STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING ______ B. WING ______	C 01/27/2022

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

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F 000	INITIAL COMMENTS COMPLAINT#: NJ146235, NJ150871 CENSUS: 166 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: C#: NJ146235, NJ150871 Based on observations, interviews, review of	F 600	This plan of correction constitutes New Grove Manor's attestation of compliance to the regulation. This does not constitute an admission of guilt. F600 SS G Abuse and Neglect	2/25/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/24/2022

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 600	Continued From page 1 medical records (MRs), and other pertinent facility documents on 1/25/2022 and 1/27/2022, it was determined that the facility failed to follow their policies and procedures titled "Abuse and Neglect-Clinical Protocol" and "Resident Abuse Neglect and Mistreatment [The Law]" for a resident who encountered verbal abuse from staff. This deficient practice was investigated and identified for 1 of 3 residents (Resident #2), involving three staff members, and placed Resident #2 at risk for psychological harm. This deficient practice was evidenced by the following: Review of a revised facility policy dated 1/2021 titled; "Abuse and Neglect-Clinical Protocol" included under "Definitions" "1. "Abuse" is defined at 483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of good (s) or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology ...4. "Willful" as defined at 483.5 and as used in the definition of "abuse" means "the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." Review of a second facility's undated Policy titled "Resident Abuse Neglect and Mistreatment "The	F 600	¿ Resident¿#2 was evaluated by LCSW on 1/28/2022 for her psychosocial well-being; No new recommendations. Resident #2 no longer resides at the facility since EX Order 26 § 4b1, therefore no care plan updates are necessary. Resident # 2 no longer resides at the facility, since Ex.Order 26.4(b)(1), therefore no further monitoring is necessary.¿ ¿ All residents are at risk to be affected by the deficient practice. All alert and oriented residents were interviewed by the current DON to ensure there were no other unreported allegations of abuse 2/24/2022. ¿ All facility staff re-educated on Customer Service, Abuse P&P which includes: Abuse and Neglect- Clinical Protocol; Abuse Investigation and Reporting; Abuse Prevention Program; (reviewed/revised date 12/2021),as well as de-escalation training on 2/24/2022 by the assistant administrator and nursing supervisors. Abuse P&P will be posted in the public areas as a visual reminder for staff. Facility LPN, SW and Former DON were counseled by administrator on customer service and de-escalation immediately following incidents in which they were involved. LPN and SW were re-educated on Abuse P&P which includes: Abuse and Neglect- Clinical Protocol; Abuse Investigation and Reporting; Abuse Prevention Program; (reviewed/revised date 12/2021), by current DON on 2/14/22.	

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F 600	Continued From page 2 Law" included under "Policy" included, "All residents must be treated with dignity and respect. In the event that an allegation of verbal, sexual, physical, or mental abuse is made regarding a resident, a prompt investigation must be conducted by the administrative staff, and their findings must by (be) reported in (a) timely manner, as specified later in this Policy." Under "Definitions" included "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma cause physical harm, or pain or mental anguish." The Policy also revealed "Verbal Abuse" refers to any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability." A further review of the Policy under " Policy and Procedure for Abuse Prevention (continued)" included the following: 1. Screening: . Two references (preferably from previous employers) . ASI registry check of current CNA (Certified Nursing Assistant) certification for new hires, with criminal background check completed. . State Board Registry Check, as well as visible check of nursing licenses. . 90-day probationary period with strict monitoring and orientation.	F 600	¿ All residents will be reminded of proper procedure to report allegations of abuse during their quarterly care conference as well as monthly resident council meeting. All allegations will be brought to the Director of Nursing and Administrator□s attention immediately, and they will implement investigation per policy and procedure of Facility titled Abuse Investigation and Reporting (reviewed/revised date 12/2021). ¿ Administrator was in serviced by regional administrator on Abuse P&P which includes: Abuse and Neglect-Clinical Protocol; Abuse Investigation and Reporting; Abuse Prevention Program; (review/revised date 12/2021)on 2/24/2022. All allegations and concerns will be reviewed monthly by the Administrator and regional administrator X3 months and then Quarterly at the QAPI meeting X 2 quarters.	

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. Outside service providers providing services on resident care units will provide the following proof of employment pre-screening requirements prior to providing services at the facility:
a. License/certification numbers pertaining to their profession. Expiration dates, and license validation will be checked through New Jersey consumer affairs.
b. Criminal background verification or employment application which indicates employee has never been convicted of a crime (such as crimes of abuse/neglect, violence, dishonesty, financial or personal misconduct, etc.)

2. Training:
. All orientees regardless of department affiliation attend initial orientation on identifying abuse and reporting abuse, with handouts pertaining to definitions and types of abuse, how to report knowledge of possible abuse to supervisors, including use of toll-free reporting that can be done anonymously.
. All employees in all departments attend regular staff in services annually and as needed to maintain knowledge and promote prevention of abuse; including identifying instances of possible abuse, how to report allegations, how to recognize increased stress, signs of burnout and frustration that may lead to abuse situations. What constitutes abuse, neglect, mistreatment and misappropriation of resident property. Help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. Focus with orientation and in-servicing in caring for difficult or aggressive residents and what options are available to caregivers to avoid abusive situations; i.e. changing assignments, "buddy-system", etc. including 1:1 counseling if

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F 600	Continued From page 4 needed. 3. Prevention: On admission and during regularly scheduled interdisciplinary meetings, quarterly, annually and as needed with families, residents and staff, provide information on how and to whom they may report all concerns, complaints and issues of possible abuse, neglect or misappropriation of personal property. Provide reassurance of no fear of retribution and outline plan of immediate investigation and intervention. Prevention Plan includes, but is not limited to the following: A. Environmental rounds by supervisors in each department of secluded areas that may make abuse and/or neglect more likely to occur B. Unit meetings with staff to discuss care issues, complaints and concerns to avoid frustration, lower stress and decrease "burnout." C. Meetings of department heads to review all previous 24 hour incident reports and Supervisor's Investigative reports to determine possibility of abuse. D. Staff scheduling daily to balance units according to resident census and acuity level. E. Shift-to-Shift daily report involving direct care staff to ensure continuity of care and empower staff with knowledge beforehand to avoid frustration in meeting residents' needs. F. Supervision of staff daily in performance of job duties to identify potential abuse/neglect; i.e. foul language, rough handling, neglect, with immediate intervention. 4. Identification: Immediate incident reporting (refer to Accident/Incident Policy & Procedure) and investigation of all falls, bruising, skin teras; increase in depressive, isolative fearful behaviors, and occurrences that may constitute abuse.	F 600		

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F 600	Continued From page 5 Chain of command monitoring of incidents from charge nurse to Supervisor to Director of Nursing to Administration to determine scope of investigation. 5. Investigation: A. The charge nurse or nursing supervisor will conduct a full body assessment (if the allegation is physical abuse) and document all findings in the medication record. B. Initiate emergency care for resident as warranted. C. complete Unusual Occurrence Report according to Accident and Incident reporting Policy and procedure. D. R.N. (Registered Nurse) Supervisor to complete Supervisory Investigate report with interviews and written statements from all persons involved, including the resident, if possible, investigate three prior shifts. E. If the allegation is against an employee, the employee will be removed from the workplace once the statement has been taken and will be suspended pending completion of the investigation. Union protocol to be followed if applicable. Resident to be protected against possible retribution... H. All written statements and documentation are to be completed and maintained under separate file cover in the Director of Nursing's office... K. Director of Nursing is responsible for the completion of abuse policy and procedure appropriately. 6. Protection: All residents involved in an investigation are monitored closely to avoid further disruption of daily quality of life. Interventions are implemented by Social Services Department and Nursing	F 600		

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Administration with (the) resident and family. Immediate removal of "threat," where an employee, other resident (s), social circumstance, or physical hazard, to provide security and safety. Counseling (is) available when warranted. "

7. Reporting:
All violations and alleged or suspected incidents of any form of abuse/neglect will be reported via LTC.reportables@doh.nj.gov system or if computers not available to Department of Health to 1-800-792-9770 or in off hours to 1-609-392-202. If resident is 60 or over report will also be made to Ombudsman Office at 1-877-582-6995. Calls to Ombudsman must be within 2 hours if suspicious event results in injury and within 24 hours if event does not cause injury.

