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 09/15/2020

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

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F 000	INITIAL COMMENTS C #: NJ 139383 Census: 109 Sample Size: 4	F 000		
F 607 SS=G	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: C #: NJ 139383 Based on interviews, record review, as well as review of other facility documents on 9/14/20 and 9/15/20, it was determined that facility failed to ensure a safe environment by not implementing their written policies and procedure to prohibit and prevent Resident abuse for 1 of 4 residents (Resident #1). On 5/25/20 approximately 6:00 am to 6:30 am, Certified Nursing Aide (CNA #1) stated that when she walked into the dining room, she saw Resident #2 (Ex.Order 26.4(b)(1)) touching Resident #1 (Ex.Order 26.4(b)(1)) pants. Resident #2 told CNA #1 that Resident 1 "wanted it." The facility failure to investigate, report and	F 607	This Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute 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	10/16/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/15/2020

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F 607	Continued From page 1 taking corrective actions when an incident was identified on 5/25/20 involving Residents #1 and #2, resulted in Resident #2 Ex.Order 26.4(b)(1) by Resident #1 the following day on 5/26/20, which led to Resident #1's Ex.Order 26.4(b)(1) This deficient practice is evidenced by the following: 1. According to the "Admission Record (AR)" Resident #1 was originally admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses which included but were not limited to: Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1). The Minimum Data Set (MDS), an assessment tool dated 3/12/20 showed that the Resident was Ex.Order 26.4(b)(1) and required extensive assistance from staff with Activities of Daily Living (ADLs). The MDS showed that the Resident would require supervision in ambulation. The "Focus" care plan for Resident #1, was initiated on 5/26/20, showed that the Resident was Ex.Order 26.4(b)(1) as evidenced by an unusual occurrence on 5/26/20 involving a Resident (Resident #2). According to the AR Resident #2 was admitted to the facility on Ex.Order 26.4(with diagnosis which included but was not limited to: Ex.Order 26.4(b)(1) The MDS for Resident #2 dated 5/14/20 showed the Resident was Ex.Order 26.4(b)(1) and required supervision from staff with ADLs. The MDS showed that the Resident would require	F 607	Resident #2 was Ex.Order 26.4(b)(1) as soon as the facility became aware of the encounter with Resident #1; Resident #2 did not return to the facility. The care plan for Resident #1 was updated and staff that provide care to Resident #1 and staff received re-education about the changes. Staff that failed to follow the facility policy were counseled and received re-education. The DON and Administrator are no longer employed at the facility. II. IDENTIFY AT RISK RESIDENTS All residents who are cognitively impaired have the potential to be affected. III. SYSTEMIC CHANGE Facility staff received re-education regarding the facility policy to immediately report any resident interactions that are questionable or may appear inappropriate to the supervisor and administration. Visual reminders regarding the facility policy were placed at each nurses station. A new DON and Administrator were hired and now include reviewing facility policies during morning management meetings and discussing any occurrences that may require reporting or action to ensure compliance with facility policies.	

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F 607	Continued From page 2 supervision in ambulation. The undated "Focus" care plan for Resident #2, showed that the Resident was Ex.Order 26.4(b)(1) [redacted] Intervention included but was not limited to: on 5/26/20, the Resident was Ex.Order 2 [redacted] and the Police Department was notified. The Resident did not return to the facility. The Facility Reportable Event (FRE) dated 5/26/20 at 4:00 am involving Residents #1 and #2 was called in to the New Jersey Department of Health (NJDOH) on 5/26/20 at 2:00 pm. Attached with the FRE the form "INVESTIGATION INTO INCIDENT OF SEXUAL ABUSE" involving Residents #1 and #2. This form showed that on 5/26/20 at approximately 4:00 am during rounds, CNA #1 saw Resident #2 getting off of Resident #1 who was lying in bed. Resident #2 verbalized that Resident #1 wanted it. Resident #2 verbalized that Resident #1 was his/her girlfriend and Resident #2 had sex with Resident #1. Resident #2 revealed that he/she had prior sexual encounter with Resident #1 which was last night (5/25/20) at 3:00 am. However, the NJDOH did not receive the FRE nor the facility conduct an investigation regarding an incident on 5/25/20 involving Residents #1 and #2, which was witnessed by CNA #1 and reported to Licensed Practical Nurse (LPN #3). The same form under Summary of the Investigation showed that on 5/26/20 at 4:00 am, CNA #1 saw Resident #2 in Resident #1's room. Resident #2 was getting up off of Resident #1 who was lying in bed, both clothing below the waist were not present. Resident #2 verbalized	F 607	IV. MONITOR CORRECTIVE ACTION The DON/Administrator/Designee reviews all concerns and occurrences daily to ensure the facility protocol is followed regarding reporting, investigation, and implementation of interventions. This review includes discussion of the 24 hour report daily in addition to any verbal concerns reported. The Regional DON will audit investigations for three months to ensure the facility protocol is followed. Results will be reported at the monthly QA meeting by the Administrator x 3 months. Completion Date: 10/16/20	

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having sex with Resident #1. Resident #1 did not respond to the questions and refused to be examined. The Police Department was notified and interviewed both residents. Resident #1 was Ex.Order 26.4(b)(1) and Resident #2 was Ex.Order 26.4(b)(1) evaluation.

The facility "NEW JERSEY UNIVERSAL TRANSFER FORM [NJUTF]" for Resident #1 dated 5/26/20 under the reason for transfer showed "Sexual Abuse Sexual Molested by another Patient."

The surveyor conducted a tour with the Licensed Practical Nurse (LPN #1), on the 5th floor on 9/14/20 at 9:30 am. LPN #1 stated that Resident #1 was confused and Resident #2, who no longer at the facility was very alert, oriented and ambulatory.

The surveyor conducted an interview Resident #1 on 9/14/20 at 9:55 am, the Resident just stared at the surveyor and could not answer the questions.

The surveyor conducted an interview with Resident #3 (the roommate of Resident #1), who had Ex.Order 26.4(b)(1), on 9/14/20 at 9:58 am. Resident #3, unable to recall the exact date and time of the incident, stated that a Resident came into their room twice and told Resident #1 that he/she was his/her woman. The privacy wall between the Resident #3 and Resident #1 prohibited Resident #3 to see who was the other Resident talking to Resident #1. Resident #3 recalled not able to use the call bell because it was not working at that time. However, a staff member came in and told the other Resident to

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leave the room.

Follow up interview with Resident #3 on 9/15/20 at 10:15 am, the Resident stated that he/she would feel terrible if someone would touch them without their consent. Resident #3 would not let anyone touch him/her because Resident #3 would beat that person up. Resident #3 stated that the facility staff should protect them. Furthermore, the Resident stated that this was like a bad dream, painful and being sent to the Hospital would not help.

On 9/14/20 at 12:12 pm, the surveyor conducted a telephone interview with the LPN #2 (the primary nurse for Residents #1 and #2, who worked on the night shift at 11:00 pm-7:00 am. She stated that when residents were on monitoring or frequent supervision they would tell the CNAs at the beginning of their shift. She stated she could not recall if there was monitoring in place for Residents #1 and #2 when she worked on the aforementioned shift. She recalled that in May 2020, was the peak of Covid 19 and residents were not allowed to be together neither were they allowed to come out of their rooms. CNA #1 did not tell her and it was on the report that there was an incident between Residents #1 and #2 in the DR on 5/25/20 between 6:00 am and 6:30 am. She explained if she knew about it, these Residents would not be on the same floor if possible or would be on constant monitoring such as one to one monitoring

Continued interview with LPN #2 on 9/14/20, she stated she was not aware of the incident involving Residents #1 and #2 when they were found in the DR together. However, she knew about the incident on 5/26/20 at approximately 4:00 am.

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LPN #2, stated what was on the aforementioned FRE. She stated that Resident #1 was confused and unable to explain what had happened on 5/26/20. The LPN stated on 5/26/20, Resident #1 was Ex.Order 26.4(b)(1) was on the floor, which made her believe something had happened. Resident #2 told LPN #2 that Resident #1 was his/her woman and they had sex. LPN #2 stated that after she was alerted by the CNA #1, she immediately reported to the nurse supervisor and the former Director of Nursing (DON). Residents #1 and #2 were Ex.Order 26.4(b)(1) separately.

The surveyor conducted a telephone interview with CNA #1 on 9/14/20 at 1:17 pm. CNA #1 stated she was doing her rounds on 5/26/20 at approximately 4:00 am and noticed that Resident #2 was not in his/her room. CNA #1 immediately went to check Resident #1's room and she went on to state what she witnessed on the aforementioned FRE dated 5/26/20 at 4:00 am. CNA #1 stated the reason she went directly to Resident #1's room to look for Resident #2 was because she saw both Residents in the Dining Room (DR) on 5/25/20 at approximately 6:00 am to 6:30 am the previous morning.

Continued telephone interview with the CNA #1 on 9/14/20 and 9/17/20. She stated that she was the CNA for both Residents #1 and #2 at 11:00 pm to 7:00 am from 5/24/20 into 5/25/20. She revealed at approximately 6:00 am to 6:30 am, when she walked into the 5th floor DR, she saw Resident #2 touching the pants of Resident #1. She revealed that Resident #1's pants was slightly pulled down from his/her waist. CNA #1 asked Resident #2 what was he/she doing and the Resident stated that Resident #1 wanted

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him/her to touch Resident #1. CNA #1 explained that Resident #1 could not consent to the touching because Resident #1 was Ex.Order 26.4(b)(1). CNA #1 stated that what she saw was inappropriate touching and with or without consent from Resident #1 she had to report what she saw. CNA #1 explained that after she separated both Residents and she immediately reported what she saw to LPN #3 (nurse assigned to Residents #1 and #2). She stated that she reported to LPN #3 what she saw in the DR. She heard LPN #3 ask Resident #2 why Resident #2 did that to Resident #1. However, LPN #3 did not check Resident #1. CNA #1 felt that LPN #3 did not listen to what she said and so she wrote her statement and went to see the Nursing Supervisor (NS #1) on 5/25/20 approximately closer to 7:00 am. She reported to NS #1 what she saw in the DR involving Residents #1 and #2 and the NS said she did not hear from LPN #3. CNA #1 gave the copy of her statement to the NS, in which she realized later she did not keep a copy to herself. The CNA stated that the original copy of her statement was given to LPN #3.

Continued telephone interview with CNA #1. The CNA stated when she returned to work on the night shift 11:00 pm to 7:00 am (5/25/20 into 5/26/20), she was surprised that Resident #2 was still on the 5th floor on the same floor with Resident #1. She was expecting that Resident #2 would have been moved to another floor away from Resident #1 because of what she saw in the DR. CNA #1 was not assigned for both Residents that night (5/25/20 into 5/26/20). However, she mentioned exactly what she saw to the CNA (CNA #2), the assigned CNA for both the Residents #1 and #2 that night shift from 5/25/20

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into 5/26/20. CNA #1 knew that LPN #2 did not know about the incident in the DR because LPN #2 did not give them report about it at the start of their shift. CNA #1 stated that she had tried to check on Resident #2 frequently if she could but it was impossible because she had to look after those residents assigned on her section.

The surveyor conducted a telephone interview with LPN #3 on 9/14/20 at 11:50 am, she stated that she was not the nurse for both Residents #1 and #2 and she did not work on the 5th floor where Residents #1 and #2 resided.

Follow-up telephone interview with LPN #3 on 9/14/20 at 2:24 pm. She confirmed she was the assigned nurse for both Residents #1 and #2 when both Residents were found in the DR on 5/25/20 approximately 6:00 am and 6:30 am. LPN #3 recalled CNA #1 told her that Resident #2 was following Resident #1, in which she told the Unit Manager (UM #1) on 5/25/20 at 7:00 am. She stated that she gave CNA #1's statement to the UM that same day (5/25/20).

On 9/15/20 at 9:00 am, the surveyor conducted an interview with the former Administrator (A #1, who was employed at the facility on 5/25/20 and 5/26/20). He stated that he was not aware of the incident on 5/25/20 approximately 6:00 am to 6:30 am. He explained that Resident #2 admitted having sex with Resident #1 the night before which was on 5/25/20. He stated that there was no investigation done on 5/25/20 because the former DON did not indicate to him that something happened that day (5/25/20).

The surveyor conducted a follow-up telephone interview with the former DON on 9/16/20 at

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12:56 pm. The DON stated that he found out about the incident in the DR involving Residents #1 and #2 the day after the incident on 5/26/20. He recalled during the interview with CNA #1, the CNA told him that Resident #1 and Resident #2 were in a close proximity to each other in the DR. The DON did not remember if the CNA mentioned inappropriate touching between the Residents. CNA #1 stated she mentioned this incident and gave her statement to LPN #3. When the DON interviewed LPN #3, on 5/26/20, LPN #3 also brought with her the Statement from CNA #1 and gave it to the DON. The DON stated that staff statements (including CNA #1 and LPN #3) were given to the Administrator and the DON had no idea what the Administrator did with those staff statements. The DON stated that he did not read the statements written by the CNA #1 and LPN #3. The DON explained that what CNA #1 witnessed between Residents #1 and #2 in the DR would need an investigation because in May residents were not allowed to leave their rooms and being in close proximity to each other was not a normal situation due to Covid-19 situation and especially that CNA #1 had concerns. The DON stated if he knew about the DR situation on 5/25/20, it would be investigated immediately, reported to the Administrator and appropriate agencies and Residents would be transferred to an ACH.

The "Progress Notes (PN)" for May 2020 for Residents #1 and #2, showed no documentation from LPN #3 regarding Residents #2 following Resident #1 in the DR.

The surveyor conducted a telephone interview with the Unit Manager (UM #1) on 9/14/20, 9/15/20 and post survey on 9/16/20. However, the

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UM was not available.

The surveyor viewed the video of the incident in the DR on 9/15/20 at 12:47 pm. The current Administrator (A #2) stated that what will be seen on the video would have a date a day ahead in which at 5/25/20 (DR incident) incident would have a date of 5/26/20. The 5/26/20 (bedroom incident) would have a date appearing 5/27/20.

Video viewing. The video dated 5/26/20 at 6:18 am (original date was 5/25/20 at 6:18 am) showed that Resident #2 was walking into the DR with Resident #1 behind Resident #2. Resident #2 pulled down his/her pants in front of Resident #1 while talking to Resident #1. Then Resident #2 appeared to touch Resident #1's clothes, then CNA #1 walked in and Resident #2 pulled up his/her pants. CNA #1 appeared to be talking to both Residents. Then both Residents followed the CNA exiting the DR.

Continued viewing the Video camera. The video dated 5/27/20 at 3:48 am (original date was 5/26/20 at 3:48 am). The video showed Resident #2 walked into Resident #1's room. Then at 4:14 am, CNA #1 went into the Room of Resident #1. Then CNA #1 stepped out of the room with Resident #2. CNA #1 came back to Resident #1's room with CNA #2 and LPN #2. The rest of the video was mentioned on the aforementioned FRE.

The NJUTF from an AH for Resident #1 dated 5/26/20 showed a primary diagnosis of Ex.Order 26.4(b [redacted] Attached with the NJUTF form was the 'ED [Emergency Department] Note-Physician" electronically signed on 5/26/20, under ED Course and Treatment showed that the Ex.Order 26.4(b)(1) [redacted]

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Ex.Order 26.4(b)(1)) Registered Nurse (RN) completed the examination and Resident #1's Representative agreed for the Resident to receive the treatment for Ex.Order 26.4(b)(1) Attached with the NJUTF form was the "Emergency Department Clinical Summary" dated 5/26/20, under Instructions given to the Patient at Discharge showed education on Ex.Order 26.4(b)(1) . Under the Medications instructed to take home, showed Ex.Order 26.4(b)(1)) to take daily.

The facility's policy titled, "POLICY FOR RESIDENT ABUSE INVESTIGATION" was reviewed/revised on 7/2020 showed:
"...Residents have the right to be free from abuse, may it be verbal, sexual, physical or mental abuse...Policy Interpretation and Implementation:...Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion or sexual assault...PREVENTION:..Situations in which abuse...are more likely to occur are identified and correction or intervention is made...INVESTIGATION:...In any instance of...abuse of residents...an incident report is completed...1. Appropriate supervisory personnel is notified, and investigation begins promptly after report of problem. Statements or interviews of resident, suspect (if one is identified), any eyewitnesses and any circumstantial witnesses are taken. 2. Relevant documentation is reviewed and preserved. 3 Alleged victim is examined promptly...and finding documented in the report...In the case of either resident to resident abuse...where warranted, the police will be notified. If resident or family requests that police be involved,...with or without an injury, police will

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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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 11 be notified...Residents involved in the investigation are monitored closely to avoid further disruption of daily quality of life. Interventions are implemented...Immediate removal of "threat". whether employee, other resident...to provide security and safety. Counseling available when warranted. REPORTING/RESPONSE: [Name of the facility] will notify New Jersey State Department of Health,...no later than two hours...Any information which person making report considers necessary to further the investigation..." The facility's policy titled, "RESIDENT RIGHTS POLICY" was reviewed/revised 12/2019, showed; "...1...c. Be free from abuse..." NJAC 8:39-27.1(a)	F 607		