STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) all emergency equipment was readily available at bedside for residents with tracheostomies (a surgical opening in the neck to provide an airway and remove secretions from the lungs), b.) staff were trained to use the emergency tracheostomy equipment, and c.) the primary care nurses were aware of the residents' inner cannula sizes for their tracheostomies. This deficient practice was identified for 2 of 3 residents reviewed for tracheostomy (Resident #6 and Resident #174). 1.Resident #174 was admitted to the facility on [DATE], and had a tracheostomy (trach). Observations and interviews on 02/17/26, revealed that emergency trach supplies were not being kept at Resident #174's bedside and readily available for use. There was no obturator (a device that fits inside the trach tube to guide it during insertion) in Resident #174's room, and staff were unable to locate any extra ones in the storage area. During an interview with the Licensed Practical Nurse (LPN #1), who cared for Resident #174, had never heard of an Ambu bag (a handheld manual resuscitation device used to provide ventilation to a person who was not breathing adequately or stopped breathing) or obturator, so I really don't know where they are. 2.Resident #6 was admitted to the facility on [DATE], and had a trach. Observations and interviews on 02/17/26, revealed that there was no Ambu bag or obturator present in Resident #6's room, and there was no crash cart (cart containing emergency supplies) visualized on the floor. During an interview with LPN #2, who cared for Resident #6, the nurse was unsure what size inner cannula (removeable tube placed inside a trach tube to maintain airway patency and facilitate cleaning and secretion management) the resident used and confirmed there was only one size, a 5.0 millimeters (mm) inner cannula on the windowsill. The facility's failure to ensure there was emergency equipment readily available at the residents' bedside and ensure staff were trained to use emergency tracheostomy equipment placed Resident #6 and Resident #174 at risk, as well as all residents with tracheostomies at risk for respiratory distress. This posed the likelihood for serious harm, impairment, or death, and resulted in an Immediate Jeopardy (IJ) situation. The facility's Administration was notified of the IJ on 02/17/26 at 10:05 PM. The facility submitted an acceptable Removal Plan (RP) on 02/19/26 at 11:26 AM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 02/20/26, and determined that the immediacy was removed as of 02/20/26 at 1:05 PM. The facility further failed to d.) obtain a physician's order for the size of an inner cannula for a resident with a tracheostomy. This deficient practice was identified for 1 of 4 residents reviewed for tracheostomy (Resident #199). Findings include:Part A A review of the facility's policy Tracheostomy Care, dated January 2026, indicated . The following disposable equipment should be at the bedside:Spare trach tube - equal in size to the tube n placeBack-up trach - one size smaller for emergencies.Suction kits 14 Fr [French] (trach smaller than 6.0 require 12 Fr)Trach care kitsSplit drain sponges250 ml [milliliters] NSS [Normal Saline Solution]Trach tiesSuction cannister with lidSuction tubingThe following equipment should be in the room:Suction Canister5-liter concentratorOxygen tank in appropriate holder. A review of Lippincott Manual of Nursing Practice, dated 2018 page 544, revealed .Have available at the patient's bedside.a resuscitation bag, oxygen source, and a mask to ventilate the patient in the event (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	of accidental tube removal. Anticipate your course of action in such an event.Tracheostomy-have extra tracheostomy tube, obturator.at the bedside. Be aware of reinsertion technique, if facility policy permits, or know how to contact someone immediately for reinserting the tube. 1.A review of Resident #174's Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated Resident #174 was admitted to the facility with diagnoses that included but were not limited to; chronic respiratory failure, tracheostomy status, and persistent vegetative state. A review of Resident #174's quarterly Minimum Data Set (MDS), located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 01/27/26, indicated that Resident #174 was coded as comatose with persistent vegetative state/no discernible consciousness. The MDS further coded that the resident required oxygen therapy, suctioning, and tracheostomy care while a resident in the facility. A review of Resident #174's Physician Orders, located under the Orders tab in the EMR, included the following physician's orders (PO):A PO dated 02/09/26, to change inner cannula daily every day shift. The order did not specify the inner cannula size.A PO dated 02/09/26, to change trach collar ties weekly on the 11:00 PM to 7:00 AM (11-7) shift, on Sundays.A PO dated 02/09/26, to administer oxygen at 6 liters per minute (lpm), every 12 hours as needed.A PO dated 02/09/26, to suction every shift and as needed (prn), every 12 hours as needed, for increased secretions and a PO dated 02/09/26, to suction every shift, and prn every shift.A PO dated 02/09/26, for trach care every shift and prn, every 12 hours and a PO dated 02/09/26, for trach care every shift and prn every shift.A PO dated 02/11/26, for chest physiotherapy (a therapeutic technique aimed at improving respiratory function by mobilizing mucus in the lungs making it easier to breathe) and suction after therapy every six hours for prevention of mucous plug. A review of Resident #174's corresponding February 2026 Treatment Administration Record (TAR), located in the EMR under the Orders tab, included documentation of the physician's orders were being followed for changing the inner cannula daily every day shift, suctioning every shift and as needed every 12 hours for increased secretions, and trach care every shift and as needed every 12 hours as needed. There was no documentation of chest physiotherapy and suctioning every six hours after therapy for prevention of mucous plug being performed as ordered by the physician. A review of Resident #174's February 2026 Medication Administration Record (MAR), located in the EMR under the Orders tab, indicated on 02/12/26 and 02/13/26 at 12:00 AM and 6:00 AM, chest physiotherapy was not performed as ordered by the physician. There was no documentation that Resident #174 received oxygen at 6 lpm every 12 hours as needed on the February 2026 MAR. A review of Resident #174's Care Plan, located under the Care Plan tab in the EMR dated 11/14/25, included a Focus area that the resident was at risk for respiratory impairment related to chronic respiratory failure with tracheostomy and continuous oxygen therapy. Interventions included to evaluate lung sounds and vital signs as needed and report significant changes to the physician; if tracheostomy becomes dislodged, maintain patent airway and notify medical doctor immediately; and suction as ordered by the physician. A review of Resident #174's hospital records included a Progress Note from the Respiratory Therapist in the hospital dated 10/20/25, that Resident #174 had a trach collar with a size 8.0 mm inner cannula. During an observation on 02/17/26 at 1:50 PM, of Resident #174's bedside, there was a size 7.5 mm inner cannula and an Ambu bag, but there was no obturator at the bedside nor a size 8.0 mm inner cannula. During an interview on 02/17/26 at 2:06 PM, the surveyor asked LPN #1 what emergency equipment should be located at the bedside of a resident who had a trach. LPN #1 stated, suction machine, Yankauer suction (firm plastic suctioning tip), and a trach care kit. I don't remember what else needs to be in there. The surveyor then asked LPN #1 if she went into the resident's room and the resident's trach cannula was dislodged, what would she do? LPN #1 stated, I cannot remember but if you could help me out, I could use it. The surveyor asked LPN #1 if she had received any training at the facility regarding trach care, and LPN #1 stated that she had not received any additional training outside of nursing school. On 02/17/26 at 3:00 PM, LPN #1 accompanied the surveyor into Resident #174's room. The surveyor asked LPN #1 where the Ambu bag and obturator were in the resident's room, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	LPN #1 stated, I have never heard of an Ambu bag or obturator, so I really don't know where they are. The surveyor and LPN #1 then walked out of Resident #174's room and there was a crash cart in the hallway across from Resident #174's room. During an interview on 02/17/26 at 8:10 PM, LPN #4 was asked if there were any trach cannulas located in the crash cart across from Resident #174's room. After reviewing what was in the crash cart, LPN #4 stated, No, there aren't any cannulas in here.During an observation on 02/17/26 at 8:20 PM, in the Clean Utility Room located on Resident #174's floor, LPN #4 confirmed there were no extra obturators located in the clean utility room. 2. A review of Resident #6's Face Sheet, located under the Profile tab in the EMR, indicated that Resident #6 was admitted to the facility with the diagnoses that included but were not limited to; malignant neoplasm of the larynx (cancer of the larynx/voice box), chronic obstructive pulmonary disease, and tracheostomy status. A review of Resident #6's comprehensive MDS, located under the MDS tab in the EMR, with an ARD of 01/05/26, included the resident had long and short-term memory problems with some difficulty in new situations for decision making. The MDS was also coded that Resident #6 required suctioning and tracheostomy care while a resident in the facility. A review of Resident #6's Physician Orders, located under the Orders tab in the EMR, included the following PO's: A PO dated 12/29/25, to change inner cannula daily every shift. The order did not indicate the size of the inner cannula.A PO dated 12/29/25, to change trach collar ties weekly in the 11-7 shift, Sundays.A PO dated 12/29/25, to suction every shift and prn, every 12 hours as needed for increased secretions and a PO dated 12/29/25, to suction every shift and prn, every shift.A PO dated 12/29/25, for trach care every shift and prn, every 12 hours as needed and a PO dated 12/29/25, for trach care every shift and prn, every shift.A PO dated 02/14/26, to transfer to the emergency department (ED) via 911 emergency services for tracheostomy decannulation (removal of the trach). A review of Resident #6's February 