

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/29/2021
NAME OF PROVIDER OR SUPPLIER MI CASA ES SU CASA II, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 BUCHANAN PLACE (PO BOX 4074) WEST NEW YORK, NJ 07093		
(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) COMPLETE DATE
M 000	Initial Comments Type of Survey: Complaint Complaint #'s NJ 00150100, NJ 00150280 Census: 50 Sample Size: 3 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 221	8:43F-3.1(a) Administration The license holder shall appoint an administrator who is a full-time employee of the facility. The administrator, or an alternate who shall be designated in writing to act in the absence of the administrator, shall be available on the premises of the facility during the hours when participant care services are being provided. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00150100, NJ 00150280	M 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/15/21

New Jersey Department of Health

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M 221	Continued From page 1 Based on observation and interview it was determined that the facility failed to ensure that an Administrator was available on the premises of the facility during programming hours or an alternate Administrator was delegated in writing for 50 participants on 11/29/21 as evidenced by the following: On 11/29/21 9 a.m., the surveyor arrived at the facility and met with the Director of Nursing (DON) at the front desk. The surveyor inquired about the Administrator or the designated alternate Administrator. The DON stated that she was the DON and also was informed by the program Owner on [REDACTED] that she was the acting Administrator. During the entrance conference, the DON stated that the Administrator was [REDACTED] on [REDACTED] and confirmed that there was no Administrator nor alternate Administrator designated to act in this position. The facility failed to ensure that an Administrator and/or alternate Administrator was designated in writing and available on the premises at all times when participants were present.	M 221		
M 481	8:43F-8.2 Medical Services A physician shall be designated to serve as the facility's medical consultant. This REQUIREMENT is not met as evidenced	M 481		

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M 481	Continued From page 2 by: Complaint #: NJ 00150100, NJ 00150280 Based on interview and record review, it was determined that the facility failed to ensure that a physician was designated to serve as the facility's medical consultant, as evidenced by the following: On 11/29/21 at 9:10 a.m., during interview with the facility's Director of Nursing (DON), she told the surveyor that the facility did not have a Medical Consultant and had not had one since June of 2021. At 11:05 a.m., during a telephone interview with the facility's Owner, the surveyor inquired if the facility had a Medical Consultant. The owner stated that the facility has not had a Medical Consultant since the program re-opened on 10/6/21 and was still in the process of hiring a Medical Consultant.	M 481		
M 577	8:43F-12.1 Social Work Services All social workers shall be licensed or certified by the New Jersey State Board of Social Work Examiners, pursuant to N.J.S.A. 45:15BB-1 et seq. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00150100, NJ 00150280 Based on interview and review of the Assistant	M 577		

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M 577	Continued From page 3 Social Worker (ASW) personnel file provided by the facility it was determined that the Social Worker (SW) NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 This deficient practice was evidenced by the following: On 11/29/21 at 9:15 a.m., during interview with the Director of Nursing (DON), the surveyor inquired if the facility's Social Worker (SW) was available for interview. The DON stated that both the Administrator and SW NJ Ex Order 26.4b1 and stated that the facility had an Assistant SW (ASW). At 9:30 a.m., the surveyor interviewed the ASW who stated that she had been employed by the facility since NJ Ex Order 26.4b1. She told the surveyor that she worked under the former Licensed SW (LSW) whose last date of employment at the facility was NJ Ex Order 26.4b1. The ASW confirmed that she was NJ Ex Order 26.4b1 and explained that she was in the process of obtaining her NJ Ex Order 26.4b1 The ASW had a NJ Ex Order 26.4b1 from a local university, however, there was no documented evidence in her personnel file that she was NJ Ex Order 26.4b1. During surveyor interview with the Owner at 11:05 a.m., he confirmed that the facility only had an ASW. The facility failed to ensure social work services were provided by a licensed or board certified by NJBSWE in accordance with this regulation.	M 577		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 09001	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/11/2022
NAME OF FACILITY MI CASA ES SU CASA II, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6120 BUCHANAN PLACE (PO BOX 4074) WEST NEW YORK, NJ 07093	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0221	Correction	ID Prefix M0481	Correction	ID Prefix M0577	Correction
Reg. # 8:43F-3.1(a)	Completed	Reg. # 8:43F-8.2	Completed	Reg. # 8:43F-12.1	Completed
LSC	12/14/2021	LSC	12/14/2021	LSC	12/14/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 11/29/2021		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			