director will check 5 areas weekly for 4 weeks, then 5 areas once a month for 2 months, and submit findings to LNHA. LNHA will review findings, audit 5 doors monthly for 3 months, and bring findings to next quarterly QAPI meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		5/26/22

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	315147	A. BUILDING **01** B. WING _____	**02/18/2022**

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GROVE PARK HEALTHCARE AND REHABILITATION CENTER	**101 NORTH GROVE STREET** **EAST ORANGE, NJ 07017**

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K 918	Continued From page 13 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not ensure a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents. On 02/17/22, the Surveyor and Maintenance Director observed that the facility generator was outside and encased. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. An interview was conducted during the observation with the Maintenance Director, where he stated that he was unsure if the exterior encased generator had a remote manual stop	K 918	K918 Electrical Systems - Essential Electric System 1. Auto Stop was immediately installed for the emergency generator. 2. All residents have the potential to be affected. 3. Maintenance director will test auto stop once a month for 3 months and submit finds to Licensed nursing home administrator (LNHA). 4. LNHA will review findings, and submit to the next quarterly QAPI meeting.	

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K 918	Continued From page 14 station. The area was observed not to have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference. NJAC 8:39-31.2(e), 31.2(g) NFPA 99	K 918		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K 923		3/11/22

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K 923	Continued From page 15 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/17/22, in the presence of the Maintenance Director, it was determined that the facility a). failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 1 of 8 portable oxygen cylinders; and b.) prohibit combustible storage within 5-feet of quantities of Oxygen exceeding 300 cubic feet in accordance with NFPA 99. This deficient practice was identified for 48 of 48 portable oxygen cylinders The findings include: 1. On 02/17/22 at 01:20 PM, the Surveyor and Maintenance Director observed on floor #5 in the oxygen storage room that 1 of 8 portable oxygen cylinders were free standing and not secured from tipping, rupture and damage. 2. On 02/17/22 at 01:45 PM, the Surveyor and Maintenance Director observed on floor #4 in the oxygen storage room that 48 portable oxygen cylinders (more then 300 cubic feet), 2 full 24 cylinder carts were next to combustible storage (approximately 25 cardboard boxes).	K 923	K923 Gas Equipment - Cylinder and Container Storage 1. Oxygen tank was put in holder. All stored tanks were removed from within 5 feet of combustible storage. 2. All residents have the potential to be affected 3. Assistant director of nursing (ADON) immediately in-serviced certified nursing assistants (CNA□s) that all oxygen tanks must be placed in holders at all times. Licensed nursing home administrator (LNHA) immediately in-serviced Maintenance Director on requirement of keeping oxygen more than 5 feet from combustible storage. 4. The maintenance director will check 2 residents who are on oxygen once a week for 4 weeks, then monthly for 2 months to ensure that oxygen tank is in holder. The maintenance director will check oxygen stored tanks once a week for 3 months to ensure that they are stored more than 5 feet from combustible storage. Findings	

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K 923	Continued From page 16 An interview was conducted with the Maintenance Director, who stated that the cylinders must be individually secured from tipping, rupture and damage at all times in the facility and 48 oxygen cylinders (more then 300 cubic feet) must be separated by 5' feet from combustibles when sprinklered. The building has a fully functional sprinkler system. The Administrator was informed of the finding at the Life Safety Code exit conference on 02/17/22. NJAC 8:39-31.2(e) NFPA 99	K 923	will be given to the LNHA. LNHA will check one storage area once a month for 3 months, to ensure that oxygen tanks are stored in holders and further than 5 feet from combustible storage. All findings will be presented at next quarterly QAPI meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315147 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/27/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION CENTER	101 NORTH GROVE STREET EAST ORANGE, NJ 07017

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	03/11/2022	LSC K0271	03/11/2022	LSC K0281	03/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	03/11/2022	LSC K0321	03/11/2022	LSC K0353	03/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	03/11/2022	LSC K0918	05/26/2022	LSC K0923	03/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO