| 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 05/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NEW GROVE MANOR** | **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<br><br>Complaint #: NJ 122171, NJ 122277<br><br>Census: 135<br><br>Sample Size: 3 | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>COMPLAINT #: NJ 00122277<br><br>Based on observation, interview and record review of documentation provided by the facility on 5/8/19, 5/20/19 and 5/21/19, it was determined that the facility failed to ensure resident safety and supervision for a resident identified as a high risk for falls. On 4/1/19 at 1:20 p.m., Resident #2 was not observed by staff self-propelling in a wheelchair to the back-exit door. The resident got out of the wheelchair and proceeded to walk in the stairwell and fell. This resulted in the resident sustaining a [redacted] that required a hospital evaluation and treatment including [redacted].<br><br>The deficient practice was identified for 1 of 3 residents, Resident #2, reviewed for falls and was evidenced by the following: | F 689 | F689 = G FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>I. CORRECTIVE ACTION<br><br>Resident #2 was re-assessed on 4/05/19 and the care plan updated by the interdisciplinary team to address her wandering behaviors. Resident #2 is under hourly visual observation as of 4/05/19 which is documented by CNA's. Staff that provide care to Resident #2 were re-educated about monitoring Resident #2 and re-directing to activities of interest if she is seen exit seeking. Social Service educated family on 4/8/19 in regard to resident's exit seeking behavior and redirection required. | 5/22/19 |

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

Electronically Signed | 07/03/2019

| 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 05/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW GROVE MANOR | 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 689 | Continued From page 1<br><br>During a tour of the facility on 5/8/19 at 9:55 a.m., in the presence of the Unit Manager (UM). The UM stated Resident #2 was [redacted]. The UM also stated that the resident had a fall and was hospitalized. At this time, the surveyor observed Resident #2 inside his/her room sitting in his/her wheel chair. The surveyor made an attempt to interview the resident but the resident refused.<br><br>The surveyor reviewed the medical record for Resident #2 on 5/8/19, revealed the following: Resident #2 was admitted to the facility [redacted], and re-admitted on [redacted], with diagnoses which included but were not limited to: [redacted].<br><br>A review of a Minimum Data Set, an assessment tool dated [redacted], in section C-Cognitive Patterns revealed Resident #2 had a Brief Interview for Mental Status score of [redacted]. This score indicated that the resident had [redacted]. According to section G-Functional Status revealed Resident #2 required assistance from one staff member with bed mobility and for transferring from the bed and into the chair.<br><br>A review of Resident #2's "Fall Risk Evaluation" dated 1/11/19, revealed the resident scored 20 points which identified the resident as being at a high risk for falls. According to the instructions found on this form, a total score of 10 or greater, the resident should be considered at "High Risk" for potential falls. Also, the evaluation indicated a prevention protocol should be initiated immediately and documented on the care plan. | F 689 | II. IDENTIFY OTHER INSTANCES<br><br>All residents who wandering or have poor safety awareness have the potential to be affected.<br><br>All residents in the facility who display exiting seeking behaviors were identified from 5/15/19 and on, to assure their care plans reflected interventions to address these behaviors.<br><br>III. SYSTEMIC CHANGE<br><br>Break times were reviewed by DON and the system changed to ensure that no fewer than three staff members are on the unit during the 7-3 and 3-11 shift and no fewer than 2 staff members on the unit during 11-7 shift to monitor and supervise safety of residents. Charge nurses ensure that there are 3 staff members on the unit during 7-3 and 3-11 shift and 2 staff members on 11-7 shift. In the event that additional staff is needed the DON/Supervisor/Designee is notified.<br><br>Inservices were held by Supervisors/Department Heads with professional and non-professional staff to review the system changes above ensuring all residents are always supervised appropriately for their safety beginning 5/22/19. There are no fewer than three staff members available to supervise and monitor residents on the unit during 7-3 and 3-11 shifts and two staff members available to supervise and monitor on the unit during 11-7 shift. | |

| 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 05/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NEW GROVE MANOR** | **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 689 | Continued From page 2<br><br>A review of Resident #2's "Interdisciplinary Care Plan" (ICP) titled "Fall" dated 4/5/16, revealed that the resident was a "Fall Risk" as related to: [redacted]. The "Goals" listed on the ICP were: Resident to remain free from injuries associated with falls through the review date, and Resident will verbalize understanding of the need for assistance. The "Intervention" listed under "Resident" on the ICP were: Remind resident to call when needing assistance, Instruct resident to sit before standing as appropriate, Keep call light and most frequently used personal items within reach, Assess medications for contributing factors. Listed under "Identification" Maintain record of falls, and evaluate for patterns and make all staff members aware that resident is at high risk for falls. Listed under "Clothing" dated 6/29/16 Shoes must fit well-non slip soles. Listed under "Mobility" Therapy evaluation (Physical Therapy and Occupational Therapy) PT-OT strength training, gait transfer and Staff monitoring and assistance. Listed under "Safety" Low beds and Beds are locked.<br><br>A review of the section titled "Evaluation of Comprehensive Care Plan" revealed that Resident #2 had documented episodes on the following dates:<br>On 4/24/16 "Resident found on floor - unwitnessed no injury, bruises by break in skin. Denies pain. Continue with plan of care."<br>On 6/29/16 "Resident fell in room returning from bathroom - slippers loose - Braden scale = 17 - Continence bowel and bladder - Fall risk = 16 - | F 689 | Charge nurses ensure that there are 3 staff members on the unit during 7-3 and 3-11 shift and 2 staff members on 11-7 shift. In the event that additional staff is needed the DON/Supervisor/Designee is notified.<br><br>Maglocks and keypads are currently being installed on all unit stairwell exit doors projected completion date July 23rd 2019.<br><br>IV. MONITOR CORRECTIVE ACTION<br><br>Audits will be conducted three times per week on all units, by Supervisor/designee on each shift, randomly for the next four weeks to ensure that there is sufficient staff on the unit to supervise residents and ensure their safety. Reports will be presented by DON at July QAPI meeting to determine necessity and continuation of monitoring. | |

| 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 05/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NEW GROVE MANOR** | **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 689 | Continued From page 3 | F 689 | | |

6/29/16 Add - fitting shoes - to prevent falls - Plan of care to continue until next review."
On 7/31/16 "Resident was found on the floor by the bed, as per resident [he/she] trying to get out bed alone. No apparent injury noted - fall assessment = 18. Resident remains at risk for fall. Care plan continue."
On [redacted] "Resident readmitted from [hospital]. Fall risk assessment score 18. Remains at risk for fall. Plan of care to to continue."
On 8/5/16 "Summary of review for activity. Resident had 1 fall on 6/29/16. No injury. Fall risk assessment - 16. Continue care plan."
On [redacted] "Readmitted from [hospital]. Remains at risk for falls. Fall risk assessment score = 19 Care plan to continue."
On 10/20/16 "Resident had no fall this review but remains at risk. Fall risk assessment 18. Continue care plan."
On 1/19/17 "Resident had no fall this review but remains at risk. Fall risk assessment 18. Continue care plan."
On 4/20/17 "Resident had no fall incident this review remains at risk continue plan of care."
On 5/26/17 "Resident was packing [his/her] clothes while sitting in [his/her] wheelchair and fell to the floor no injury but c/o headache. No [redacted] noted. Resident did not lock [his/her] wheelchair that caused [his/her] to fall. MD was notified to send resident to hospital."
On [redacted] "Resident was found sitting on the floor. No injury but MD ordered to send resident to [hospital]."
On 7/6/17 "Resident had 2 falls this review continue care plan."
On 7/20/17 "Resident had 2 falls 6/11/17 & 7/6/17 continue care plans."
On 10/4/17 "Resident was trying to get to the elevator. Trying to stop her, she started cursing in

| 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 05/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW GROVE MANOR | 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 689 | Continued From page 4 | F 689 | | |

[redacted] and slid down to the floor from her wheelchair landed to the floor in supine position and [redacted] on the floor, no bump, no injury noted. No headache no pain on movement. Fall risk assessment = 22 Neurological evaluation initiated. Remains at risk for fall. Care plan to continue."
10/19/17 "Resident had 1 fall this review remains at risk. Continue care plan."
1/18/18 "Resident had no fall this period but remains at risk fall assessment 18. Plan of care will continue until next review."

A review of the facility's "Incident/Accident Report" dated 4/1/19 at 1:48 p.m., provided by the Assistant Director of Nursing (ADON) on [redacted] at approximately 1:35 p.m., revealed Resident #2, who resided on the [redacted] floor, was found lying in supine position (lying on his/her back) inside the back-exit door stairwell on the [redacted]. The resident was found to have a [redacted] to the back of his/her head and was sent out to the hospital for an evaluation. The resident was admitted to the hospital with the diagnosis of having a [redacted]

Attached to the "Incident/Accident Report" a form titled " Unusual Occurrence Statement" dated 4/1/19, revealed when the UM returned to the nurse's station she heard someone "yelling" and started walking towards the back-exit door and Resident #2's wheelchair was at the door. The UM opened the door and walked down to the first-floor landing and the resident was laying in a supine position. According to this form, Resident #2 was last seen at 1:20 p.m. sitting in the dining room.

| 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 05/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NEW GROVE MANOR** | **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 689 | Continued From page 5 | F 689 | | |

A review of a Reportable Event Record/Report dated 4/1/19 at 1:48 p.m. which was submitted to the Department of Health, revealed Resident #2 was observed on the [redacted] floor by a Sub-Contractor walking down the stairs. According to the documentation, the resident lost his/her balance and fell.

During an interview conducted by the surveyor on 5/20/19 at 9:50 a.m., with Certified Nursing Assistant (CNA #1) stated on 4/1/19 Resident #2 was inside the dining room however; she did not see when the resident left the room because she was sitting with her back turned away from the door. CNA #1 stated she was the only staff member in the dining room when she heard a door alarm bell ringing. CNA #1 stated the UM came to the dining room and alerted her that there may be a resident at one of the exit doors because the bell was ringing unusually long. CNA #1 stated they went to check the back exit door and when they opened the door, Resident #2 was sitting on the [redacted] floor landing and was surrounded by people. When interviewed further, CNA #1 stated that there were 3 CNAs working on 4/1/19 and that all staff were responsible for supervising the residents on the floor.

During an interview with CNA #2 on 5/20/19 at 10:00 a.m., CNA #2 stated Resident #2 was on visual observation checks which required for her to check on the resident's whereabouts throughout the day.

When interviewed by the surveyor on 5/20/19 at 10:20 a.m., the UM stated Resident #2 required redirection and observation and was talking about going to see his/her parents that day. The UM stated on 4/1/19 there were 3 CNAs working and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315147 | A. BUILDING _____ B. WING _____ | C 05/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW GROVE MANOR | 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 689 | Continued From page 6 | F 689 | | |

2 of them were on their break and CNA #1 was inside the dining room. The UM stated she left the nurse's desk to use the restroom and when she returned from the restroom, she heard a faint noise. The UM stated she and CNA #1 started to check around the unit and saw Resident #2's wheelchair by the back-exit door. The UM stated when she opened the door, she found Resident #2 on the [redacted]-floor landing with other facility staff arriving at the scene. When asked about staff supervision for Resident #2 on 4/1/19, the UM stated, "there was none at that time". When further interviewed, the UM stated when they have 4 CNAs working she assigns a CNA to the dining room however, when 3 CNAs are working they go by whoever is available to supervise the dining room and/or they collectively watch the residents.

A review of a form titled "CNA Assignment (When There Were 3 CNA's)" dated 4/1/19 presented by the UM on 5/20/19 at 10:20 a.m. revealed that CNA #2 and CNA #3 were assigned to take their lunch breaks from 1:00 p.m.-1:30 p.m. and CNA #1 was assigned to cleaning the dining room after the resident's lunch.

During an interview conducted by the surveyor on 5/20/19 at 11:55 a.m., in the presence of the Assistant Administrator, the Director of Nursing (DON), ADON, and the UM, the DON stated that the nursing unit would be adequately staffed with 1 nurse and 4 CNAs however; on 4/1/19 the nursing unit was staffed with 1 nurse and 3 CNAs. The DON also stated that on 4/1/19 from 1:00 p.m.- 1:30 p.m., CNA #2 and CNA #3 were on their lunch break . Also, CNA #1 was in the dining room feeding a resident and did not see when Resident #2 left the dining room. The AA

| 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 05/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NEW GROVE MANOR** | **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 689 | Continued From page 7 | F 689 | | |

stated that when a staff member takes a break they should notify the nurse or the Supervisor to provide supervision of the nursing unit. During this same interview, the UM stated that she did not call the supervisor on 4/1/19 to provide supervision of the nursing unit when she left the nurse's desk. At this time, the DON stated because there was no supervision, Resident #2 was able to exit and suffered a fall. The UM stated Resident #2 was on visual checks but after the fall the resident was placed on frequent monitoring.

Review of the Facility Policy titled, "Patient Care Policy Manual", undated, under "Risk Assessment Screens" 1. A fall risk assessment is completed on admission, readmission, quarterly and annually and documented in the medical record. If score is higher than ten, resident is considered at high risk for falls. Prevention protocol must be initiated immediately and documented on the care plan. Under "Fall Prevention/Intervention Strategy" "Mental State:" 1. Try to re-orient and re-direct confused patients 2. Staff monitoring as needed.

NJAC 8:39-27.1(a)