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 _____	C 12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION	**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 Complaint # NJ 141738, NJ 141847 CENSUS: 128 SAMPLE SIZE: 3 Based on observations, interviews, review of Medical Records (MR), and review of other pertinent facility documents on [redacted] and [redacted], it was determined that the facility failed to ensure that a resident with a recent resident to resident [redacted] with a [redacted] resident, was consistently monitored to protect, and prevent against further abuse of other [redacted] residents from [redacted] for 1 of 3 residents (Resident #1) sampled for abuse. When on [redacted], Resident #1 was able to enter Resident #3's room, who is [redacted], and [redacted]l, and was able to [redacted], and [redacted] before a staff member could intervene. Resident #1 was placed on [redacted] on [redacted] for the inappropriate behavior. On 12/15/20 at 10:15 a.m., during a tour observation of the unit it was observed by the surveyor and the Unit Manager (UM) that the assigned Certified Nursing Assistant (CNA #1) left Resident #1 unattended and the surveyor observed no other staff in the area. The facility also failed to follow their policies titled "Safety and Supervision of Residents" and "Abuse Prevention Program" to protect residents	F 000		

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

Electronically Signed | 01/15/2021

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 000	Continued From page 1 from abuse for 1 of 3 residents (Resident #1) sampled for abuse. This placed all residents with [redacted] living on the unit in an Immediate Jeopardy (IJ) situation. The IJ was identified on 12/18/20 at 2:21 p.m., when the Administrator (ADMIN) and the Director of Nursing (DON) were notified of the IJ situation and were provided the IJ template. The Immediate Jeopardy was Past Non-Compliance and ran from 12/15/20 at 10:15 a.m., to 12/15/20 at 12:00 p.m., when CNA #1 was in-serviced on [redacted] and the facility provided an acceptable Removal Plan to remove the immediacy which included staff in-servicing.	F 000		
F 600 SS=J	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: Complaint # NJ 141738, NJ 141847 Based on observations, interviews, review of Medical Records (MR), and review of other	F 600	This Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute	12/21/20

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F 600	Continued From page 2 pertinent facility documents on 12/15/20 and 12/18/2020, it was determined that the facility failed to ensure that a resident with a recent resident to resident [redacted] with a [redacted] resident, was consistently monitored to protect, and prevent against further abuse of other [redacted] residents from [redacted] for 1 of 3 residents (Resident #1) sampled for abuse. When on 12/15/20, Resident #1 was able to enter Resident #3's room, who is [redacted] and [redacted] and was able to [redacted], and [redacted], before a staff member could intervene. Resident #1 was placed on [redacted] on 12/15/20 at 8:40 a.m., for the inappropriate behavior. On 12/15/20 at 10:15 a.m., during a tour observation of the unit it was observed by the surveyor and the Unit Manager (UM) that the assigned Certified Nursing Assistant (CNA #1) left Resident #1 unattended and the surveyor observed no other staff in the area. The facility also failed to follow their policies titled "Safety and Supervision of Residents" and "Abuse Prevention Program" to protect residents from abuse for 1 of 3 residents (Resident #1) sampled for abuse. This placed all residents with [redacted] living on the unit in an Immediate Jeopardy (IJ) situation. The IJ was identified on 12/18/20 at 2:21 p.m., when the Administrator (ADMIN) and the Director of Nursing (DON) were notified of the IJ situation and were provided the IJ template. The Immediate Jeopardy was Past Non-Compliance and ran from 12/15/20 at 10:15 a.m., to 12/15/20 at 12:00 p.m., when CNA #1 was in-serviced on [redacted] and the facility provided an acceptable Removal Plan to remove the immediacy which included staff in-servicing. This	F 600	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully denies this deficiency, notwithstanding the following actions that have been taken: I. CORRECTIVE ACTION CNA#1 was educated about the responsibilities of 1:1 supervision and in-serviced about the requirement to ensure that the resident would not be left unattended for any period of time. Subsequent staff assuming responsibility for [redacted] supervision were educated on the role and the expectation that the resident be visualized at all times. Resident #1 [redacted] II. IDENTIFY AT RISK RESIDENTS All residents are at risk. III. SYSTEMIC CHANGE All nursing staff were educated about the responsibility of 1:1 supervision and the requirement to find coverage should they have to attend to something that will inhibit them from visualizing the resident.	

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F 600	Continued From page 3 deficient practice was further evidenced by the following: 1. According to the "Admission Record" (AR), Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident had [redacted]. The MDS also revealed that Resident #1 required [redacted] on the unit. 2. According to the AR, Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted] indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident had [redacted]. The MDS also revealed that Resident #2 required supervision with [redacted] and was able to [redacted] on the unit with supervision. 3. According to the AR, Resident #3 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted]	F 600	IV. MONITOR CORRECTIVE ACTION For the next three months, for any resident that requires 1:1 supervision, the Unit Manager will audit compliance by performing visual checks to ensure the resident is supervised at all times and will audit the 1:1 supervision logs to ensure coverage is obtained for any period when the caregiver must leave the resident. Findings will be reported at quarterly QA meeting. Completion Date: 12/21/20	

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F 600	Continued From page 4	F 600		

[redacted].
Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], indicated that Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident had [redacted] The MDS also revealed that the resident required total staff assistance with [redacted] and is unable [redacted]

Review of Resident #3's "Progress Notes" dated [redacted]., the Nurse Practitioner documented that the resident is only able to communicate " [redacted] and [redacted]

According to the documentation on the Facility's Reportable Event Record/Report (FRE), reported to the New Jersey Department of Health (NJDOH) by the DON on [redacted] with an event date of [redacted]., the DON reported the type of incident as [redacted]

According to the "Summary of Investigation" (SOI) the DON documented that Resident #1 and Resident #2 were observed by the staff having [redacted] in Resident [redacted]. When the staff entered the room Resident [redacted] stated: [redacted] The DON also documented on the SOI that the incident appeared to be an "isolated incident."

According to the statements on the FRE which were obtained by the facility staff regarding the

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incident, the Certified Nursing Assistant (CNA #2) reported, she was making rounds and observed 2 residents in a resident's room [redacted]. She notified the nurse and upon returning to the room she recognized the 2 residents as Resident #1 and Resident #2.

The Licensed Practical Nurse (LPN#1) reported, that she was called to the room by the CNA and upon arrival she observed Resident #1 [redacted] Resident #2. Both residents [redacted] and the [redacted]. The LPN also reported that Resident #2 stated, [redacted]."

LPN #2 reported that she was also called to the room by the CNA and upon arrival she observed Resident #1 [redacted]. Resident #2 [redacted] Resident #2's [redacted]. Both residents [redacted] Resident #2 [redacted]

According to the FRE, statements were taken from Resident #1 and Resident #2 after the [redacted]. Resident #1 [redacted]. Resident #2 stated that [redacted], and [redacted], and [redacted]

The FRE also indicated that the facility staff reported the incident to the Primary Nurse Practitioner (NP), the Psychiatric NP, the Emergency contact of both parties and Local Law

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F 600	Continued From page 6 Enforcement on [redacted] In addition, the FRE verified that the residents were immediately separated and seen by the [redacted]. Changes were made to Resident #1's [redacted] medications. Resident #1 [redacted] to deter any further incidents between the two residents. Resident #2 was sent out to the [redacted]) panel. Both residents were placed on [redacted]. Review of Resident #1's Care Plan (CP) dated [redacted], revealed a "Focus" of: "[redacted] related to [redacted] with another resident." Interventions in place included but were not limited to: [redacted] in place for one week, consultation with [redacted] regarding [redacted], and [redacted] and [redacted]. Seen by [redacted] and medication [redacted] According to the documentation on the FRE dated [redacted] the DON reported the following summary of the investigation: "In my best professional opinion, I do not believe that any [redacted] occurred. [redacted]. Despite a BIMS score [redacted] Resident #2 [redacted] and [redacted] evaluations immediately following the incident confirmed that [redacted]. However, given	F 600		

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F 600	Continued From page 7 Resident #2's [redacted] and [redacted], [redacted] will be seen by the [redacted]t to assess [redacted] Both residents will be seen by the [redacted] in a facility. At this time the residents [redacted] According to the "[redacted] Progress Note" dated [redacted], Resident #1 was seen by the [redacted] and the following recommendations were made: [redacted], According to the [redacted] Progress Note" dated [redacted], Resident #2 was seen by the [redacted] and the following recommendations were made: continue medications, send the [redacted] During an interview on 12/15/20 at 9:30 a.m., the DON reported that Resident #1 was placed on [redacted] The DON also stated that Resident #1 had [redacted] with Resident #2. During an interview on 12/15/20 at 9:55 a.m., the DON reported that in addition to the incident on [redacted] Resident #1 and Resident #2, there was another incident involving Resident #1	F 600		

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F 600	Continued From page 8 that morning on [redacted]. Resident #1 was observed by staff members in another resident's room, [redacted] was observed [redacted] of Resident #3 who is [redacted]. According to the DON Resident #1 was immediately removed from the room [redacted]. The [redacted] was notified of the second incident involving Resident #1 and the [redacted] reported to the facility staff that the [redacted] could be a [redacted], and that was why the [redacted]. The DON also reported that the Social Worker (SW) will investigate placing Resident #1 in a facility [redacted] Resident #1 will remain on [redacted] During a tour observation on 12/15/20 at 10:15 a.m., accompanied by the unit manager (UM), upon entering the room, Resident #1 was observed by the surveyor to be in his room sitting in his wheelchair without a [redacted] in sight. No staff member was observed in the room, in the hallway, or outside of the doorway to Resident #1's room. During an interview on 12/15/20 at 10:16 a.m., the UM was asked where the monitor should be? The UM responded that the 1:1 monitor should be "with the resident." The UM further stated that a 1:1 monitor is "someone who is with the resident at all times." During this interview the surveyor and the UM observed the CNA #1	F 600		

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F 600	Continued From page 9 assigned to the [redacted] of Resident #1 come out of the [redacted] department/break room. During an interview on 12/15/20 at 10:16 a.m. with the CNA#1/[redacted] assigned to Resident #1 on [redacted] reported she started monitoring the resident around 8:45 that morning and she was told to watch the resident from a distance. When asked why she left the resident the CNA stated: "I went to take my 15-minute break. My breakfast came. I was hungry. It was 5 minutes that I was gone from him, 5 minutes. I was told to be there but not on top on him." The CNA further stated she did not get anyone to cover for her while she took her break. On 12/15/20 at 10:20 a.m., the surveyor observed the [redacted] department/staff break room, which was located at the end of the hallway, appropriately 30 feet from Resident #1's room. Observed was a kitchenette on the right side with a table and chairs. Resident #1's room was not visible from the kitchenette. During an interview on 12/15/20 at 10:25 a.m., the UM reported that [redacted] had given CNA #1 instructions on [redacted] that morning, by instructing her to remain with the resident at all times and she should not have left the resident without someone covering for her. The UM manager also reported that a [redacted] is someone who is with the resident at all times. In addition, the UM reported that staff sometimes take their breaks in the PT room. During an interview on 12/15/20 at 10:55 a.m., the UM reported that at 8:40 a.m., [redacted] was	F 600		

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F 600	Continued From page 10 making rounds on the unit and saw Resident #1 in Resident #3's room in his wheelchair "[redacted] self-propels... I saw him [redacted] ... [redacted] was [redacted]. The housekeeper was passing and came in. [redacted]. [redacted]" [redacted] further stated that [redacted] immediately put Resident #1 on a [redacted] and notified the DON. Review of the facility document provided to the surveyor by the DON on [redacted] revealed that Resident #1 was monitored by the staff every [redacted] minutes from 4:00 p.m., on [redacted] to 9:00 a.m. on [redacted], when placed on [redacted]. On 12/18/20 at 12:44 p.m., the facility's security video camera recording was reviewed for the 12/15/20 8:30 a.m., incident involving Resident #1 entering Resident #3's room and [redacted]. The video was reviewed in the presence of the Admin, DON and the Executive Director. The video verified that Resident #1 did enter Resident #3's [redacted] by self-propelling [redacted] wheelchair. The video also verified that the UM and the Housekeeper (HK) never entered the room while Resident #1 was inside Resident #3's room. The video recording revealed that the HK saw Resident #1 in the room from the hallway and went immediately to the nursing station to notify the UM. When the UM got to the room Resident #1 had already back out of the room in his wheelchair and was in the hallway. Review of the facility document titled "One to One Inservice/Education" dated 12/15/20,	F 600		

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indicated that CNA #1 was educated on the role and duties of her job as a 1:1 monitor to Resident #1. She signed to acknowledge that she will not leave the resident unattended without another staff member in place to consistently monitor the resident until she returns. The document was signed by the UM and CNA #1 on 12/15/20 at 12:00 p.m.

Review of the facility policy titled "Abuse Prevention Program" with a revised date of 12/2019, revealed the following under Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident symptoms.

Review of the facility policy titled "Safety and Supervision of Residents" with a revised date of 12/2018, revealed the following under Policy Statement: Our facility strives to make the environment as free from accident hazards as possible, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Under "Individualized, Resident-Centered Approach Safety:" section #5: Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently; b. Evaluating the effectiveness of interventions; c. Modifying or replacing interventions as needed and d. Evaluating the effectiveness of new or revised interventions.

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F 600	Continued From page 12 The IJ was identified on 12/18/20 at 2:21 p.m., when the Admin, the Executive Director and the DON, were notified of the IJ situation. The IJ was Past Non-Compliance and ran from 12/15/20 at 10:15 a.m., to 12/15/20 at 12:00 p.m., when the facility provided an acceptable Removal Plan to remove the Immediacy. The Removal Plan included in-servicing the CNA who left Resident #1 unmonitored on 12/15/20. The Removal Plan was verified the second day 12/18/20, of the survey. The surveyor observed Resident #1 with a 1:1 monitor in place on 12/18/20 at 3:35 p.m. A planned discharge to another facility was scheduled for [redacted] N.J.A.C. 8:39-4.1(a)5	F 600		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060704 Y1	A. Building B. Wing Y2	1/21/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE PARK HEALTHCARE AND REHABILITATION	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 S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 01/15/2021	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
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

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 12/18/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			