2026 TAR, included documentation that the physician's orders were being followed for changing the inner cannula every day shift except on 02/03/26, 02/05/26, 02/13/26, and 02/15/26, when it was documented Resident #6 refused. There was no documentation of suction every shift and as needed every 12 hours for increased secretions. There was documentation that indicated suctioning was being performed every shift and as needed every shift except on 02/03/26, 02/12/26, 02/13/26, 02/14/26, and 02/16/26 on day shift and 02/01/26, 02/04/26, 02/14/26, on night shift when Resident #6 either refused or was sent out to the hospital. Trach care was performed per physician's order except on 02/03/26, 02/12/26, 02/13/26, 02/15/26, and 02/16/26, on day shift and 02/01/26, 02/04/26, and 02/14/26, on night shift when either Resident #6 refused or was sent out to the hospital. A review of Resident #6's Nursing Progress Notes, located under the Progress Note tab in the EMR, indicated on 02/12/26 at 7:39 PM, . resident very combative and verbally abusive to staff during care, refused all [the resident's] due [sic] care. trach and personal care. A continued review of the progress notes on 02/14/26 at 3:07 PM, indicated sent to ER [emergency room] for trach dislodgement. A review of Resident #6's Hospital Record dated 12/22/25, in the EMR under the Misc tab, indicated Resident #6's inner cannula size was 6.0 mm. A review of Resident #6's Care Plan, located under the Care Plan tab in the EMR dated 12/30/25, included a Focus area that the resident was at risk for respiratory impairment related to chronic obstructive pulmonary disease (COPD), and the resident had a tracheostomy. Interventions included Administer medications/treatments per physician's orders. Collaborate with Hospice about respiratory symptoms and management. Encourage deep breathing exercises. During an observation on 02/17/26 at 2:36 PM, of Resident #6's bedside, the Ambu bag and obturator were not present in the room. There was a size 5.0 mm inner cannula noted on the windowsill and a suction machine was at the bedside. The surveyor did not visualize a crash cart on Resident #6's floor. During an interview on 02/17/26 at 2:45 PM, LPN #2 was asked what emergency equipment should be at the bedside of a resident with a trach. LPN #2 stated, sterile water, Ambu bag, split gauze and a trach care kit. The surveyor then asked LPN #2 what size inner cannula Resident #6 had in and she stated, Off the top of my head, I don't remember. I would have to look. LPN #2 accompanied the surveyor to Resident #6's room and confirmed there was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	no Ambu bag or obturator in the resident's room with only one size 5.0 mm cannula on the windowsill. During an interview on 02/17/26 at 4:40 PM, the Regional Director of Clinical Services (RDCS) confirmed that she would expect the resident with a trach to have the required emergency equipment at their bedside and in their room as outlined in the facility's policy. During an interview on 02/17/26 at 8:10 PM, LPN #4 was asked if she needed trach supplies that were not in the resident's room, where would she go to obtain these supplies. LPN #4 stated, I would have the supervisor who would go to the ground floor and get them out of the stock room and then bring them to me here on the fifth floor. During an observation on 02/17/26 at 9:00 PM, the Registered Nurse Supervisor (RNS #1) took the surveyor into the Central Supply Room on the ground level. There were trach inner cannulas sizes 6.0, 7.0, and 8.0 mm located in the storage room. RNS #1 was asked where the obturators were stored in this room, and RNS #1 stated, I know what they are, I just can't find them right now. I can call the person responsible for this room in the morning and find out where they are. RNS #1 was asked to describe the obturators to the surveyor and RNS #1 stated, It's hard to describe. RNS #1 walked around the storage room and picked up the blue oxygen tubing that would connect to the oxygen condenser and connect to the trach mask or collar and stated, It looks like this. (An obturator is a curved rod that fits in the tracheal cannula and not tubing.)During a telephone interview on 02/21/25 at 10:56 AM, the Medical Director was asked what his expectations were for residents with a trach. The Medical Director stated, I believe our current treatment and care is good. Replacement supplies are available in the residents' rooms or in the supply closets. I believe the staff is competent to provide trach care and if there are any immediate concerns, they are to contact 911. My expectations are that the staff follow the orders that have been written at any time and if there is any discomfort to the [resident], the staff should call 911. The Medical Director continued that supplies should be readily available for emergency purposes with the staff being trained, then retrained annually and as needed. An acceptable Removal Plan (RP) was received on 02/19/26 at 11:26 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the immediacy including: a size 8.0 mm replacement trach kit was immediately placed at Resident #174's bed, and the PO was updated to reflect the current size of the resident's inner cannula. A size 6.0 mm replacement trach kit was immediately placed at Resident #6's bed, and the PO was updated to reflect the current size of the resident's inner cannula. The Respiratory Therapy (RT) and Licensed Nursing Home Administrator (LNHA) reviewed the facility's Tracheostomy Care policy. The RT conducted education with all licensed nurses regarding necessary emergency supplies for residents with trachs in accordance with facility policy and the procedure to follow in the event of a trach dislodgement. The surveyor verified the implementation of the Removal Plan on-site on 02/20/26, and determined the immediacy was removed as of 02/20/26 at 1:05 PM. NJAC 8:39-27.1(a) PART B A review of Resident #199's Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated that Resident #199 was admitted to the facility with diagnoses which included but were not limited to; chronic embolism and thrombosis of other specified veins (chronic blood clots in a deep vein), atrial fibrillation, and tracheostomy (trach) status. A review of Resident #199's JLMC - Admission/re-admission Evaluation - V13 dated 02/10/26 at 7:59 PM, in the EMR under the Evaluation tab, indicated Resident #199 was receiving oxygen therapy at 8 liters per minute (lpm) via trach. A review of Resident #199's Order Summary, located under the Orders tab in the EMR, included a physician's order (PO) dated 02/10/26, to change inner cannula every day shift. The PO did not include the size of the inner cannula. A review of Resident #199's Progress Note, documented by the hospital Registered Nurse (RN) in the EMR under the Misc tab, indicated Resident #199 had a tracheostomy size 7.0 mm XLT. A review of Resident #199's Care Plan, located under the Care Plan in the EMR dated 02/11/26, included a Focus area that the resident had a trach with supplemental oxygen with regards to Impaired [sic] breathing mechanics. Interventions were to . Keep obturator/spare trach/resuscitator bag/mask at bedside. If tube dislodges, maintain airway and notify (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	respiratory/[physician] immediately. During an interview on 02/20/26 at 9:42 AM, the Licensed Practical Nurse (LPN #5) was asked where she could locate Resident #199's trach size and LPN #5 stated, I would look in the physician's orders for that. After reviewing Resident #199's PO in the EMR, LPN #5 confirmed Resident #199 did not have a PO which indicated their inner cannula size. During an interview on 02/20/26 at 9:47 AM, the Registered Nurse/Unit Manager (RN/UM) stated, There are no physician orders for the size of trach that [Resident #199] has. The RN/UM confirmed there should have been an order to reflect the size of Resident #199's inner cannula. During a telephone interview on 02/21/25 at 10:56 AM, the Medical Director was asked what his expectations were for residents with a trach. The Medical Director stated, I believe our current treatment and care is good. Replacement supplies are available in the residents' rooms or in the supply closets. I believe the staff is competent to provide trach care and if there are any immediate concerns, they are to contact 911. My expectations are that the staff follow the orders that have been written at any time and if there is any discomfort to the [resident], the staff should call 911. The Medical Director continued that supplies should be readily available for emergency purposes with the staff being trained, then retrained annually and as needed. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policies, the facility failed to ensure that three residents (R4, R62, and R175) out of a sample of 36 were treated with dignity and respect. Specifically, R4 was not permitted to go out on a pass without an escort even though the resident was their own responsible party. R62's Do Not Resuscitate (DNR) wristband was not removed at the time of admission and could be observed by residents and visitors. R175 was denied the ability to leave the facility due to a past positive drug test and was not informed that he/she could refuse to submit to a drug screening. In addition, facility staff entered R175's room without knocking or announcing themselves. These failures resulted in actual and potential impacts on residents' dignity, autonomy, and rights.Findings include:1. Review of R4's Face Sheet located in the Electronic Medical Record (EMR) revealed the most recent admission date of 08/09/25, with diagnoses of paraplegia and muscle weakness. The Face Sheet documented that R4 was his/her own responsible party. Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 was cognitively intact. During an interview on 02/19/26 at 5:43 PM, R4 stated that he/she wanted to become his/her own responsible party and be able to leave the facility on pass without his/her mother signing him/her out and escorting him/her. During an interview on 02/20/26 at 10:36 AM, the Social Services Director (SSD) stated that residents who are alert, oriented, and their own responsible party may request a pass to leave the facility. The SSD was informed that R4 had been unable to sign himself/herself out of the facility despite being his/her own responsible party. The SSD stated that even when a resident is documented as their own responsible party, the facility obtains a physician's order, therapy assessment, and requires accompaniment by a family member or escort. The SSD acknowledged that this process may violate residents' rights. Interview on 02/20/26 at 5:53 PM, the SSD confirmed that R4 had requested a pass to leave the facility and had a physician order permitting the pass but R4 required an escort. During an interview on 02/21/26 at 10:56 AM, the Medical Director (MD) stated that R4 has a history of substance abuse and alleged that R4 had overdosed on two occasions in the facility. The facility was unable to provide documentation supporting the MD's statements about the two occasions R62 overdosed in the facility. The MD stated, I am afraid for their life and obligated to take care of them. During an interview on 02/21/26 at 12:25PM, R4 reported a feeling of being helpless and there was no one that could help him/her. Review of the facility's policy titled Out on Pass revised 10/25 revealed, It is the policy of the Facility to meet residents' physical and psychological needs to go out on pass. The Facility will make reasonable efforts to ensure the resident safety and uphold resident rights.When a resident requests to go out on pass, the Interdisciplinary Team (IDT) will assess the resident's ability to participate in activities outside the Facility, while taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications. The Attending Physician will review the IDT's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment and evaluate the resident's ability to participate in activities outside the Facility, while taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications. If the Attending Physician determines that the resident may participate in activities outside the Facility, the Attending Physician will write/give an order for a pass on the physician order sheet.The Attending Physician's order should indicate whether the resident needs to be accompanied by a responsible person while out on pass. 2. Review of R62's Face Sheet located in the EMR indicated an admission date of 01/12/26 with diagnoses of hemiplegia and hemiparesis following cerebral infarction, dysphagia, cognitive communication deficit, and unspecified dementia. Review of R62's admission MDS with an ARD of 01/19/26 with a BIMS score of 00 indicating severe cognitive impairment. Observation on 02/19/26 at 12:16 PM and on 02/19/26 at 1:37PM, R62 had a purple wristband with white DNR on R62's left wrist, making R62's endˆofˆlife code status visible to anyone present. During an observation on 02/21/26 at 12:50 PM, R62 was still wearing the DNR wristband even though the facility had already been made aware of the dignity concern. Interview with Certified Nurse Aide (CNA)5 on 02/19/26 at 1:53 PM, CNA5 confirmed that R62 was the only resident in the facility wearing a DNR wristband. During an interview on 02/19/26 at 4:58 PM, the Assistant Director of Nursing (ADON) stated code statuses are documented in two locations via a written order and on the Face sheet in the EMR. The ADON confirmed that the admitting nurse should have removed R62's wristband upon admission. Interview on 02/20/26 at 10:26 AM, the Regional Director of Clinical Services (RDCS) stated that the DNR wristband should have been removed at the time of admission. She stated that nursing staff are expected to follow facility procedures and remove all hospital identifiers as part of the admission process. During an interview on 02/20/26 at 1:06 PM, R62's Power of Attorney (POA) stated that the facility should follow its processes and ensure the wristband was removed. Interview on 02/21/26 at 12:15 PM, Licensed Practical Nurse (LPN) 3 stated that the use of codeˆstatus wristbands is not part of the facility's practices and confirmed the band should have been removed at admission. Review of the facility's policy titled admission Process revised 08/25 indicated:.The facility will follow policies for the admission process for residents, and the Administrator will be responsible for the development of and adherence to procedures implementing the policies. Review of the facility's policy titled Quality of Life – Dignity revised 01/26 indicated, .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. staff shall maintain an environment in which confidential clinical information is protected; for example, residents' clinical status or care needs shall not be openly posted. Treating all residents with dignity means the resident will be assisted in maintaining and enhancing their selfˆesteem and selfˆworth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.Interview on 02/17/26 at 11:20 AM, R175 stated that staff do not knock or announce themselves, they just come into your room. R175 stated that this makes them uncomfortable. At 11:36 AM, while interviewing R175, Administrator in Training (AIT) opened R175's bedroom door and walked in without knocking or announcing themselves. The surveyor redirected the AIT out the door. In addition, R175 stated that on 01/16/26, he/she went on an overnight weekend visit with his/her son, and when he/she returned, he/she was drug tested. R175 stated that he/she tested positive for fentanyl. R175 could not give a reason why he/she was randomly drug tested; however, he/she now cannot have visitors and/or go on any other overnight family visits. R175 denied using any illegal substance, has a history of using drugs but has not used in a long time. R175 stated that the facility staff did not want to hear this information. During a further interview on 02/20/26 at 12:00 PM, R175 stated that he/she consented for the drug screen and did not refuse the drug screen. On 02/21/26 at 2:00 PM, R175 stated that he/she did not know that he/she could refuse the drug screens. During an interview on 02/18/26 at 1:55 PM, the Ombudsman met with R175 on 02/06/26 and R175 complained to them about not being able to go anywhere. The Ombudsman said that R175 stated that when he/she returned he/she had a drug test which was positive for fentanyl, and that the facility would not let him/her go out anymore. R175 said it will be reevaluated in March 2026. The Ombudsman stated that he/she confirmed this information with the Administrator, who did not deny the information. Review of admission Record located under tab Census in the EMR indicated that R175 was re-admitted on [DATE], with a diagnosis of traumatic brain injury (TBI) and bipolar disorder. Review of Order Recap Report located under Orders dated 01/14/26, in the EMR indicated, May go out on overnight pass from 01/16/26 at 9:00 AM to 01/18/26 at 10:00 PM with responsible party. Review of Order Recap Report dated 01/14/26, located under the results tab in the EMR indicated, Lab on 01/18/26: Urine drug screen one time only for history of substance abuse for one day. Review of Lab Results Report dated 01/19/26 located under results tab in the EMR indicated, Positive for ethyl glucuronide and positive for fentanyl. During an interview on 02/20/26 at 2:23 PM, Physician1 stated they look at the history of substance abuse, any underlying psych history and drug tests to find out what to tell psych. Physician 1 stated that R175 refuses their drug screens. Physician1 could not give a reason for the drug screening after R175's overnight pass from 01/16/26 to 01/18/26. Interview on 02/20/26 at 3:30 PM, the RDCS confirmed that R175 does not refuse his/her drug screens. RDCS stated that the facility looks at physician orders, history of the resident, and signs and symptoms (S/S) that resident may be having from baseline prior to giving a resident a drug screen. RDCS could not confirm that R175 came back displaying any S/S from his/her baseline behavior. Review of facility's policy titled, Resident Substance (Drug and Alcohol) Abuse revised 01/26 indicated, To provide a safe and drug-free environment for residents while at the facility.Procedure: 4. A. Violations of this policy will result in notifications to the attending physician, responsible party, and law enforcement or state agencies as appropriate.D. If a resident violates this policy, the resident may be asked to voluntarily submit drug screening to test for the presence of any illegal substances if there are concerns that suspected drug us could adversely affect the resident's condition. I. If the drug screening is positive, the resident will be discharged to a more appropriate setting according to 'facility discharge procedures. Review of facility's policy titled, Quality of Life-Dignity revised 01/26 indicated, Each resident shall (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.Policy Interpretation and Implementation.6. Residents' private space and property shall be respected at all times. A. Staff will knock and request permission before entering resident's rooms. NJAC 8:39-4.1(a)(3)(18)(25)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, interview, and policy review, the facility failed to ensure a resident's rooms was clean and in good repair creating a homelike environment for one resident (Resident (R)83) of 175 residents in the facility. Failure to provide a homelike environment has the potential to affect the resident's quality of life.Findings include:Review of R83's admission Record located under the admission tab of the Electronic Medical Record (EMR) revealed R83 was admitted to the facility with diagnoses of dementia, major depressive disorder, and anxiety disorder. Review of R83's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 02/03/26, with a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated R83's cognition was severely impaired. Review of R83's care plan initiated on 08/15/24, located under the Care plan tab revealed that R83 had a focus that R83 was at risk for changes in mood related to dementia with interventions in place, to assess for physical/environmental changes that may precipitate change in mood. During an observation on 02/17/26 at 1:26 PM and 02/18/26 at 10:37 AM, revealed R83's room to have old food and trash on the floor, no blinds or curtains on the window, and no personal items hung on the walls or displayed on the furniture. The baseboard near the right side of the door was chipped. R83 did not have a trash can. During an interview on 02/17/26 at 1:26 PM, R83's family member (FM83) stated, .I have been asking nursing staff for curtains for weeks, since they moved her to this room back in October last year. I don't know how they dress her in the mornings with the window wide open like that. You know she doesn't even have a trash can in here. I have been asking for a trash can for weeks .During an interview on 02/18/26 at 11:12 AM, Certified Nursing Aide (CNA) 3 stated when asked when R83 needs assistance with dressing, where does she assist R83. CNA 3 stated, .in his/her room. Sometimes I help him/her inside the bathroom.During an interview on 02/18/26 at 11:17 AM, Registered Nurse/Unit Manager (RN/UM) stated, I have not reported the issue of no blind or curtains on the window.During an interview on 02/18/26 at 11:24 AM, Housekeeping Aide (HA) 2 stated that she was not aware there was no trash can in the room. During an interview on 02/18/26 at 12:39 PM, Maintenance (MAIN) stated that he did not know that there was no blind or curtain on R83's window.Review of the facility's policy titled, Safe and Homelike Environment dated 12/2025 indicated, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible . NJAC 8:39-4.1(a)(11)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure a written transfer notice that contained all required information and the bed hold notice was provided for one of four residents (Resident (R)174) and/or their resident representatives (RR) reviewed for hospital transfer out of 36 sample residents. This failure had the potential to result in the resident and their RR to not have the knowledge of where and why a resident was transferred, the bed hold policy and/or how to appeal the transfer, if desired.Findings include:Review of R174's undated Face Sheet in the electronic medical record (EMR) indicated R174 was originally admitted to the facility with diagnoses of chronic respiratory failure, tracheostomy status, and persistent vegetative state. Review of R174's Nursing Progress Notes located under the Progress Note tab in the EMR indicated on 02/07/26 at 1:10 PM, . Resident family member did ask the nurse that Resident responsible party [sic]. have instructed we send resident to [name of hospital] for further evaluation as they observed resident left side of his/her face is swollen from forehead to scalp. NP [nurse practitioner].gave order to send resident to [name of hospital] for further evaluation as requested by family. On 02/08/26 at 7:08 AM, the nursing progress note indicated, . patient is being admitted for facial swelling.Review of R174's EMR did not indicate documentation of the facility providing a written transfer and bed hold policy to the resident and RR when R174 was transferred to the hospital on [DATE].During an interview on 02/20/26 at 4:45 PM, the Social Service Director (SSD) stated, The resident went to the hospital on Friday and when I came back to work on Monday, I don't know why I did not send this information by email to the RR. The SSD also confirmed that the bed hold policy and the transfer notice should have been provided in writing to the resident and RR.During an interview on 02/21/26 at 5:00 PM, the Regional Director of Clinical Services stated, The expectation is for the social worker to follow the policy and procedures the facility has in place when a resident is transferred to the hospital.Review of the facility's policy titled, Transfer or Discharge Notice dated 04/2025 indicated, . The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility. The resident and/or representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged , d. A statement to the resident's rights to appeal the transfer or discharge, including: (1) the name, address, email, and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed hold policy, f. The name, address, and telephone number of the Office of the State Long-term Ombudsman; g. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies), h. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies), and i. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. NJAC 8:39-4.1(a)(32)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on, record review, interviews, policy review, the facility failed to provide training for three nurses (Licensed Practical Nurse (LPN)1, LPN2 and Registered Nurse (RN)3) to have the knowledge and competency to care for three of three residents (Resident (R)6, R174 and R199) with a tracheostomy. This failed practice had the potential to cause harm to the residents that had a tracheostomy. Findings include:During an interview on 02/17/26 at 2:06 PM, LPN11 was asked what emergency equipment needed to be at the bedside of a resident that has a tracheostomy. LPN1 stated, suction machine, Yankauer suction and a tracheostomy care kit. I don't remember what else needs to be in there. LPN1 was asked if he/she went into the resident's room and the tracheostomy cannula was dislodged, what would he/she do. LPN1 stated, I cannot remember but if you could help me out, I could use it. LPN1 stated that she could not remember receiving any in-service training regarding emergency tracheostomy care at the facility.During an interview on 02/17/26 at 2:45 PM, LPN 2 was asked what emergency equipment should be at the bedside of a resident with a tracheostomy. LPN2 stated, sterile water, Ambu bag, split gauze and a trach care kit. LPN2 was asked what size Shiley cannula did R6 have and he/she stated, Off the top of my head, I don't remember. I would have to look. LPN2 accompanied the surveyor to R6's room and confirmed there was no Ambu bag or obturator in the resident's room with only one size 5.0 inner cannula in the windowsill. During an interview on 02/17/26 at 3:00 PM, LPN1 accompanied the surveyor into R174's room. LPN1 was asked where the Ambu bag and obturator were in the resident's room. LPN1 stated, I have never heard of an Ambu bag or obturator, so I really don't know where they are. During an interview on 02/17/26 at 4:40 PM, the Regional Director of Clinical Services confirmed that he/she would expect the resident with a tracheostomy to have the required emergency equipment at the bedside and in the room as outlined in the policy.During an interview on 02/19/26 at 2:30 PM, RN3 was asked what emergency equipment was needed at the bedside of a resident with a trach. RN3 replied, An Ambu bag, inner cannulas, suction catheters and suction machine, trach care kit, and trach ties. RN3 was asked what size of trach did R6 have and he/she stated, I would have to google it to find out. RN3 accompanied the surveyor to R6's room and the surveyor asked where the obturator was located. RN3 stated, I really don't know. I didn't check my supplies this morning. RN3 stated that she had received emergency tracheostomy care training that morning but was unable to state the size of R6's cannula. RN3 stated that the in-service training indicated that she was to check for emergency equipment at the bedside of tracheostomy residents at the beginning of her shift however, she did not do this. Review of the facility's policy Tracheostomy Care dated January 2026 indicated, . The following disposable equipment should be at the bedside:Spare trach tube - equal in size to the tube in placeBack-up trach - one size smaller for emergencies.Suction kits 14 Fr [French] (trach smaller than 6.0 require 12 Fr)Trach care kitsSplit drain sponges250 ml [milliliters] NSS [Normal Saline Solution]Trach ties-Suction cannister with lid-Suction tubingThe following equipment should be in the room:Suction Canister5-liter concentratorOxygen tank in appropriate holder. NJAC 8:39-5.1(a)NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure that one resident (Resident (R) 119) out of five residents did not receive an unnecessary medication during medication pass. Findings include: Review of R119's admission Record located in the Electronic Medical Record (EMR) under the tab Census revealed readmitted to the facility on [DATE] with a diagnosis of chronic pain syndrome. Observation during medication pass on 02/17/26 at 8:34PM, Registered Nurse (RN) 1 administered to R119 Ibuprofen 800 milligrams (mg) by mouth (PO) because R119 had complained of pain. During review of R119's Order Summary Report located in the EMR under the tab Orders dated 02/18/26 indicated no evidence of an order for Ibuprofen 800 mg being ordered as of 02/17/26. Review of R119's Blister Package dated 01/07/26 indicated, Ibuprofen 800 mg one tablet by mouth (PO) every six hours (Q6H) when needed (PRN) for moderate to severe pain for 14 days.Interview on 02/18/26 at 3:45 PM, RN1 stated that he/she was unaware of R119 not having an order.Interview on 02/18/26 at 4:00 PM, Licensed Practical Nurse (LPN) 2 confirmed that R119 did not have a physician order for Ibuprofen. Interview on 02/19/26 at 2:45 PM, the Director of Nursing (DON) stated that he/she would have expected RN1 to call the physician and explained that R119 was having pain and get an order for the medication. The DON confirmed that there was no order for the Ibuprofen on 02/17/26. Review of the facility's policy titled, Administering Medications revised date 09/25 indicated, Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation .7. The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication. NJAC 8:39-29.3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, interviews, and facility policy review, the facility failed to ensure that one resident (Resident (R) 142) out of five residents observed during medication administration received medication in a manner to prevent possible cross contamination in a sample of 36 residents. Findings include: Observation during medication pass on 02/17/26 at 8:34 PM, Registered Nurse (RN) 2 placed all of R142's medications into the medication cup except one medication, gabapentin (medication to treat neuropathic pain) 300 milligram (mg). RN2 placed the gabapentin in another medication cup. RN2 picked up the gabapentin with her bare right hand, opened the gabapentin capsule and with her bare hands, poured the contents on top of the other medication. RN2 then administered R142 his/her medications. Review of admission Record, located in the Electronic Medical Record (EMR) under the Census tab was admitted to the facility with diagnoses of type2 diabetes mellitus, and contracture of muscle-right upper arm, and right thigh. Review of R142's Order Summary Report dated 02/21/26, located in the EMR under the Orders tab indicated, gabapentin 300 mg PO [by mouth] three times a day [TID]. Interview on 02/19/26 at 4:15 PM, the Director of Nursing (DON) expects that the nurses do not pick up medication with their bare hands. They can use a spoon or gloves instead. Interview on 02/19/26 at 5:15 PM, RN2 stated that he/she should have put on gloves instead of using his/her bare hands. Review of the facility's policy titled, Administering Medications revised 09/25 indicated, .Policy Interpretation and Implementation .22. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for the administration of medications, as applicable . NJAC 8:39-19.4