This deficient practice was evidenced by the following:

During a tour on 1/25/2022 at 12:21 p.m., the Surveyors interviewed Resident #2, who appeared emotional and stated, "I've been dealing with ongoing harassment, I feel targeted and bullied with the Administrator." Resident #2 said three separate incidents involving three staff members: the Social Worker (SW), the Director of Nursing (DON), and a nurse occurred. Resident #2 said all of the incidents happened within the past two weeks. Resident #2 stated on 12/27/2021, the former DON called me a prostitute in front of the Administrator, and he did nothing. The resident explained the issue was due to a room change, and Ex.Order refused. According to Resident #2, the DON said, [why don't you want to switch rooms? You won't be able to prostitute]. Resident #2 stated other

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residents were present, but he/she didn't want to say who was there. According to Resident #2, another incident occurred on 1/3/2022 with a nurse on the 4th floor who said, "me she will f... me up," and the SW yelled at me and called me a "prince/princess."

During an interview on 1/25/2022 at 2:04 p.m., the SW stated that Resident #2 requested to go out on pass on a Friday, 12/17/2021, but the resident did not give 72 hours' notice per the facility's policy, so the pass was denied. The SW further stated the resident emailed her about the pass at 3:00 a.m. that morning, then he/she came to the lobby and was yelling and using profanity, so the SW felt threatened, so she called the Police, who took a statement from her and the resident. After the Police left, the resident stayed in the lobby yelling at her, so she yelled back at the resident and called the resident a "prince/princess." The SW stated she then informed Resident #2 that the Administrator would meet with the resident on Monday. The SW said I should not have raised my voice and the name-calling was unprofessional. She stated she had a meeting with the Administrator and Resident #2 the following week, and she was removed as the resident's SW.

During an interview on 1/25/2022 at 2:46 p.m., the Licensed Practice Nurse (LPN) stated Resident #2 came to the fourth floor from the fifth floor on the elevator, and she told Resident #2 he/she was not allowed on her floor due to quarantine and Covid. The resident walked past her and went down the hall; the LPN called the Director of Nursing on the phone with no reply and then the Administrator. There was another staff there (the Receptionist). The LPN stated

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F 600	Continued From page 8 Resident #2 used aggressive language towards her and behaved in a threatening manner. The LPN explained, "I may have said, I'll f... you up! I don't remember; I didn't curse at (him/her)." She continued to explain, "I used expressive language. Cursing is unprovoked, verbal language." The LPN said, "...what I said was inappropriate ..." She also stated that she did not document the incident and did not receive training on abuse at the facility. The LPN further explained to the Surveyors that she spoke to the Administrator on 1/3/2022 about the incident involving Resident #2, and he said he would handle it. She was not asked to provide a statement about the incident. During an interview on 1/25/2022 at 3:53 p.m., the Administrator stated he was leaving for the day on Friday afternoon (12/17/2021) at 3:00 p.m. when Resident #2 wanted to go out on pass; the resident kept pushing the idea but needed a Physician Order to go out on pass. The Administrator explained he spoke with Resident #2 on the phone on his way home. So, on that Monday, he met with the SW and Resident #2 and the agreement was to switch the SW. The Administrator further stated this incident went to a place that was not professional. He met with the SW that Monday and counseled her on the verbal unprofessionalism and name-calling that happened with Resident #2. The Administrator explained, "I don't feel the resident was threatened by it. The resident knows exactly very well (how) to follow protocol." When asked by the Surveyor what he meant by the SW was counseled? He explained he told the SW not to raise her voice and name-call. "I don't feel the resident felt threatened. (The resident) was not getting what(he/she) wanted" because the pass	F 600		

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F 600	Continued From page 9 was not approved. According to the Administrator, Resident #2 said he/she "felt angry & humiliated and being picked on." The Administrator explained when the incident occurred between Resident #2 and the LPN; the resident went to the fourth floor from the fifth floor to shower. The nurse said to the resident, "You shouldn't be down here, " and the resident used profanity towards the nurse. According to the Administrator, Resident #2 threatened to hurt the LPN physically. When asked by the Surveyors why he did not complete an investigation, the Administrator stated Resident #2 manipulated staff and instigated both incidents. He explained, "I did an investigation, I did the camera, spoke to the Receptionist and the resident." The Administrator explained: there's a camera but no audio footage. He received a statement from the Receptionist (who observed a portion of the incident between the LPN and the resident) and thought he got a statement from the nurse, but he had to check on it. The Surveyors continued to interview the Administrator about the incident with the former DON on 12/27/2021. He explained that Resident #2 was in a private room, the room was needed for isolation, and the resident did not want to move. According to the Administrator, the DON said the resident wanted the room for prostituting; it was unprofessional. He continued to explain Resident #2 verbally puts down staff; "there was only so much someone could take, but there is always room for improvement." As a result, he verbally counseled the DON and removed her from the floor, and the ADON (Assistant Director of Nursing) would interact with the resident. The Surveyors asked the Administrator how he	F 600		

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counseled the DON? He explained: "to remove self from the situation, sustain a professional tone of voice and word choice. There was no copy of the counseling because it was done verbally."

When the Surveyor asked the Administrator what was verbal abuse, he replied, "I would consider verbal abuse to be the words that would make the resident feel threatened, scared to do something ... it hits you, I'm scared to do this, shakes me, shuts me down ...goes a step further than talking, afraid to do something. In my eyes, I don't see the resident feeling threatened or scared."

When the Surveyor asked the Administrator if he asked the resident how he/she felt after each of the incidents, he replied the following: After the SW incident, I didn't ask his/her feelings until Monday, and the resident said his/her [feelings were angry, upset, and felt like you're picking on me]. The resident did not say, "my needs are not met; never said I feel scared or threatened...." After the incident with the nurse, he further explained that the resident called me on the phone and complained of the nurse using profanity. The Administrator explained with the DON ane Resident #2's incident he was present, and the resident was "upset, not scared or threatened." The Administrator stated, "I'm good with body language; I could tell the resident was not threatened. He/she was angry and upset."

During a phone interview on 1/25/2022 at 4:48 p.m., the former DON stated she asked Resident #2 to change his/her room, which the resident previously agreed to do, but things escalated. Resident #2 said he/she could not change the room because the resident was transgender. This was the first time I heard this about the resident.

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F 600	Continued From page 11 It was out of the left field. There was no clinical indication for him/her to have a private room. I might have said he/she was making that up. "I said, it's difficult to be a prostitute when you have roommates. I was frustrated ...." The DON continued to explain, "... I did act out of line. I'm a professional and a DON. I'm upset with myself. It's hard to keep emotions in line ...." The DON stated, "... I let emotions get the best of me." It was not a professional thing to do." The Surveyor asked the DON if referring to Resident #2 as a prostitute was appropriate. She replied, "Of course not, it was not appropriate, I would not act in that way." She explained after the situation escalated, she walked away. According to the DON, the Administrator spoke with her after the incident. "It was unprofessional. I already knew." She stated she did not write a statement. The DON stated, "I don't think it was verbal abuse. I don't think (he/she) felt threatened by what I was saying to (him/her)." During an interview on 1/25/2022 at 5:13 p.m. with the current DON (the former ADON), he stated he was rounding the floors when Resident #2 and the former DON altercation happened. According to the DON, he vaguely remembered it. He recalled there was a lot of yelling, but he could recall the exact words. When the Surveyor asked him, what verbal abuse was, he replied, "definitely the intent to do harm ...." During an interview on 1/27/2022 at 11:33 a.m. with the Receptionist, when the Surveyor asked her about the incident on 1/3/2022 with the LPN, she explained, she got off the elevator on the fourth floor, the resident told the nurse, [You think I threw water on you yesterday? I'm going to put my hands on you today].	F 600		

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(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 600	Continued From page 12 During a second interview on 1/27/2022 at 12:00 p.m., Resident #2 stated the issue was not what happened. "It's the Administrator not doing anything or protecting me." When the Surveyor asked Resident #2 how he/she felt after each incident, Resident #2 explained the first incident with the SW. Resident #2 felt embarrassed, so he/she reached out to the Administrator, and they had a meeting two days after. Resident #2 stated during the meeting, the SW continued to be demeaning and, rolling her eyes, she got up and walked out of the meeting. The resident said he/she then told the Administrator there needs to be accountability and requested the SW be changed, and she was removed. Resident #2 further explained the second incident involving the DON, the Administrator, and the DON was standing in the resident's doorway. The resident, he/she, didn't want to move; it was his/her home. According to Resident #2, the DON told [EX Order] in a condescending voice, "I won't be able to prostitute. The Administrator didn't do anything. He had no response or no defense." The resident stated he/she felt embarrassed, uncomfortable, horrible, and sad. He/She did not want to leave his/her room. Resident #2 stated he/she did not speak to the Administrator about this incident. Resident #2 stated the LPN; there was a personality clash. Resident #2 knew the nurse from the fifth floor, where they had a previous conflict. According to Resident#2, he/she went to visit a friend on the fourth floor. The nurse said to Resident #2, "Take your disrespectful ass off the floor, and then the resident replied, "what else are you going to do? Then, the nurse said to the	F 600		

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resident, "I'll f you up!" The resident replied, "do it!" The resident went to see the Administrator and told him what had happened. The Administrator said to Resident #2, what do you want me to do? The resident said to him, "I can't feel safe here." The Administrator asked the resident to explain what he/she meant by that statement. The resident continued to explain what happens if he/she sees the nurse on the elevator and the nurse wants to "f..k me up"? He/she stated at the moment, "I felt angry" Afterwards, "I felt very unsure and unsafe with the nurse. The nurse could do something to me."

During a second interview on 1/27/2022 at 12:32 p.m., the Administrator indicated he didn't see the result of the harm to the (resident) as being humiliated. He explained the resident felt comfortable with each incident; the SW was switched, the ADON was the clinical point of contact, and the nurse was switched to another floor. He stated, "I was involved with all the resolutions and spoke to the resident." The Surveyor showed the Administrator a copy of the "Abuse" Policy and asked him if he followed it; he explained that he assessed and de-escalated the situation, he told the former DON to go away, and he would handle it. He spoke to the resident that he/she could stay in the room and figured out a solution with the resident. He stated the resident repeated that he/she was angry and upset, there was no anguish, and the resident was comfortable with the solution.

The Administrator further explained he de-escalated and handled the situation concerning the nurse incident and found a resolution. The Administrator stated he spoke to the nurse and the resident, he did not remember

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what the nurse said, but it was profanity. The Administrator said Resident #2 told him the resident said the profanity first, and the nurse repeated the words back to the resident. He informed the resident that the nurse was moved to another floor, and he told the resident, "I'll make it a safe situation." He informed the resident if the nurse was there to call him. The Administrator stated the resident felt angry, but he didn't recall the resident saying he/she felt unsafe. The Administrator explained that if the resident would've said he/ she felt threatened, he would have reported the incidents to the NJDOH. He also said I would have reported it to NJDOH and get a Psychiatrist or Psychologist to see him/her; if I knew she felt like that, I would have acted on it. The Administrator stated he would like everyone to be more professional. Also, after the Surveyor's visit on 1/25, he has now implemented behavioral training on how to handle, de-escalate situations, and not react.

He further explained counseling was done in the conference room, talked about the incident, what each person thought happened, how it fits into policy and mission statement, and the staff would sign it; but he did not do it with these three incidents. He only counseled each staff with no documentation.

During the exit conference on 1/27/2022 at 1:57 p.m., in the presence of the current DON, ADON, and Regional Nurse Consultant, the Surveyor asked the Administrator what is the meaning of the word derogatory, as stated; in the facility's" Abuse" Policy under "Verbal Abuse?" The Administrator replied that Derogatory means it was more than regular name-calling, putting someone down, not on the same level as

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everyone else, and context, tone.

At the time of the survey, the facility could not prove a thorough investigation was completed for each incident for the verbal altercations between Resident #2 and the aforementioned staff members.

A review of the Electronic Medical Record (EMR) revealed the following:

According to the facility Admission Record, Resident #2 was initially admitted to the facility EX Order 26 § 4b1 and was readmitted on EX Order 26 § 4b1 with diagnoses included but were not limited to: EX Order 26 § 4b1

A Minimum Data Set (MDS), an assessment tool, dated 12/21/2021, revealed the resident had a Brief Interview of Mental Status (BIMS) score of EX Order 26 § meaning the resident was cognitively intact and the resident was independent with all Activities of Daily Living (ADLs).

A review of Resident #2's Care Plan (CP) included under "Focus": Resident has impaired behaviors related to refusals of care/vital signs/weights ... dated 2/13/2021. Under "Goal": Resident will adjust to facility staff and routines. The resident will be compliant and cooperative with care and treatments through the next review date, revision dated 9/3/2021, under "Interventions/Tasks": Avoid power struggles and confrontation ... Encourage verbal communication/simple words to communicate

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F 600	Continued From page 16 wants and needs. Further review of the CP showed under "Focus": Resident has evidence of ineffective coping and behavioral symptoms related to: EX Order 26 § 4b1 . Under "Goal": Resident will not consume EX Order 26 § 4b1 while residing in the facility through next review date, revision dated 9/3/2021, under "Interventions/Tasks": Psychology consult as needed, set firm limits to prevent EX Order 26 § 4b1 .	F 600		
F 609 SS=D	N.J.A.C.: 8:39-4.1 (a) 5 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		2/25/22

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§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
C#: NJ146235, NJ150871

Based on interviews, medical record (MR) review, and review of other pertinent facility documentation on 1/25/2022 and 1/27/2022, it was determined that the facility failed to report Staff to Resident verbal altercations to the New Jersey Department of Health (NJDOH), as well as failed to follow the facility's policies titled "Abuse and Neglect-Clinical Protocol" and "Resident Abuse Neglect and Mistreatment [The Law]" for 1 of 3 residents (Resident # 2) involving three staff members. This deficient practice was evidenced by the following:

During a tour on 1/25/2022 at 12:21 p.m., the Surveyors interviewed Resident #2, who appeared emotional and stated, "I've been dealing with ongoing harassment, I feel targeted and bullied with the Administrator." Resident #2 said three separate incidents involving three staff members: the Social Worker (SW), the Director of Nursing (DON), and a nurse occurred. Resident #2 said all of the incidents happened within the past two weeks. Resident #2 stated on 12/27/2021, the former DON called me a prostitute in front of the Administrator, and he did nothing. The resident explained the issue was

This plan of correction constitutes New Grove Manor's attestation of compliance to the regulation. This does not constitute an admission of guilt.

F609 Reporting¿

¿ Resident #2's Investigation summary report was submitted to the Department of Health with fax confirmation on 2/24/22. Resident #2 no longer resides in the facility since Ex.Order 26.4(b)(1) 2.

¿ All residents are at risk to be affected by the deficient practice. Admin and DON were in serviced by regional Administrator on 2/24/2022 on what is considered a reportable event including, allegation of abuse or exploitation by anyone, be it verbal, sexual, physical or mental abuse, corporal punishment, mistreatment, involuntary seclusion, neglect or misappropriation of property.

¿ All facility staff were re-educated on the facility Abuse Investigation and Reporting policy (reviewed/revised date 12/2021),) by Assistant Administrator and Nursing

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F 609	Continued From page 18 due to a room change, and Ex.Order refused. According to Resident #2, the DON said, [why don't you want to switch rooms? You won't be able to prostitute]. Resident #2 stated other residents were present, but he/she didn't want to say who was there. According to Resident #2, another incident occurred on 1/3/2022 with a nurse on the 4th floor who said, "me she will f... me up," and the SW yelled at me and called me a "prince/princess." A review of the Electronic Medical Record (EMR) revealed the following: According to the facility Admission Record, Resident #2 was initially admitted to the facility Ex.Order 26.4(b)(1) and was readmitted on Ex.Order 26.4(b)(1) with diagnoses included but were not limited to: EX Order 26 § 4b1 A Minimum Data Set (MDS), an assessment tool, dated 12/21/2021, revealed the resident had a Brief Interview of Mental Status (BIMS) score of EX Order 26, meaning the resident was Ex.Order 26.4(b)(1) and the resident was independent with all Activities of Daily Living (ADLs). A review of Resident #2's Care Plan (CP) included under "Focus": Resident has impaired behaviors related to refusals of care/vital signs/weights ... dated 2/13/2021. Under "Goal": Resident will adjust to facility staff and routines. The resident will be compliant and cooperative with care and treatments through the next review date, revision dated 9/3/2021, under	F 609	Supervisors on 2/24/2022. ¿ DON/ADMIN will review all incidents to determine if they are reportable events and ensure the policy of Abuse Investigation and Reporting is being followed (reviewed/revised date 12/2021) monthly for three months. ¿ ADMIN/DON will report weekly for three months, to the Corporate DON or designee who will audit one reportable event file per month x 3 months for evidence of appropriate event reporting. ¿ Findings will be reviewed by ADMIN monthly X3 months and then Quarterly by facility QAPI committee who will determine further interventions as needed.	

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F 609	Continued From page 19 "Interventions/Tasks": Avoid power struggles and confrontation ... Encourage verbal communication/simple words to communicate wants and needs. Further review of the CP showed under "Focus": Resident has evidence of ineffective coping and behavioral symptoms related to: EX Order 26 § 4b1 . Under "Goal": Resident will not consume EX Order 26 § 4b1 while residing in the facility through next review date, revision dated 9/3/2021, under "Interventions/Tasks": Psychology consult as needed, set firm limits to prevent Ex.Order 26.4(b)(1) . During an interview on 1/25/2022 at 2:04 p.m., the SW stated that Resident #2 requested to go out on pass on a Friday, 12/17/2021, but the resident did not give 72 hours' notice per the facility's policy, so the pass was denied. The SW further stated the resident emailed her about the pass at 3:00 a.m. that morning, then he/she came to the lobby and was yelling and using profanity, so the SW felt threatened, so she called the Police, who took a statement from her and the resident. After the Police left, the resident stayed in the lobby yelling at her, so she yelled back at the resident and called the resident a "prince/princess." The SW stated she then informed Resident #2 that the Administrator would meet with the resident on Monday. The SW said I should not have raised my voice and the name-calling was unprofessional. She stated she had a meeting with the Administrator and Resident #2 the following week, and she was removed as the resident's SW. During an interview on 1/25/2022 at 2:46 p.m., the Licensed Practice Nurse (LPN) stated	F 609		

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Resident #2 came to the fourth floor from the fifth floor on the elevator, and she told Resident #2 he/she was not allowed on her floor due to quarantine and Covid. The resident walked past her and went down the hall; the LPN called the Director of Nursing on the phone with no reply and then the Administrator. There was another staff there (the Receptionist). The LPN stated Resident #2 used EX Order 26 § 4b1 [redacted] The LPN explained, "I may have said, I'll f... you up! I don't remember; I didn't curse at (him/her)." She continued to explain, "I used expressive language. Cursing is unprovoked, verbal language." The LPN said, "...what I said was inappropriate ..." She also stated that she did not document the incident and did not receive training on abuse at the facility. The LPN further explained to the Surveyors that she spoke to the Administrator on 1/3/2022 about the incident involving Resident #2, and he said he would handle it. She was not asked to provide a statement about the incident.

During an interview on 1/25/2022 at 3:53 p.m., the Administrator stated the incident with the SW was not reported to the NJDOH. He explained that he was leaving for the day on Friday afternoon (12/17/2021) at 3:00 p.m. when Resident #2 wanted to go out on pass; the resident kept pushing the idea but needed a Physician Order to go out on pass. The Administrator told the resident to report abuse. The Administrator explained he spoke with Resident #2 on the phone on his way home. So, on that Monday, he met with the SW and Resident #2 and the agreement was to switch the SW. The Administrator further stated this incident went to a place that was not professional. He met

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with the SW that Monday and counseled her on the verbal unprofessionalism and name-calling that happened with Resident #2. The Administrator explained, "I don't feel the resident was threatened by it. The resident knows exactly very well (how) to follow protocol." When asked by the Surveyor what he meant by the SW was counseled? He explained he told the SW not to raise her voice and name-call. "I don't feel the resident felt threatened. (The resident) was not getting what(he/she) wanted" because the pass was not approved. According to the Administrator, Resident #2 said he/she "felt angry & humiliated and being picked on."

The Administrator explained when the incident occurred between Resident #2 and the LPN; the resident went to the fourth floor from the fifth floor to shower. The nurse said to the resident, "You shouldn't be down here, " and the resident used profanity towards the nurse. According to the Administrator, Resident #2 threatened to hurt the LPN physically. When asked by the Surveyors why he did not complete an investigation, the Administrator stated Resident #2 manipulated staff and instigated both incidents. He explained, "I did an investigation, I did the camera, spoke to the Receptionist and the resident." The Administrator explained: there's a camera but no audio footage. He received a statement from the Receptionist (who observed a portion of the incident between the LPN and the resident) and thought he got a statement from the nurse, but he had to check on it.

The Surveyors continued to interview the Administrator about the incident with the former DON on 12/27/2021. He explained that Resident #2 was in a private room, the room was needed

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for isolation, and the resident did not want to move. According to the Administrator, the DON said the resident wanted the room for prostituting; it was unprofessional. He continued to explain Resident #2 verbally puts down staff; "there was only so much someone could take, but there is always room for improvement." As a result, he verbally counseled the DON and removed her from the floor, and the ADON (Assistant Director of Nursing) would interact with the resident. The Surveyors asked the Administrator how he counseled the DON? He explained: "to remove self from the situation, sustain a professional tone of voice and word choice. There was no copy of the counseling because it was done verbally."

When the Surveyor asked the Administrator what was verbal abuse, he replied, "I would consider verbal abuse to be the words that would make the resident feel threatened, scared to do something ... it hits you, I'm scared to do this, shakes me, shuts me down ...goes a step further than talking, afraid to do something. In my eyes, I don't see the resident feeling threatened or scared."

When the Surveyor asked the Administrator if he asked the resident how he/she felt after each of the incidents, he replied the following: After the SW incident, I didn't ask his/her feelings until Monday, and the resident said his/her [feelings were angry, upset, and felt like you're picking on me]. The resident did not say, "my needs are not met; never said I feel scared or threatened...." After the incident with the nurse, he further explained that the resident called me on the phone and complained of the nurse using profanity. The Administrator explained with the DON ane Resident #2's incident he was present, and the resident was "upset, not scared or

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threatened." The Administrator stated, "I'm good with body language; I could tell the resident was not threatened. He/she was angry and upset."

During a phone interview on 1/25/2022 at 4:48 p.m., the former DON stated she asked Resident #2 to change his/her room, which the resident previously agreed to do, but things escalated. Resident #2 said he/she could not change the room because the resident was transgender. This was the first time I heard this about the resident. It was out of the left field. There was no clinical indication for him/her to have a private room. I might have said he/she was making that up. "I said, it's difficult to be a prostitute when you have roommates. I was frustrated ...." The DON continued to explain, " .... I did act out of line. I'm a professional and a DON. I'm upset with myself. It's hard to keep emotions in line ...." The DON stated, " .... I let emotions get the best of me." It was not a professional thing to do." The Surveyor asked the DON if referring to Resident #2 as a prostitute was appropriate. She replied, "Of course not, it was not appropriate, I would not act in that way." She explained after the situation escalated, she walked away.

According to the DON, the Administrator spoke with her after the incident. "It was unprofessional. I already knew." She stated she did not write a statement. The DON stated, "I don't think it was verbal abuse. I don't think (he/she) felt threatened by what I was saying to (him/her)."

During an interview on 1/27/2022 at 11:33 a.m. with the Receptionist, when the Surveyor asked her about the incident on 1/3/2022 with the LPN, she explained, she got off the elevator on the fourth floor, the resident told the nurse, [You think

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I threw water on you yesterday? I'm going to put my hands on you today].

During a second interview on 1/27/2022 at 12:00 p.m., Resident #2 stated the issue was not what happened. "It's the Administrator not doing anything or protecting me." When the Surveyor asked Resident #2 how he/she felt after each incident, Resident #2 explained the first incident with the SW. Resident #2 felt embarrassed, so he/she reached out to the Administrator, and they had a meeting two days after. Resident #2 stated during the meeting, the SW continued to be demeaning and, rolling her eyes, she got up and walked out of the meeting. The resident said he/she then told the Administrator there needs to be accountability and requested the SW be changed, and she was removed.

Resident #2 further explained the second incident involving the DON, the Administrator, and the DON was standing in the resident's doorway. The resident, he/she, didn't want to move; it was his/her home. According to Resident #2, the DON told her in a condescending voice, "I won't be able to prostitute. The Administrator didn't do anything. He had no response or no defense." The resident stated he/she felt embarrassed, uncomfortable, horrible, and sad. He/She did not want to leave his/her room. Resident #2 stated he/she did not speak to the Administrator about this incident.

Resident #2 stated the LPN; there was a personality clash. Resident #2 knew the nurse from the fifth floor, where they had a previous conflict. According to Resident#2, he/she went to visit a friend on the fourth floor. The nurse said to Resident #2, "Take your disrespectful ass off the

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F 609	Continued From page 25 floor, and then the resident replied, "what else are you going to do? Then, the nurse said to the resident, "I'll f you up!" The resident replied, "do it!" The resident went to see the Administrator and told him what had happened. The Administrator said to Resident #2, what do you want me to do? The resident said to him, "I can't feel safe here." The Administrator asked the resident to explain what he/she meant by that statement. The resident continued to explain what happens if he/she sees the nurse on the elevator and the nurse wants to "fuck me up"? He/she stated at the moment, "I felt angry" Afterwards, "I felt very unsure and unsafe with the nurse. The nurse could do something to me." During a second interview on 1/27/2022 at 12:32 p.m., the Administrator indicated he didn't see the result of the harm to the (resident) as being humiliated. He explained the resident felt comfortable with each incident; the SW was switched, the ADON was the clinical point of contact, and the nurse was switched to another floor. He stated, "I was involved with all the resolutions and spoke to the resident." The Surveyor showed the Administrator a copy of the "Abuse" Policy and asked him if he followed it; he explained that he assessed and de-escalated the situation, he told the former DON to go away, and he would handle it. He spoke to the resident that he/she could stay in the room and figured out a solution with the resident. He stated the resident repeated that he/she was angry and upset, there was no anguish, and the resident was comfortable with the solution. The Administrator further explained he de-escalated and handled the situation concerning the nurse incident and found a	F 609		

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F 609	Continued From page 26 resolution. The Administrator stated he spoke to the nurse and the resident, he did not remember what the nurse said, but it was profanity. The Administrator said Resident #2 told him the resident said the profanity first, and the nurse repeated the words back to the resident. He informed the resident that the nurse was moved to another floor, and he told the resident, "I'll make it a safe situation." He informed the resident if the nurse was there to call him. The Administrator stated the resident felt angry, but he didn't recall the resident saying he/she felt unsafe. The Administrator explained if the resident would've said he/ she felt threatened, then he would have reported the incidents to the NJDOH. The Administrator stated he would like everyone to be more professional, doing behavioral training now on how to handle de-escalating situations and not reacting. He further explained counseling was done in the conference room, talked about the incident, what each person thought happened, how it fits into policy and mission statement, and the staff would sign it; but he did not do it with these three incidents. He only counseled each staff with no documentation. During the exit conference on 1/27/2022 at 1:57 p.m., in the presence of the current DON, ADON, and Regional Nurse Consultant, the Surveyor asked the Administrator what is the meaning of the word derogatory, as stated in the facility's" Abuse" Policy under "Verbal Abuse," he stated the Derogatory means it was more than regular name-calling, putting someone down, not on the same level as everyone else, and context, tone. Review of an undated facility policy titled "Resident Abuse Neglect and Mistreatment "The	F 609		

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Law" included but was not limited to;
"Policy: Resident Abuse/Neglect Mistreatment" included: "It is the policy of this facility to protect all residents from physical or mental abuse, involuntary seclusion, corporal punishment, any physical or chemical restraint not required to treat the resident's medical symptoms or neglect, exploitation or misappropriation of personal property, and to investigate and report all alleged or suspected occurrences of abuse, neglect or misappropriation to the appropriate regulatory agencies."

"All residents must be treated with dignity and respect. In the vent that an allegation of verbal, sexual, physical, or mental abuse is made regarding a resident, a prompt investigation must be conducted by the administrative staff, and their findings must by (be) reported in timely manner, as specified later in this policy."

"All employees are expected and must immediately report any sign of injury sustained by a resident, whether or not the nature if (of) the injury is known. Any employee witnessing any form of abuse is also required to promptly report the incident to the charge nurse. Any staff member failing to report these incidents will be subject to disciplinary action which may include immediate discharge. Such action may as well be grounds for civil actions."

"Definitions" included "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing.

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F 609	Continued From page 28 This presumes that instances of abuse of all residents, even those in a coma cause physical harm, or pain or mental anguish." "Verbal Abuse" refers to any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability." A further review of the Policy under " Policy and Procedure for Abuse Prevention (continued)" included the following: 7. Reporting: All violations and alleged or suspected incidents of any form of abuse/neglect will be reported via the LTC.reportables@doh.nj.gov system or if computers are not available to the Department of Health to 1-800-792-9770 or in off-hours to 1-609-392-202. Any employee who has reasonable cause to believe a resident has been abused, mistreated or neglected shall report the alleged incident to their Supervisor, Director of Nursing, or Administrator. Any questions in regard to Abuse policy should be directed to the Director of Nursing. . Necessary corrective action, including termination, change of environment etc. depending on results of the investigation. . Report any employee unfit for service or any knowledge of any actions by a court of law to the State Nurse Aide Registry or NJ State Board of Nurses, etc.	F 609		

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F 609	Continued From page 29 . Report any employee unfit for service or any knowledge of actions by a court of law to Department of Consumer Affairs. N.J.A.C.: 8:39-13.4 (c) (2) (v)	F 609		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: C#: NJ146235, NJ150871 Based on interviews, medical record (MR) review, and review of other pertinent facility documentation on 1/25/2022 and 1/27/2022, it was determined that the facility Administrator failed to investigate and report verbal altercations to the New Jersey Department of Health (NJDOH). The Administrator also failed to ensure the facility's policies titled "Abuse and Neglect-Clinical Protocol" and "Resident Abuse Neglect and Mistreatment [The Law]" and the "Administrator" job description was followed. This deficient practice was for three Staff to Resident verbal altercations for 1 of 3 residents (Resident #2) and was evidenced by the following: According to the facility Admission Record,	F 835	This plan of correction constitutes New Grove Manor's attestation of compliance to the regulation. This does not constitute an admission of guilt. F835 Administration¿ ¿ Resident #2 no longer resides at the facility since Ex.Order 26.4(b)(1) Resident #2's Investigation summary reports were documented and submitted to the Department of Health by facility Administrator on 2/24/2022. ¿ All residents are at risk to be affected by the deficient practice. Administrator in-serviced by regional administrator, 0n 2/24/2022 on proper methods for	2/25/22

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F 835	Continued From page 30 Resident #2 was initially admitted to the facility EX Order 26 § 4b1 and was readmitted on EX Order 26 § 4b1 with diagnoses included but were not limited to: EX Order 26 § 4b1 A Minimum Data Set (MDS), an assessment tool, dated 12/21/2021, revealed the resident had a Brief Interview of Mental Status (BIMS) score of EX Order 26, meaning the resident was Ex.Order 26.4(b)(1) and the resident was independent with all Activities of Daily Living (ADLs). A review of Resident #2's Care Plan (CP) included under "Focus": Resident has impaired behaviors related to refusals of care/vital signs/weights ... dated 2/13/2021. Under "Goal": Resident will adjust to facility staff and routines. The resident will be compliant and cooperative with care and treatments through the next review date, revision dated 9/3/2021, under "Interventions/Tasks": Ex.Order 26.4(b)(1) e words to communicate wants and needs. Further review of the CP showed under "Focus": Resident has evidence of ineffective coping and behavioral symptoms related to: EX Order 26 § 4b1. Under "Goal": Resident will not consume EX Order 26 § 4b1 while residing in the facility through next review date, revision dated 9/3/2021, under "Interventions/Tasks": Psychology consult as needed, set firm limits to prevent Ex.Order 26.4(b)(1)	F 835	investigating, documenting and reporting interventions when an incident is brought to his attention or witnessed. ¿ All facility staff were re-educated on the facility Abuse Investigation and Reporting policy (reviewed/revised date 12/2021)by Assistant Administrator and Nursing Supervisors on 2/24/2022. ¿ Administrator will review all investigations and allegations of abuse to ensure the Abuse Investigation and Reporting policy (reviewed/revised date 12/2021) is being followed and will report weekly to the facility's regional Administrator for three months. Regional Administrator or designee will audit one investigation per week X4 weeks and then one per month X 3 months ¿ Findings will be reviewed by Regional Administrator monthly X3 months and then Quarterly by facility QAPI committee who will determine further interventions as needed.	

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During a tour on 1/25/2022 at 12:21 p.m., the Surveyors interviewed Resident #2, who appeared emotional and stated, "I've been dealing with ongoing harassment, I feel targeted and bullied with the Administrator." Resident #2 said three separate incidents involving three staff members: the Social Worker (SW), the Director of Nursing (DON), and a nurse occurred. Resident #2 said all of the incidents happened within the past two weeks. Resident #2 stated on 12/27/2021, the former DON called me a prostitute in front of the Administrator, and he did nothing. The resident explained the issue was due to a room change, and Ex.Order refused. According to Resident #2, the DON said, [why don't you want to switch rooms? You won't be able to prostitute]. Resident #2 stated other residents were present, but he/she didn't want to say who was there. According to Resident #2, another incident occurred on 1/3/2022 with a nurse on the 4th floor who said, "me she will f... me up," and the SW yelled at me and called me a "prince/princess."

During an interview on 1/25/2022 at 2:04 p.m., the SW stated that Resident #2 requested to go out on pass on a Friday, 12/17/2021, but the resident did not give 72 hours' notice per the facility's policy, so the pass was denied. The SW further stated the resident emailed her about the pass at 3:00 a.m. that morning, then he/she came to the lobby and was yelling and using profanity, so the SW felt threatened, so she called the Police, who took a statement from her and the resident. After the Police left, the resident stayed in the lobby yelling at her, so she yelled back at the resident and called the resident a "prince/princess." The SW stated she then informed Resident #2 that the Administrator

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would meet with the resident on Monday. The SW said I should not have raised my voice and the name-calling was unprofessional. She stated she had a meeting with the Administrator and Resident #2 the following week, and she was removed as the resident's SW.

During an interview on 1/25/2022 at 2:46 p.m., the Licensed Practice Nurse (LPN) stated Resident #2 came to the fourth floor from the fifth floor on the elevator, and she told Resident #2 he/she was not allowed on her floor due to quarantine and Covid. The resident walked past her and went down the hall; the LPN called the Director of Nursing on the phone with no reply and then the Administrator. There was another staff there (the Receptionist). The LPN stated Resident #2 used aggressive language towards her and behaved in a threatening manner. The LPN explained, "I may have said, I'll f... you up! I don't remember; I didn't curse at (him/her)." She continued to explain, "I used expressive language. Cursing is unprovoked, verbal language." The LPN said, "...what I said was inappropriate ..." She also stated that she did not document the incident and did not receive training on abuse at the facility. The LPN further explained to the Surveyors that she spoke to the Administrator on 1/3/2022 about the incident involving Resident #2, and he said he would handle it. She was not asked to provide a statement about the incident.

During an interview on 1/25/2022 at 3:53 p.m., the Administrator stated he was leaving for the day on Friday afternoon (12/17/2021) at 3:00 p.m. when Resident #2 wanted to go out on pass; the resident kept pushing the idea but needed a Physician Order to go out on pass. The

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F 835	Continued From page 33 Administrator explained he spoke with Resident #2 on the phone on his way home. So, on that Monday, he met with the SW and Resident #2 and the agreement was to switch the SW. The Administrator further stated this incident went to a place that was not professional. He met with the SW that Monday and counseled her on the verbal unprofessionalism and name-calling that happened with Resident #2. The Administrator explained, "I don't feel the resident was threatened by it. The resident knows exactly very well (how) to follow protocol." When asked by the Surveyor what he meant by the SW was counseled? He explained he told the SW not to raise her voice and name-call. "I don't feel the resident felt threatened. (The resident) was not getting what(he/she) wanted" because the pass was not approved. According to the Administrator, Resident #2 said he/she "felt angry & humiliated and being picked on." The Administrator explained when the incident occurred between Resident #2 and the LPN; the resident went to the fourth floor from the fifth floor to shower. The nurse said to the resident, "You shouldn't be down here, " and the resident used profanity towards the nurse. According to the Administrator, Resident #2 threatened to hurt the LPN physically. When asked by the Surveyors why he did not complete an investigation, the Administrator stated Resident #2 manipulated staff and instigated both incidents. He explained, "I did an investigation, I did the camera, spoke to the Receptionist and the resident." The Administrator explained: there's a camera but no audio footage. He received a statement from the Receptionist (who observed a portion of the incident between the LPN and the resident) and thought he got a statement from the nurse, but he	F 835		

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had to check on it.

The Surveyors continued to interview the Administrator about the incident with the former DON on 12/27/2021. He explained that Resident #2 was in a private room, the room was needed for isolation, and the resident did not want to move. According to the Administrator, the DON said the resident wanted the room for prostituting; it was unprofessional. He continued to explain Resident #2 verbally puts down staff; "there was only so much someone could take, but there is always room for improvement." As a result, he verbally counseled the DON and removed her from the floor, and the ADON (Assistant Director of Nursing) would interact with the resident. The Surveyors asked the Administrator how he counseled the DON? He explained: "to remove self from the situation, sustain a professional tone of voice and word choice. There was no copy of the counseling because it was done verbally."

When the Surveyor asked the Administrator what was verbal abuse, he replied, "I would consider verbal abuse to be the words that would make the resident feel threatened, scared to do something ... it hits you, I'm scared to do this, shakes me, shuts me down ...goes a step further than talking, afraid to do something. In my eyes, I don't see the resident feeling threatened or scared."

When the Surveyor asked the Administrator if he asked the resident how he/she felt after each of the incidents, he replied the following: After the SW incident, I didn't ask his/her feelings until Monday, and the resident said his/her [feelings were angry, upset, and felt like you're picking on me]. The resident did not say, "my needs are not met; never said I feel scared or threatened...."

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After the incident with the nurse, he further explained that the resident called me on the phone and complained of the nurse using profanity. The Administrator explained with the DON ane Resident #2's incident he was present, and the resident was "upset, not scared or threatened." The Administrator stated, "I'm good with body language; I could tell the resident was not threatened. He/she was angry and upset."

During a phone interview on 1/25/2022 at 4:48 p.m., the former DON stated she asked Resident #2 to change his/her room, which the resident previously agreed to do, but things escalated. Resident #2 said he/she could not change the room because the resident was transgender. This was the first time I heard this about the resident. It was out of the left field. There was no clinical indication for him/her to have a private room. I might have said he/she was making that up. "I said, it's difficult to be a prostitute when you have roommates. I was frustrated ...." The DON continued to explain, "... I did act out of line. I'm a professional and a DON. I'm upset with myself. It's hard to keep emotions in line ...." The DON stated, "... I let emotions get the best of me." It was not a professional thing to do." The Surveyor asked the DON if referring to Resident #2 as a prostitute was appropriate. She replied, "Of course not, it was not appropriate, I would not act in that way." She explained after the situation escalated, she walked away.

According to the DON, the Administrator spoke with her after the incident. "It was unprofessional. I already knew." She stated she did not write a statement. The DON stated, "I don't think it was verbal abuse. I don't think (he/she) felt threatened by what I was saying to (him/her)."

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

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During an interview on 1/27/2022 at 11:33 a.m. with the Receptionist, when the Surveyor asked her about the incident on 1/3/2022 with the LPN, she explained, she got off the elevator on the fourth floor, the resident told the nurse, [You think I threw water on you yesterday? I'm going to put my hands on you today].

During a second interview on 1/27/2022 at 12:00 p.m., Resident #2 stated the issue was not what happened. "It's the Administrator not doing anything or protecting me." When the Surveyor asked Resident #2 how he/she felt after each incident, Resident #2 explained the first incident with the SW. Resident #2 felt embarrassed, so he/she reached out to the Administrator, and they had a meeting two days after. Resident #2 stated during the meeting, the SW continued to be demeaning and, rolling her eyes, she got up and walked out of the meeting. The resident said he/she then told the Administrator there needs to be accountability and requested the SW be changed, and she was removed.

Resident #2 further explained the second incident involving the DON, the Administrator, and the DON was standing in the resident's doorway. The resident, he/she, didn't want to move; it was his/her home. According to Resident #2, the DON told her in a condescending voice, "I won't be able to prostitute. The Administrator didn't do anything. He had no response or no defense." The resident stated he/she felt embarrassed, uncomfortable, horrible, and sad. He/She did not want to leave his/her room. Resident #2 stated he/she did not speak to the Administrator about this incident.

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Resident #2 stated the LPN; there was a personality clash. Resident #2 knew the nurse from the fifth floor, where they had a previous conflict. According to Resident#2, he/she went to visit a friend on the fourth floor. The nurse said to Resident #2, "Take your disrespectful ass off the floor, and then the resident replied, "what else are you going to do? Then, the nurse said to the resident, "I'll f you up!" The resident replied, "do it!" The resident went to see the Administrator and told him what had happened. The Administrator said to Resident #2, what do you want me to do? The resident said to him, "I can't feel safe here." The Administrator asked the resident to explain what he/she meant by that statement. The resident continued to explain what happens if he/she sees the nurse on the elevator and the nurse wants to "fuck me up"? He/she stated at the moment, "I felt angry" Afterwards, "I felt very unsure and unsafe with the nurse. The nurse could do something to me."

During a second interview on 1/27/2022 at 12:32 p.m., the Administrator indicated he didn't see the result of the harm to the (resident) as being humiliated. He explained the resident felt comfortable with each incident; the SW was switched, the ADON was the clinical point of contact, and the nurse was switched to another floor. He stated, "I was involved with all the resolutions and spoke to the resident." The Surveyor showed the Administrator a copy of the "Abuse" Policy and asked him if he followed it; he explained that he assessed and de-escalated the situation, he told the former DON to go away, and he would handle it. He spoke to the resident that he/she could stay in the room and figured out a solution with the resident. He stated the resident repeated that he/she was angry and upset, there

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was no anguish, and the resident was comfortable with the solution.

The Administrator further explained he de-escalated and handled the situation concerning the nurse incident and found a resolution. The Administrator stated he spoke to the nurse and the resident, he did not remember what the nurse said, but it was profanity. The Administrator said Resident #2 told him the resident said the profanity first, and the nurse repeated the words back to the resident. He informed the resident that the nurse was moved to another floor, and he told the resident, "I'll make it a safe situation." He informed the resident if the nurse was there to call him. The Administrator stated the resident felt angry, but he didn't recall the resident saying he/she felt unsafe. The Administrator explained that if the resident would've said he/ she felt threatened, he would have reported the incidents to the NJDOH. The Administrator stated he would like everyone to be more professional, doing behavioral training now on how to handle de-escalating situations and not reacting. He further explained counseling was done in the conference room, talked about the incident, what each person thought happened, how it fits into policy and mission statement, and the staff would sign it; but he did not do it with these three incidents. He only counseled each staff with no documentation.

During the exit conference on 1/27/2022 at 1:57 p.m., in the presence of the current DON, ADON, and Regional Nurse Consultant, the Surveyor asked the Administrator what is the meaning of the word derogatory, as stated; in the facility's" Abuse" Policy under "Verbal Abuse." The Administrator said that Derogatory means it was

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more than regular name-calling, putting someone down, not on the same level as everyone else, and context, tone.

At the time of the survey, the facility could not prove a thorough investigation was completed for each incident for the verbal altercations between Resident #2 and the aforementioned staff members.

Review of a Revised 1/2021 facility policy titled; "Abuse and Neglect-Clinical Protocol" included but was not limited to; "Definitions" "1. "Abuse" is defined at 483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of good or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology ...4. "Willful" as defined at 483.5 and as used in the definition of "abuse," means "the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

Review of a second facility's undated Policy titled "Resident Abuse Neglect and Mistreatment "The Law" included under "Policy" included, "All residents must be treated with dignity and respect. In the event that an allegation of verbal, sexual, physical, or mental abuse is made regarding a resident, a prompt investigation must

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be conducted by the administrative staff, and their findings must by (be) reported in (a) timely manner, as specified later in this Policy." Under "Definitions" included "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma cause physical harm, or pain or mental anguish." The Policy also revealed "Verbal Abuse" refers to any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability."

A further review of the Policy under " Policy and Procedure for Abuse Prevention (continued)" included the following:

"1. Screening:
. Two references (preferably from previous employers)
. ASI registry check of current CNA (Certified Nursing Assistant) certification for new hires, with criminal background check completed.
. State Board Registry Check, as well as visible check of nursing licenses.
. 90-day probationary period with strict monitoring and orientation.
. Outside service providers providing services on resident care units will provide the following proof of employment pre-screening requirements prior to providing services at the facility:
a. License/certification numbers pertaining to

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their profession. Expiration dates, and license validation will be checked through New Jersey consumer affairs.
b. Criminal background verification or employment application which indicates employee has never been convicted of a crime (such as crimes of abuse/neglect, violence, dishonesty, financial or personal misconduct, etc.)

2. Training:
. All orientees regardless of department affiliation attend initial orientation on identifying abuse and reporting abuse, with handouts pertaining to definitions and types of abuse, how to report knowledge of possible abuse to supervisors, including use of toll-free reporting that can be done anonymously.
. All employees in all departments attend regular staff in services annually and as needed to maintain knowledge and promote prevention of abuse; including identifying instances of possible abuse, how to report allegations, how to recognize increased stress, signs of burnout and frustration that may lead to abuse situations. What constitutes abuse, neglect, mistreatment and misappropriation of resident property. Help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. Focus with orientation and in-servicing in caring for difficult or aggressive residents and what options are available to caregivers to avoid abusive situations; i.e. changing assignments, "buddy-system", etc. including 1:1 counseling if needed.

3. Prevention:
On admission and during regularly scheduled interdisciplinary meetings, quarterly, annually and

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F 835	Continued From page 42 as needed with families, residents and staff, provide information on how and to whom they may report all concerns, complaints and issues of possible abuse, neglect or misappropriation of personal property. Provide reassurance of no fear of retribution and outline plan of immediate investigation and intervention. Prevention Plan includes, but is not limited to the following: A. Environmental rounds by supervisors in each department of secluded areas that may make abuse and/or neglect more likely to occur B. Unit meetings with staff to discuss care issues, complaints and concerns to avoid frustration, lower stress and decrease "burnout." C. Meetings of department heads to review all previous 24 hour incident reports and Supervisor's Investigative reports to determine possibility of abuse. D. Staff scheduling daily to balance units according to resident census and acuity level. E. Shift-to-Shift daily report involving direct care staff to ensure continuity of care and empower staff with knowledge beforehand to avoid frustration in meeting residents' needs. F. Supervision of staff daily in performance of job duties to identify potential abuse/neglect; i.e. foul language, rough handling, neglect, with immediate intervention. 4. Identification: Immediate incident reporting (refer to Accident/Incident Policy & Procedure) and investigation of all falls, bruising, skin teras; increase in depressive, isolative fearful behaviors, and occurrences that may constitute abuse. Chain of command monitoring of incidents from charge nurse to Supervisor to Director of Nursing to Administration to determine scope of investigation.	F 835		

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F 835	Continued From page 43 5. Investigation: A. The charge nurse or nursing supervisor will conduct a full body assessment (if the allegation is physical abuse) and document all findings in the medication record. B. Initiate emergency care for resident as warranted. C. complete Unusual Occurrence Report according to Accident and Incident reporting policy and procedure. D. R.N. (Registered Nurse) Supervisor to complete Supervisory Investigate report with interviews and written statements from all persons involved, including the resident, if possible investigate three prior shifts. E. If the allegation is against an employee, the employee will be removed from the work place once the statement has been taken and will be suspended pending completion of the investigation. Union protocol to be followed if applicable. Resident to be protected against possible retribution. F. Allegation must be reported to Director of Nursing, Social Services and Administration as soon as allegation has been made. G. Reporting to all regulatory agencies to be done by Director of Nursing or Designee of alleged occurrence within proper time frame for reporting. H. All written statements and documentation are to be completed and maintained under separate file cover in the Director of Nursing's office. I. Local authorities i.e. Police will be called as warranted. NJ Department of Health and Senior Services reportable event record/report to be filed by computer on Hippocrates system, no later than 2 hours to the Department. Full investigative report is sent within 72 hours. (If computer is not available call is made to 609-633-9060). NJ Office of the Ombudsman notified within 2 hour if	F 835		

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there is injury or 24 hours if the events causing suspicion do not cause injury.
J. Specific reportable events, as per list following, will be reported immediately to the NJ Department of Health & Senior services.
K. Director of Nursing is responsible for completion of abuse policy and procedure appropriately.

6. Protection:
All residents involved in an investigation are monitored closely to avoid further disruption of daily quality of life. Interventions are implemented by Social Services Department and Nursing Administration with resident and family. Immediate removal of "threat", where an employee, other resident, social circumstance, or physical hazard, to provide security and safety. Counseling available when warranted.

7. Reporting:
All violations and alleged or suspected incidents of any form of abuse/neglect will be reported via LTC.reportables@doh.nj.gov system or if computers not available to Department of Health to 1-800-792-9770 or in off hours to 1-609-392-202. If resident is 60 or over report will also be made to Ombudsman Office at 1-877-582-6995. Calls to Ombudsman must be within 2 hours if suspicious event results in injury and within 24 hours if event does not cause injury.

Any employee who has reasonable cause to believe a resident has been abused, mistreated or neglected shall report the alleged incident to their Supervisor, Director of Nursing, or Administrator.
Any questions in regard to Abuse policy should be

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F 835	Continued From page 45 directed to the Director of Nursing. . Necessary corrective action, including termination, change of environment etc. depending on results of the investigation. . Report any employee unfit for service or any knowledge of any actions by a court of law to the State Nurse Aide Registry or NJ State Board of Nurses, etc. . Report any employee unfit for service or any knowledge of actions by a court of law to Department of Consumer Affairs" Review of the facility "Administrator" job description revealed the following: Under "Job Summary" revealed, "The Administrator is delegated with the full responsibility and authority for internal operations of the facility in accordance with Federal and State regulations and standards and established policies...It is the administrator's duty to see that the patients receive the best possible medical care as ordered by the physician, and that while receiving this care, their safety, social, religious, domiciliary needs and any other needs that fall within the scope of the policies of the nursing home are met in an efficient manner...The Administrator must also inerpret and transmit the policies of the home to the personnel and to insure compliance with these policies..." N.J.A.C.: 8:39-13.1 (a)	F 835		

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)	3/14/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 03/14/2022	ID Prefix F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 03/14/2022	ID Prefix F0835 Reg. # 483.70 LSC	Correction Completed 03/14/2022
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
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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	
1/27/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO