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	315164	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD TENAFLY, NJ 07670**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #s NJ00168846 STANDARD SURVEY: 11/22/23 CENSUS: 55 SAMPLE SIZE: 18 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		12/30/23

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

Electronically Signed | 12/08/2023

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F 690	Continued From page 1 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide Ex Order 26.4B1 care in a manner to prevent the spread of infection to a resident with a history of Ex Order 26.4B1 Ex Order 26.4. The deficient practice was identified for 1 of 1 resident (Resident #7) reviewed for Ex Order 26.4B1 care and was evidenced by the following. On 11/14/23 at 10:37 AM, the surveyor observed Resident #7 awake in bed. The resident's large (overnight) Ex Order 26.4B1 was observed placed in a Ex Order 26.4B1 hanging on the bed frame. The surveyor inspected the resident's bathroom on 11/14/23 at 10:37 AM and again on	F 690	Concern. F 690-Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25 €(1)-#(3) Based on observation, interview, and record review it was determined that the facility failed to provide Ex Order 26.4B1 Ex Order 26.4B1 care in a manner to prevent the spread of infection to a resident with a history of Ex Order 26.4B1). The deficient practice was identified for 1of 1 resident (Resident #7) reviewed for Ex Order 26.4B1 care and was evidenced by the following.	

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F 690	Continued From page 2 11/15/23 at 9:38 AM and observed a small (daytime) Ex Order 26.4B1 with uncapped Ex Order 26.4B open to air stored in a plastic bag which hung from a handrail next to the toilet. On 11/15/23 at 9:38 AM, the surveyor interviewed the US FOIA (b)(6)) assigned to Resident #7. The US FOIA (b) confirmed the Ex Order 26.4B1 Ex Order 26.4B1 was uncapped and open to air. She stated the Ex Order 26.4B1 should be capped. She further stated "I don't know anything about it" when asked whose NJ Exec Order 26.4B1 it was. On 11/15/23 at 9:45 AM, the surveyor interviewed the US FOIA (b)(6)) in charge of the unit. The US FOIA (b) confirmed the presence of an uncapped Ex Order 26.4B1 bag in the resident's bathroom. She stated of the four residents sharing the bathroom, only one resident, Resident #7, had an Ex Order 26.4B1 Ex Order 26.4B1. She stated she would educate the US FOIA (b) as to why the Ex Order 26.4B needed to be capped. A review of the electronic medical record revealed the following information. The resident was admitted to the facility with the diagnoses of Ex Order 26.4B1 . The Ex Order 26.4B1 Treatment Administration Record included a Ex Order 26.4B1 physician's order for the use of an Ex Order 26.4B1 . The NJ Exec Order 26.4B1 Admission Minimum Data Set (MDS), an assessment tool used to guide the care of the resident, included in Section NJ S that the resident used an Ex Order 26.4B1 and in Section N that the resident had a current Ex Order .	F 690	Resident #7 was identified that the NJ Exec Order 26 with uncapped tubing open to air stored in aplastic bag which hung from a handrail next to the toilet. How the corrective action will be accomplished for any resident affected by deficient practice. Resident #7 was immediately assessed and the bag was immediately discarded and changed. All residents will foley catheter was assessed to ensure the catheter tip was capped and stored in the plastic bag. Policy and Procedure regarding care of Foley catheter was discussed with US FOIA (b) and License nurses that the urinary bag will be capped and stored properly No other residents were affected of this deficient practice. How we identified other residents/areas that could potentially be affected. All residents in the Facility have the potential to be affected by the deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. All Certified Nursing Assistance and License Nurses were re in serviced regarding the policy and procedure of	

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F 690	Continued From page 3 On 11/17/23 at 1:15 PM, the surveyor discussed the concern of the uncapped Ex Order 26.4B1 Ex Order 26.4B1 with US FOIA (b)(6) the US FOIA (b)(6), and the US FOIA (b)(6). The US FOIA (b) provided the surveyor with the facility's policy for Urinary Catheter Care, revised October 2010. General Guideline #1 included the directive to "maintain a closed drainage system." NJAC 8:39-19.4(a)5	F 690	Foley catheter care. DON or designee will review/ audit residents with Foley Catheter weekly x 90 days and thereafter. DON or designee will check resident with Foley catheter during clinical rounds 2x weekly. Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. Results of this review and audit will be discussed in morning clinical meeting for immediate resolution. ADON/Designee will present findings in monthly QAPI and will be a part of Center quarterly Quality Assurance. Dates when concern will be completed. 12/30/23.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		12/30/23

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F 755	Continued From page 4 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to a.) acquire, accurately administer and document a medication (Ex Order 26.4B1) from Ex Order 26.4B1 until surveyor inquiry on Ex Order 26.4B1 one (1) of five	F 755	Concern. F755- Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	

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F 755	Continued From page 5 (5) residents, (Resident #50), observed during the medication administration observation, b.) administer medications in a timely manner to five (5) residents, (2 sampled residents :Resident #23 and #53 and 3 unsampled Residents #1, #2 and #3) by one (1) of two (2) nurses observed administering morning medications on [NJ Exec Order 26.4b] and c.) accurately document the administration of an as needed (PRN) medication [Ex Order 26.4B1]) for one (1) of nine (9) residents, (Resident #44), reviewed for medication management. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 755	Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to a.)acquire, accurately administer and document a medication ([Ex Order 26.4B1] [NJ Exec Order 26.4b1] from10/7/23 until surveyor inquiry on 11/16/23 for one (1) of five (5) residents, (Resident #50),observed during the medication administration observation, b.) administer medications in a timely manner to five (5) residents, (2 sampled residents :Resident #23 and #53 and 3unsampled Residents #1, #2 and #3) by one (1)of two (2) nurses observed administering morning medications on 11/16/23 and c.)accurately document the administration of an as needed (PRN) medication ([NJ Exec Order 26.4] for one (1)of nine (9) residents, (Resident #44), reviewed for medication management. Resident #50, #23 #53, #1, #2, #3 and resident #44 were re assessed after medication administration with no significant changes. Resident with [Ex Order 26.4B1] [redacted] order was confirmed that the said medication was not available in the cart during medication administration and was not given to the resident timely. Resident #50 was assessed with [NJ Ex] [redacted] No other resident was affected of this deficient practice.	

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F 755	Continued From page 6 The deficient practices were evidenced by the following: REFER TO F759 1. On 11/16/23 at 9:37 AM, during the morning medication administration pass, the surveyor, in the presence of another surveyor, observed the US FOIA (b)(6) preparing seven (7) medications which included one Ex Order 26.4B1 for Resident #50. The US FOIA (b) stated that he was unable to find the Ex Order 26.4B1 capsule in the medication cart and would have to check with the US FOIA (b)(6) or call the physician. On 11/16/23 at 9:55 AM, the surveyors observed the US FOIA (b)(6) join the US FOIA (b) at the medication cart and assisted the US FOIA (b) in searching the medication cart for the Ex Order 26.4B1 capsules. The US FOIA (b)(6) stated that she was unable to find the Ex Order 26.4B1 capsules and would have to check why it was not available. On 11/16/23 at 10:08 AM, the US FOIA (b) had completed administering the morning medications to Resident #50 which included six (6) of the seven (7) medications that had an administration time of 9 AM. The surveyors had not observed the US FOIA (b) administer the Ex Order 26.4B1 Ex Order 26.4B1 according to the PO. The US FOIA (b) signed the electronic medication administration record (EMAR) indicating the number five (5) which corresponded with "Hold/see Progress Notes" for the administration of the Ex Order 26.4B1 Ex Order 26.4B1	F 755	How the corrective action will be accomplished for any resident affected by deficient practice. Resident # 50 was assessed with NJ Exec Affected US FOIA (b) was counselled regarding failure to document Corporate educator performed a competency on 11/26/23 to licensed regarding medication administration. No residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. License nurses was re in serviced regarding medication administration focusing on omission, reading the medication label correctly. When medication is unavailable to report to MD immediately for medication substitution. Don or designee will educate licensed nurses to report any missing medications or when medication is not delivered.	

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F 755	Continued From page 7 The surveyor reviewed the medical record for Resident #50. A review of the resident's Admission Record (AR) revealed diagnoses which included Ex Order 26.4B1 [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of Ex Order 26.4B1, reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident had a Ex Order 26.4B1 [redacted]. In addition, the MDS revealed in section [redacted] for [redacted] that the resident spoke [redacted] and NJ Exec Order 26.4b1. A review of the Order Summary Report revealed a physician's order (PO) dated [redacted] for 'Ex Order 26.4B1 [redacted], Give [redacted] capsule Ex Order 26.4B1 [redacted] for [redacted] A review of the nursing Progress Notes (PN) dated Ex Order 26.4B1 [redacted] completed by the [redacted] indicated that "MD called made aware of AM medication being administered late." On 11/16/23 at 1:30 PM, the surveyor interviewed the [redacted] who stated that he was an agency nurse and that this was his [redacted] at the facility. The [redacted] stated that he was given an orientation handout that morning but was unsure who had given it to him. The [redacted] added that the [redacted] was working on locating the Ex Order 26.4B1 [redacted] and had called the physician.	F 755	Unit manager or designee will audit 5 charts weekly X 1 month then monthly for 90 days and thereafter for new orders and availability of medication. Pharmacy Consultant or designee will be observed 3 licensed nurses monthly X 6 months and thereafter for medication administration pass. Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. Results on this Audits will be discussed in clinical morning meeting for immediate resolution. This will be included in monthly Quality Assurance Performance Improvement and this will a part of quarterly QA program. Dates when concern will be completed. 12/30/23.	

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F 755	Continued From page 8 On 11/16/23 at 1:38 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the US FOIA was in the facility this morning and gave out Med Pass information to the nurses. On 11/16/23 at 1:44 PM, the surveyor interviewed the US FOIA who stated that she had given an in-service information handout on Medication Pass that morning to the nurses who were doing the medication pass because there were agency nurses. A review of the Medication Pass in-service information handout provided by the US FOIA reflected that under "Miscellaneous Situations: Missing Medications: If a medication is not found on the med cart, notify another nurse to first check the backup supply. If not available from back up, notify the physician for further orders, such as stat delivery from pharmacy and a one-time order to administer later in the day. Follow up with the surveyor to let them know how the problem was resolved." On 11/16/23 at 1:16 PM, the surveyor interviewed the US FOIA (b)(6) who stated that she was the not the usual US FOIA (b)(6) and was acting as the US FOIA for that day. The US FOIA (b)(6) stated that the Ex Order 26.4B1 was technically an over the counter (OTC) medication and was a house stock medication to be provided by the facility. The US FOIA (b)(6) added that she could not find the Ex Order 26.4B1 capsules and thought they were on order, so she had called the provider pharmacy and requested Ex Ord capsules to be delivered. The US FOIA (b)(6) explained that the facility could order any OTC but that the order could take a couple days to come in so during the interim they requested a small amount	F 755		

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F 755	Continued From page 9	F 755		

of the OTC medication be delivered from the provider pharmacy so that it would be available to the resident.

At that time, the surveyor, with the US FOIA (b)(6), reviewed a Fax Log dated Ex Order 26.4B1 and timed for 10:29 AM that she had completed so that the facility would receive the Ex Order 26.4B1 Ex Order 26.4B1 in the next delivery from the provider pharmacy. The NJ Exec Order 26.4B also stated that the 3 PM to 11 PM shift would administer the medication because she had also called the physician and obtained a PO to administer the medication late. The US FOIA (b)(6) could not speak to why the medication was not available for the 9 AM medication pass.

At that time, the US FOIA (b)(6) reviewed the electronic PO for the Ex Order 26.4B1 and stated that the start date for the PO was Ex Order 26.4B1 The US FOIA (b)(6) also reviewed an electronic Progress Note (EPN) which indicated that the pharmacy was contacted with regard to delivering the Ex Order 26.4B1 but could not speak to whether the medication was delivered.

On 11/16/23 at 1:48 PM, the surveyor interviewed the US FOIA (b)(6)) who stated that she was aware that the Ex Order 26.4B1 Ex Order 26.4B1 capsules were not available during the medication pass and had called the provider pharmacy. The US FOIA (b) added that the provider pharmacy had never delivered any Ex Order 26.4B1 capsules for Resident #50 because it was an OTC medication. The US FOIA (b) then explained that she had checked with their supplier and the Ex Order 26.4B1 Ex Order 26.4B1 was out of stock. The US FOIA (b) then stated that she would have to investigate what the

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F 755	Continued From page 10	F 755		

nurses were administering since the EMAR indicated that the medication was administered and why there was no follow up when the medication was not administered and documented as awaiting delivery or called pharmacy.

A review of the October EMAR for Resident #50 revealed that the Ex Order 26.4B1 had a start date of Ex Order 26.4B1 Ex Order 26.4B1 the medication was not administered and had a chart code of the number nine (9) entered for the 9 AM administration which indicated "Other/See Progress Notes." In addition, on Ex Order 26.4B1 there was a chart code of the number five (5) which indicated "Hold/see Progress Notes." Further review of the EMAR revealed that the medication was administered on Ex Order 26.4B1

A review of the corresponding EPN regarding the PO for Ex Order 26.4B1 revealed the following:
Ex Order 26.4B1 "Pharmacy to deliver"
Ex Order 26.4B1 "on order"
Ex Order 26.4B1 AM "meds not available"

A review of the November EMAR for Resident #50 revealed that Ex Order 26.4B1 was not administered at Ex Order 26.4B1 Ex Order 26.4B1 and had a chart code of the number nine (9) which indicated "Other/See Progress Notes." Further review of the EMAR revealed that the medication was administered on Ex Order 26.4B1 Ex Order 26.4B1

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A review of the corresponding EPN regarding the PO for Ex Order 26.4B1 revealed the following:
Ex Order 26.4B1 "Pending delivery from pharmacy; US FOIA notified regarding missing dose."
Ex Order 26.4B1 "on order"
Ex Order 26.4B1 "On order. US FOIA notified of missed dose. No new orders at this time."
Ex Order 26.4B1 "Med on order. Pending pharm delivery."
Ex Order 26.4B1 "waiting for pharmacy"
There was no corresponding EPN found for Ex Order 26.4B1.
Ex Order 26.4B1 "Pending med delivery"

On 11/17/23 at 9:31 AM, the surveyor, in the presence of the survey team, interviewed the US FOIA who stated that he was responsible for the Central Supply of the facility which required keeping stock and ordering of the OTC medications that the facility provided. The US FOIA explained that there was a list of the usual OTC medications that he ordered but the list could be added to. The US FOIA further explained that if an OTC medication that was not on the list had to be ordered that sometimes it would take a couple days to receive and that the nurses were aware of that. The US FOIA was unaware of the need to order Ex Order 26.4B1 capsules.

A review of the "House Stock Medications" list provided by the US FOIA (b) reflected that Ex Order 26.4B1 were not on the list.

On 11/17/23 at 10:40 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the Ex Order 26.4B1

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had been delivered on [redacted] and was able to show the surveyor the capsules in the medication cart. The [redacted] added that one (1) capsule was missing from the delivery of [redacted] capsules because it had been administered that morning for the 9 AM dose. The [redacted] also added that it was her mistake that the medication was not administered in the evening on [redacted] because she had not entered the PO to administer the medication as a one-time PO correctly in the electronic system. The [redacted] stated that she had verbally told the 3 PM to 11 PM shift but had not electronically entered the PO correctly to prompt the medication nurse to administer the medication on 11/16/23. The [redacted] acknowledged that the PO for [redacted] was to be administered on [redacted] and that the resident had not received any doses on [redacted]. The [redacted] stated that the [redacted] was currently not working and could not speak to the administration of the medication when it was not available.

On 11/20/23 at 9:39 AM, the surveyor interviewed the [redacted] in the presence of the survey team. The [redacted] stated that the facility policy does not speak to the process when a medication is not available. The [redacted] added that the nurses should know that if a medication was not available that they have to find out why and let the physician know to get a PO to discontinue the medication or change to another medication. The [redacted] stated that she was still investigating what the nurses had administered and why there was no follow up. The [redacted] acknowledged that the [redacted] capsules were not available from [redacted] when the provider pharmacy delivered the medication.

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On 11/20/23 at 1:23 PM, the survey team met with the facility administrative team. The [US FOIA (b)] provided the surveyor with an Investigational Summary regarding the [Ex Order 26.4B1] [Ex Order 26.4B1] The [US FOIA (b)] stated that some of the nurses who signed as administering the [Ex Order 26.4B1] were agency nurses and was not able to contact every nurse. The [US FOIA (b)] added that the nurses that she had contacted had stated that they had administered the [NJ Ex Order 26.4b1] but were unable to remember what [NJ Exec] medication or exact name they administered. The [US FOIA (b)] added that the nurses should have followed up when the medication was not available on [NJ Ex Order 26.4b1]

2. On 11/16/23 at 9:26 AM, during the morning medication observation, the surveyor in the presence of another surveyor, observed the [US FOIA (b)] preparing to administer medications to an unsampled Resident #1. The [US FOIA (b)] attempted to obtain a [NJ Exec Order 26.4b1] result for and was unable to get the [NJ Exec] machine to function. The [US FOIA (b)] stated that he was going to skip to another resident.

On 11/16/23 between 9:37 AM and 10:08 AM, during the morning medication administration observation, the surveyor in the presence of another surveyor, observed the [US FOIA (b)] prepare and administer medications to Resident #50.

On 11/16/23 at 10:12 AM, after the [US FOIA (b)] completed the administration documentation for Resident #50, the surveyors interviewed the [US FOIA (b)] regarding the names highlighted in red on the EMAR. The [US FOIA (b)] stated that he just had to administer medications to the unsampled Resident #1 and was then complete with his

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morning medication pass. The [redacted] added that he would have to call the physician for the unsampled Resident #1 because the medications were going to be administered late and that was the reason why the name was highlighted in red. The [redacted] explained that the medications were due at 9 AM and he had one (1) hour before 9 AM and one (1) hour after 9 AM to administer the medications to be on time. The surveyors, with the [redacted] again reviewed the EMAR which revealed five (5) resident names that were highlighted in a red color which included the unsampled Resident #1. The [redacted] stated that he thought the four (4) other residents that were highlighted in red just had monitoring information that he was able to document during his shift. The surveyors, with the [redacted] then reviewed each of the five (5) residents that were highlighted in red (Residents #23, #53, and unsampled Residents #1, #2 and #3), and revealed that each resident had morning medications that were due for 9 AM that had not been administered yet. The [redacted] stated that the physician would have to be contacted for all the residents that had late medications.

On 11/16/23 at 1:22 PM, the surveyors interviewed the [redacted] who stated that she had called the physicians regarding the medications being administered late and there was no issue. The [redacted] stated that this was the [redacted] and knew that should not be an excuse, but she handled as much as she could. The [redacted] stated that nothing unusual occurred this morning to make the medications late.

On 11/16/23 at 1:30 PM, the surveyors interviewed the [redacted] who stated that he was an agency nurse, and this was [redacted] at the

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facility. The [US FOIA (b)] also stated that he was late getting to the facility this morning since it was the [NJ Ex Order 28.4b1] coming to the facility and then had to get a login password for the electronic system and do a walk around which he explained meant that the [US FOIA (b)(6)] showed him where things were available in the facility and which residents he was responsible for. In addition, the [US FOIA (b)] stated that he thought he received an orientation information packet when he came to the floor but was unable to speak to who had given him the handout. The [US FOIA (b)] stated that his shift started at 7 AM but knew he arrived after 7 AM but could not speak to what time he actually started his morning medication pass.

On 11/16/23 at 1:48 PM, the surveyor interviewed the [US FOIA (b)] who stated that the usual process for a new agency nurse was an onboarding orientation which meant that they were given a packet that had to be completed before starting work. The [US FOIA (b)] thought the [US FOIA (b)] had received an orientation packet.

At that time the [US FOIA (b)] made a phone call and then stated that the [US FOIA (b)] had not received or completed an orientation packet. The [US FOIA (b)] further explained that the [US FOIA (b)] had received an in-service handout on Med Pass from the [US FOIA (b)(6)].

The [US FOIA (b)] provided the surveyor with the facility Agency Employee & Temporary Staff Orientation Packet.

On 11/20/23 at 11:15 AM, the surveyor interviewed the [US FOIA (b)] who stated that the orientation packet had not contained any information regarding the medication pass and

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F 755	Continued From page 16 that she would have to have the packet updated. The surveyor reviewed the EMAR for the five (5) residents that were highlighted in red, (Residents #23, #53, and unsampled Residents #1, #2 and #3), which revealed the following medications that were due at[redacted] -Resident #23 had a total of seven (7) medications timed for 9 AM which included: [redacted] -Resident #53 had a total of ten (10) medications timed for 9 AM which included: [redacted] -Unsampled Resident #1 had a total of [redacted] medications timed for 9 AM which included: [redacted]	F 755		

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F 755	Continued From page 17 Ex Order 26.4B1 [redacted] -Unsampled Resident #2 had a total of Ex Order 26.4B1 medications timed for Ex Order 26.4 which included: Ex Order 26.4B1 [redacted]). -Unsampled Resident #3 had a total of Ex Order 26.4B1 medications timed for Ex Order 26.4B which included: Ex Order 26.4B1 [redacted] On 11/21/23 at 12:59 PM, the surveyor interviewed the US FOIA (b) who stated that the managers on the floor should be checking the electronic dashboard to make sure medications were not administered out of the time compliance. The US FOIA (b) acknowledged that the medications were to be administered one hour before the time of administration or one hour after the administration time in order to be in compliance. The US FOIA (b) added that if a nurse was going to be late or there was an issue administering medications on time then the US FOIA [redacted] should step in and help out. The US FOIA (b) added that the US FOIA (b)(6) was covering for the usual US FOIA (b)(6).	F 755		

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F 755	Continued From page 18 On 11/22/23 at 9:20 AM, the surveyor interviewed the [US FOIA (b)] who stated that she had done an investigation regarding the medications being administered late. The [US FOIA (b)] stated that the physicians were notified and that there were no negative outcomes. The [US FOIA (b)] acknowledged that the [US FOIA (b)] was aware that he had residents with overdue medications and were not administered in a timely manner and that the US FOIA (b)(6) should have taken over if the [US FOIA (b)] was starting late for medication administration or going to be late administering medications. A review of the "Medication Pass" in-service handout provided by the [US FOIA] reflected "General Rule: For medications scheduled at the times designated by facility policy (i.e., BIS at 9am and 5 pm), they must be administered up to one hour before and one hour after the scheduled time." A facility policy dated as revised 6/3/2323 for "Administering Medications Using Electronic System (name redacted)" reflected that "Medications shall be administered in a safe and timely manner, and as prescribed." In addition, "Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)." 3. On 11/14/23 at 11:51 AM, the surveyor interviewed Resident #44. Resident reported [Ex Order 45] in [Ex Order 45] at times due to "[Ex Order 45 45]". Surveyor asked if [NJ Ex Ord] reported this to the staff or her doctor. The resident stated that [NJ Ex O] doctor was aware, and	F 755		

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F 755	Continued From page 19 the staff gave the resident [NJ Exec O] medication when it was needed. The surveyor reviewed the medical record for Resident #44. On 11/20/23 at 09:58 AM, the surveyor reviewed the paper chart for physician's progress notes. A diagnosis of Ex Order 26.4B1 was noted. The Physician's progress note dated [Ex Order 26.4B1] revealed that the resident's main complaint is [Ex Order 26.4B1] and the resident had Ex Order 26.4B1 On 11/21/23 at 12:12 PM, the surveyor reviewed the resident's electronic medical record, nurses/progress notes and electronic medication administration record (eMAR) for use of [Ex Order 26] relief medications. There were two nurse progress notes that stated Ex Order 26.4B1 was administered for [Ex Order 26] as needed on [Ex Order 26.4B1] and [Ex Order 26.4B1]. Upon reviewing the [NJ Exec Order 26.4] eMAR for this resident, there was no electronic documentation for Ex Order 26.4B1 which was administration on Ex Order 26.4B1 . On 11/21/23 at 12:27 PM, the surveyor discussed the concern with the US FOIA (b)(6)). The [US FOIA (b)] stated that she would look into this concern. On 11/21/23 at 1:00 PM, the [US FOIA (b)] provided a statement from medication nurse, that the nurse gave the Ex Order 26.4B1 but forgot to sign the administration of the medication in the [NJ Exec Order 26.4] eMAR. NJAC 8:39-11.2(b), 29.2 (a)(d)	F 755		

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 11/16/23, the surveyors observed two (2) nurses administer medications to five (5) residents. There were 28 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.1%. This deficient practice was identified for one (1) of five (5) residents, (Resident #50), that were administered medications by one (1) of two (2) nurses that were observed. The deficient practice was evidenced by the following: 1. On 11/16/23 at 9:37 AM, during the morning medication administration pass, the surveyor, in the presence of another surveyor, observed the US FOIA (b)(6) preparing seven (7) medications which included one red colored tablet of Ex Order 26.4B1 for Resident #50. The [redacted] stated that the [redacted] tablet was house stock meaning that the [redacted] was an over the counter (OTC) medication that was provided by the facility. On 11/16/23 at 9:52 AM, the surveyors observed	F 759	Concern. F759 SSS-D Free of Medication Error Rts 5 Prcnt or More CFR (S): 483.45(f)(1) Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on11/16/23, the surveyors observed two (2) nurses administer medications to five (5) residents. There were 28 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.1%. This deficient practice was identified for one (1) of five (5) residents, (Resident #50), that were administered medications by one (1) of two (2) nurses that were observed. On 11/16/23 at 9:55 AM, the surveyors, with the [redacted] reviewed the electronic medication administration record (EMAR) which revealed a physician's order (PO) dated [redacted] for 'NJ Exec Order 26.4b1 [redacted] Give 1	12/30/23

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F 759	Continued From page 21 the [US FOIA (b)] attempting to administer six (6) of the seven (7) medications which included the red colored [Ex Order 26.4B1] tablet. Resident #50 was on the telephone speaking in another language and the [US FOIA (b)] was unable to administer the medications. The [US FOIA (b)] placed the medication cup containing the (6) medications on the resident's overbed table. At that time, the [US FOIA (b)(6)] joined the [US FOIA (b)] in the resident's room and spoke to the resident and then spoke on the resident's phone. While the [US FOIA (b)(6)] was speaking on the phone, the surveyor asked the [US FOIA (b)] to review the medications that were in the medication cup that were ready to be administered to the resident. On 11/16/23 at 9:55 AM, the surveyors, with the [US FOIA (b)] reviewed the electronic medication administration record (EMAR) which revealed a physician's order (PO) dated [Ex Order 26.4B1] for [Ex Order 26.4B]) Give [Ex Order] tablet [Ex Order 26.4B1] one time a day for [NJ Ex Order 26.4b1] The surveyors with the [US FOIA (b)] reviewed the house stock bottle in the medication cart that the [US FOIA (b)] had removed the red colored [Ex Order] tablet from. The surveyors observed the [US FOIA (b)] remove the red colored tablet of [Ex Order 26.4B1] from the resident's medication cup. The [US FOIA (b)] stated that the red colored [Ex Order 26.4B1] had not contained minerals. The [US FOIA (b)] then stated that usually from his experience there was another house stock bottle that contained [Ex Order 26.4B1] with minerals but was unable to find one in his medication cart. The [US FOIA (b)] stated that he would have to check with the [US FOIA (b)(6)]. (ERROR #1) At that time, the surveyors observed the [US FOIA (b)(6)] join the [US FOIA (b)] at the medication cart and assisted	F 759	tablet by mouth one time a day for [NJ Exec Order 26.4b1] The surveyors with the [US FOIA (b)] reviewed the house stock bottle in the medication cart that the [US FOIA (b)] had removed the red colored [Ex Order 26.4B1] tablet from. The surveyors observed the [US FOIA (b)] remove the red colored tablet of [NJ Exec Order 26.4b1] from the resident's medication cup. The [US FOIA (b)] stated that the red colored [Ex Order 26.4B1] tablet had not contained minerals. The [US FOIA (b)] then stated that usually from his experience there was another house stock bottle that contained [Ex Order 26.4B1] with [NJ Exec Order 26.4b] but was unable to find one in his medication cart. The [US FOIA (b)] stated that he would have to check with the [US FOIA (b)(6)]. The [US FOIA (b)] preparing seven (7) medications which included one [redacted] ( ) for Resident #50. The [US FOIA (b)] stated that he was unable to find the [redacted] in the medication On 11/16/23 at 9:37 AM, during the morning medication administration pass, the surveyor, in the presence of another surveyor, observed the [US FOIA (b)] preparing seven (7) medications which included one [redacted] (an [NJ Exec Order 26.4b1]) for Resident #50. The [US FOIA (b)] stated that he was unable to find the [redacted] in the medication cart and would have to check with the [US FOIA (b)(6)] or call the physician.	

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F 759	Continued From page 22 the US FOIA (b) in searching the medication cart for a house stock bottle containing Ex Order 2 with NJ Exec Order 26.4b1 The US FOIA (b)(6) stated that the facility had a house stock of Ex Order 2 with NJ Exec Order 26.4b and it was an orange or peach colored tablet. The US FOIA (b)(6) verified that the red colored Ex Order 2 tablet was not the Ex Order 2 with minerals. The US FOIA (b)(6) stated that she would obtain the house stock bottle of Ex Order 2 with NJ Exec Order 26.4b1 On 11/16/23 at 10:08 AM, the surveyors observed the US FOIA (b)(6) give the US FOIA (b) a house stock bottle of Ex Order 2 with NJ Exec Order 26.4b that contained peach-colored tablets. The surveyor reviewed the medical record for Resident #50. A review of the resident's Admission Record (AR) revealed diagnoses which included Ex Order 26.4B1 A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of Ex Order 26.4B1, reflected the resident had a brief interview for mental status (BIMS) score of Ex Ord out of 15, indicating that the resident had a Ex Order 26.4B1 . In addition, the MDS revealed in section NJ Exec Order 2 for NJ Exec Order 26.4b1 that the resident NJ Exec Order 26.4b1 and required an NJ Exec Order 26.4b1 A review of the Order Summary Report revealed a physician's order (PO) dated Ex Order 26.4B1 for "Ex Order 2 Ex Order 26.4B1) Give Ex O tablet by mouth one time a day for NJ Exec Order 26.4b1	F 759	Nurse search the medication cart and unable to find the On 11/17/23 at 10:40 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the capsules had been delivered on NJ Exec Order 26.4b and was able to show the surveyor the capsules in the medication cart. The US FOIA (b)(6) added that one (1) capsule was missing from the delivery of 20capsules because it had been administered that morning for the 9 AM dose. The US FOIA (b)(6) also added that it was her mistake that the medication was not administered in the evening on NJ Exec Order 26.4b because she had not entered the PO to administer the medication as a one-time PO correctly in the electronic system. The US FOIA (b)(6) stated that she had verbally told the 3PM to 11 PM shift but had not electronically entered the PO correctly to prompt the medication nurse to administer the medication on NJ Exec Order 26.4b. The US FOIA (b)(6) acknowledged that the PO for Ex Order 26.4B1 was to administer on NJ Exec Order 26.4b at a later time and that the resident had not received the 9 AM dose or any dose on Ex Order 26.4B1 The PO for the Ex Order 26.4B1 , although received on , was omitted. How the corrective action will be accomplished for any resident affected by deficient practice. US FOIA (b)(6) who prepared and attempted to administer the	

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	315164	A. BUILDING _____ B. WING _____	C 11/22/2023

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F 759	Continued From page 23 On 11/16/23 at 1:30 PM, the surveyor interviewed the [US FOIA (b)] who stated that he was an agency nurse and that this was his [NJ Ex Order 26.4b1] at the facility. The [US FOIA (b)] stated that he was given an orientation handout that morning but was unsure who had given it to him. On 11/16/23 at 1:38 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the [US FOIA (b)(6)] was in the facility that morning and gave out Med Pass information to the nurses. On 11/16/23 at 1:44 PM, the surveyor interviewed the [US FOIA] who stated that she had given an in-service information handout on Medication Pass that morning to the nurses who were doing the medication pass because there were agency nurses. A review of the Medication Pass in-service information handout provided by the [US FOIA] reflected that "The rights of med pass" included "Right Drug: Compare the pharmacy label/package to the MAR-the medication and strength must match exactly what is ordered. Example: multivitamin with minerals is NOT equivalent to a regular multivitamin or a multivitamin with iron." In addition, "OTC (stock meds) are a common cause of medication errors due to the multiple different types and strengths." A review of the "House Stock Medications" list provided by the [US FOIA (b)] reflected that the facility provided Multivitamin with Minerals tablets. A review of the facility policy dated as revised 6/3/23 for "Administering Medications Using Electronic System (name redacted)" provided by	F 759	medication [Ex Order 26.4B1] does not contain [NJ Exec Order 26.4b1] to resident #50 was immediately stop by the surveyor and have reviewed the medications labelled. Nurse was immediately council of her action to read the label 3x before pouring the medications. [US FOIA (b)(6)] also confirmed that it was her mistake that the medication was not administered in the evening on [NJ Exec Order 26.4b] because she had not entered the PO to administer the medication as a one-time PO correctly in the electronic system [US FOIA (b)(6)] was in serviced on transcription of orders. Resident # 50 was assessed for [NJ Exec Order 26.4b1]. Medication errors were completed. [US FOIA (b)] Family member and [US FOIA (b)(6)] made aware. This deficient practice did not affect other residents. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern.	

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F 759	Continued From page 24 the US FOIA (b) reflected that "Medications must be administered in accordance with doctor's orders, including any required time frame and following medication cautionary." In addition, "The individual administering medications must check the label THREE (3) times to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication." REFER TO F755 2. On 11/16/23 at 9:37 AM, during the morning medication administration pass, the surveyor, in the presence of another surveyor, observed the US FOIA (b) preparing seven (7) medications which included one Ex Order 26.4B1 n Ex Order 26.4B1 for Resident #50. The US FOIA (b) stated that he was unable to find the Ex Order 26.4B1 capsule in the medication cart and would have to check with the US FOIA (b)(6) or call the physician. On 11/16/23 at 9:55 AM, the surveyors observed the US FOIA (b)(6) join the US FOIA (b) at the medication cart and assisted the US FOIA (b) in searching the medication cart for the Ex Order 26.4B1 capsules. The US FOIA (b)(6) stated that she was unable to find the Ex Order 26.4B1 capsules and would have to check why it was not available. On 11/16/23 at 10:08 AM, the US FOIA (b) had completed administering the morning medications to Resident #50 which included six (6) of the seven (7) medications that had an administration time of 9 AM. The surveyors had not observed the US FOIA (b) administer the Ex Order 26.4B1 according to the PO. The US FOIA (b) signed	F 759	All licensed nurses were re in serviced regarding Medication Administration, transcription of orders and policy and procedure when medication is un available. Agency Nurses and new hire employee will be received Medication Pass information handout. If a medication is not found on the med cart, notify another nurse to first check the backup supply. If not available from back up, notify the physician for further orders, such as stat delivery from pharmacy, changed in medication if appropriate and a one-time order to administer will be obtained. Pharmacy Consultant or designee will be observed 3 licensed nurses monthly X 6 months and thereafter for medication administration pass. Regional nurses or designee will review Policy and Procedure for administration of medications for new hire employee monthly x 6 months and thereafter. Pharmacy Consultant or designee will be observed 3 nurses monthly X 90 days and thereafter. Medication Pass observation will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated.	

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F 759	Continued From page 25 the EMAR indicating the number five (5) which corresponded with "Hold/see Progress Notes" for the administration of the Ex Order 26.4B1 . The surveyor reviewed the medical record for Resident #50. A review of the resident's Admission Record (AR) revealed diagnoses which included Ex Order 26.4B1 A review of the admission MDS, an assessment tool used to facilitate the management of care, with an assessment reference date of Ex Order 26.4B1 reflected the resident had a BIMS score of Ex Order 26.4B1, indicating that the resident had a Ex Order 26.4B1 In addition, the MDS revealed in section NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 that the resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of the Order Summary Report revealed a PO dated Ex Order 26.4B1 " Ex Order 26.4B1 Give Ex O capsule by mouth one time a day for Ex Order 26.4B1 A review of the nursing Progress Notes dated NJ Exec Order 26.4b at 10:58 AM completed by the US FOIA (b)(6) indicated that " US FOIA called made aware of AM medication being administered late." On 11/16/23 at 1:30 PM, the surveyor interviewed the US FOIA (b who stated that he was an agency nurse and that this was his NJ Ex Order 26.4b1 at the facility. The US FOIA (b stated that he was given an orientation handout that morning but was unsure who had given it to him. The US FOIA (b added that the US FOIA (b)(6) was working on locating the Ex Order 26.4B1 Ex Order 26.4B1 capsules and had called the physician.	F 759	Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. Results of this audit and observation will be discussed in morning clinical meeting for immediate resolution. ADON/Designee will present findings in monthly QAPI and will be a part of quarterly QA. Dates when concern will be completed. 12/30/23.	

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F 759	Continued From page 26	F 759		

On 11/16/23 at 1:38 AM, the surveyor interviewed the [US FOIA (b)] who stated that the [US FOIA] was in the facility that morning and gave out Med Pass information to the nurses.

On 11/16/23 at 1:44 PM, the surveyor interviewed the [US FOIA] who stated that she had given an in-service information handout on Medication Pass that morning to the nurses who were doing the medication pass because there were agency nurses.

A review of the Medication Pass in-service information handout provided by the [US FOIA] reflected that under "Miscellaneous Situations: Missing Medications: If a medication is not found on the med cart, notify another nurse to first check the back up supply. If not available from back up, notify the physician for further orders, such as stat delivery from pharmacy and a one-time order to administer later in the day. Follow up with the surveyor to let them know how the problem was resolved."

On 11/16/23 at 1:16 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that she was the not the usual [US FOIA (b)(6)] and was acting as the [US FOIA] for that day. The [US FOIA (b)(6)] stated that the [Ex Order 26.4B1] was technically an OTC medication and was a house stock medication to be provided by the facility. The [US FOIA (b)(6)] added that she could not find the [Ex Order 26.4B1] capsules and thought they were on order, so she had called the provider pharmacy and requested [Ex Ord] capsules to be delivered. The [US FOIA (b)(6)] explained that the facility could order any OTC but that the order could take a couple days to come in so during the

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F 759	Continued From page 27	F 759		

interim the nurses would request a small amount of the OTC medication be delivered from the provider pharmacy so that it would be available to the resident.

At that time, the surveyor with the [US FOIA (b)(6)] reviewed a Fax log dated for [Ex Order 26.4B1] and timed for 10:29 AM that she had completed so that the facility would receive the [Ex Order 26.4B1] in the next delivery from the provider pharmacy. The [US FOIA (b)(6)] also stated that the 3 PM to 11 PM shift would administer the medication because she had called the physician and obtained a PO to administer the medication when it arrived. The [US FOIA (b)(6)] could not speak to why the medication was not available for the 9 AM medication pass.

On 11/17/23 at 9:31 AM, the surveyor, in the presence of the survey team, interviewed the [US FOIA] who stated that he was responsible for the Central Supply of the facility which required keeping the stock and ordering of the OTC medications that the facility provided. The [US FOIA] explained that there was a list of the usual OTC medications that he ordered but the list could be added to. The [US FOIA] further explained that if an OTC medication that was not on the list had to be ordered and that would take a couple days to receive, and the nurses were aware of that. The [US FOIA] was unaware of the need to order [Ex Order 26.4B1] capsules.

A review of the "House Stock Medications" list provided by the [US FOIA (b)] reflected that [Ex Order 26.4B1] were not on the list.

On 11/17/23 at 10:40 AM, the surveyor

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F 759	Continued From page 28	F 759		

interviewed the [redacted] who stated that the [redacted] capsules had been delivered on [redacted] and was able to show the surveyor the capsules in the medication cart. The [redacted] added that one (1) capsule was missing from the delivery of [redacted] capsules because it had been administered that morning for the 9 AM dose. The [redacted] also added that it was her mistake that the medication was not administered in the evening on [redacted] because she had not entered the PO to administer the medication as a one-time PO correctly in the electronic system. The [redacted] stated that she had verbally told the 3 PM to 11 PM shift but had not electronically entered the PO correctly to prompt the medication nurse to administer the medication on [redacted]. The [redacted] acknowledged that the PO for [redacted] was to administer on [redacted] at a later time and that the resident had not received the 9 AM dose or any dose on [redacted]

The PO for the [redacted] although received on [redacted], was omitted. (ERROR #2)

A review of the Progress Notes (PN) for dated [redacted] by the [redacted] indicated "MD called-made aware of AM medication being administered late." In addition, a PN dated [redacted] by the [redacted] indicated "[redacted] aware time to be changes." And a PN on [redacted] by the [redacted] indicated "Dr. (name redacted) contacted, updated, medication received. To start [redacted] am."

A review of the [redacted] EMAR reflected that

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F 759	Continued From page 29 there was no administration Ex Order 26.4B1 [redacted]. Further review revealed that on Ex Order 26.4B1 the Ex Order 26.4B1 was administered. On 11/20/23 at 9:39 AM, the surveyor interviewed the US FOIA (b) in the presence of the survey team. The US FOIA (b) stated that the facility policy does not speak to the process when a medication is not available. The US FOIA (b) added that the nurses should know that if a medication was not available that they have to find out why and let the physician know to get a PO to discontinue the medication or change to another medication.	F 759		
F 761 SS=D	NJAC 8:39-11.2(b), 29.2(d) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		12/30/23

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F 761	Continued From page 30 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in two (2) of four (4) medication carts inspected on 2 of 2 units. This deficient practice was evidenced by the following: On 11/20/23 at 11:46 AM, the surveyor inspected Ex Order 26.4B Cart 1 in the presence of the US FOIA (b)(6) ([redacted] and observed one (1) vial Ex Order 26.4B1 test strips (Ex Order 26.4B1 [redacted]) with no date documented on the vial when opened. The surveyor also observed Ex Order 26.4B1 [redacted], which contained one (1) open foil packet with two (2) vials. There was no date when opened observed on the foil packet or box. On 11/20/23 at 11:55 AM, the surveyor interviewed the [redacted] who stated that he could not find any dates when opened on the Ex Order 26.4B1 vial or the Ex Order 26.4B1 [redacted]. The surveyor with the [redacted] reviewed the test strip manufacturer label and packaging which indicated "discard remaining test strips 90 days after first opening date". The surveyor with the [redacted] reviewed the manufacturer label for the Ex Order 26.4B1 [redacted]	F 761	Concern. F 761 SS-D Labelled/ Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in two (2) of four (4) medication carts inspected on 2 of 2 units. This deficient practice was evidenced by the following On 11/20/23 at 11:46 AM, the surveyor inspected Ex Order 26.4B Cart [redacted] in the presence of the US FOIA (b)(6) [redacted]) and observed one (1) vial Ex Order 26.4B1 [redacted] (testing strips used to check Ex Order 26.4B1 [redacted] with a Ex Order 26.4B1 [redacted]) with no date documented on the vial when opened. The surveyor also observed Ex Order 26.4B1 [redacted] of Ex Order 26.4B1 [redacted] (Ex Order 26.4B1 [redacted] tion Ex Order 26.4B1 [redacted] to Ex Order 26.4B1), which contained one (1) open foil packet with two (2) vials. There was no date when opened observed foil packet or box.	

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F 761	Continued From page 31 indicated once opened they should be used within one (1) week of opening. The [US FOIA] acknowledged that he was unsure of when the test strips or the [Ex Order 26.4B1] were opened. The [US FOIA] stated he would talk to the staff about dating medications when opened. On 11/20/23 at 12:42 PM, the surveyor inspected [NJ Exec Orde] Cart 1 in the presence of the [US FOIA (b)(6)] and observed one (1) box of Ex Order 26.4B1) containing one (1) foil packet that was opened and contained three (3) vials that had no date when opened on the foil package or on the box. At that time, the surveyor interviewed the [US FOIA (b)] who stated there should be a date on the foil package when it is opened but did not see one on this package. The surveyor with the [US FOIA (b)] reviewed the manufacturer label for the Ex Order 26.4B1 which reflected once the foil pouch was opened, use [redacted] within 2 weeks. On 11/21/23 at 10:57 AM, the surveyor interviewed US FOIA (b)(6)) by telephone. The [US FOIA] stated she is the regular consultant and conducts unit inspections on a regular basis. The [US FOIA] stated that she checks medication carts, for expired items and for items to be properly labeled. The [US FOIA] also stated that any irregularities were documented and immediately reported to the staff and then put into a written report to the facility. The [US FOIA] added that the staff will usually correct any issue right away. On 11/21/23 at 11:15 AM, the surveyor	F 761	On 11/20/23 at 12:42 PM, the surveyor inspected [NJ Exec Orde] Cart 1 in the presence of the US FOIA (b)(6)) and observed one (1) box of Ex Order 26.4B1 [Ex Order 26.4B1] r solution (Ex Order 26.4B1) containing one (1) foil packet that was opened and contained three (3) vials that had no date when opened on the foil package or on the box. How the corrective action will be accomplished for any resident affected by deficient practice. One (1) Ex Order 26.4B1 with no date documented on the vial when opened and Ex Order 26.4B1 which contained one (1) open foil packet with two (2) vials. There was no date when opened. Above open items with no date documented were discarded and replaced. US FOIA (b)(6) were in serviced the important of Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable All medication carts were checked for	

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F 761	Continued From page 32 interviewed the US FOIA (b)(6)) who stated that she spoke to the staff regarding dating when medications were opened, and the staff said they were unaware. The US FOIA (b) added that the staff should have known because they were dating medications when opened prior. On 11/21/23 at 12:32 PM, the surveyor interviewed the US FOIA (b) who stated that the US FOIA had previously provided a handout to the nurses regarding "Medications with shortened expiration dates." A review of the handout "Medications with shortened expiration dates" provided by the US FOIA (b) reflected under "miscellaneous" "Test Strips Expires: 90 days after opening (or per manufacturer)", under "Nebulizer Inhalation Solutions" "DuoNeb (ipratropium bromide & albuterol) Date foil package or vial: Discard 7 or 14 days once removed from foil pouch, refer to manufacturer packaging", "Pulmicort respules (budesonide) Date foil package or vial: Discard 14 days after opening foil package." NJAC 8:39-29.4(d)(g)	F 761	undated items. This deficient practice did not affect in house residents. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Licensed Nurses was re-educated regarding the policy and procedure of the storage of biologicals that Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable The Unit managers or designee will check medication carts weekly x 3 months for 6 months and thereafter for storage and proper labeling on Nebulizer solution and Ultra Tract test to ensure they are properly labelled according to the manufacturing instructions. The Pharmacy Consultant will check all medication carts monthly for proper labelling and storage. The Regional nurses will conduct weekly	

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	315164	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

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F 761	Continued From page 33	F 761	audits X 1 month for 90 days and thereafter of medication carts for storage of biologicals. Findings of Labeling of medications and Ultra Track, the findings will be discussed in morning Clinical meeting for immediate resolution. Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. The Director of Nursing or Unit Manager will conduct daily rounding for 1 month then weekly x 90 days and thereafter. Therefore, the Inspection for the Storage of Biologicals will be discussed in monthly QAPI and will be a part of the facility quarterly Quality Assurance program. Dates when concern will be completed. 12/30/23.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		12/30/23

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F 883	Continued From page 34 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 883		

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F 883	Continued From page 35 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was identified that the facility failed to offer a resident the NJ Exec Order 26.4b1. This deficient practice was identified for 2 (two) of 5 (five) residents, (Resident # 5 and # 16), reviewed for NJ Exec Order 26.4b1 status and was evidenced by the following: CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults 65 years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown: (last reviewed 9/21/23). 1. The surveyor reviewed Resident #16's medical record, NJ Exec Order 26.4b1. A review of the resident's NJ Exec Order 26.4b1 history in the resident's electronic medical record revealed that there was no evidence that the resident had been NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 2. The surveyor reviewed Resident #5's medical	F 883	Concern. F883 SS=D Influenza and Pneumonia Immunizations CFR9S): 483:80(d)(1) (20 Based on observation, interview, record review and review of pertinent facility documentation it was identified that the facility failed to offer a resident the NJ Exec Order 26.4b1. This deficient practice was identified for 2 (two) of 5(five) residents, (Resident # 5 and # 16), reviewed for NJ Exec Order 26.4b1 status and was evidenced by the following: CDC recommends routine administration of NJ Exec Order 26.4b1 for all adults 65 years or older who have never received any NJ Exec Order 26.4b1 or whose previous NJ Exec Order 26.4b1 history is unknown: (last reviewed 9/21/23). 1. The surveyor reviewed Resident	

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F 883	Continued From page 36 record, NJ Exec Order 26.4b1 . A review of the resident's NJ Exec Order 26.4b1 history in the resident's electronic medical record revealed that there was no evidence that the resident had been NJ Exec Order 26 or NJ Exec Order 26.4b1 the NJ Exec Ord On 11/17/23 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6) , who stated, "I don't know why NJ Exec Order 26.4b1 was not documented that it was offered on admission." On 11/17/23 at 11:43 AM, the surveyor interviewed the LPN # 1, who stated that this is her first time to work on the Ex Order 26.4 Wing, and another LPN # 2 stated she has been working here for NJ Ex Order 26. LPN # 2 stated, "The protocol on admission is we ask residents for NJ Exec Order 26.4 information. We make sure to offer all NJ Exec Order 26.4b1 and ask the doctor for orders if resident wants to receive them." On 11/20/23 at 9:40 AM, the surveyor interviewed the US FOIA (b)(6)), who confirmed that the documentation for NJ Exec Ord being offered on admission was not documented in the progress notes. She stated, "The company did away with the consent form but staff should document on the progress notes." On 11/20/23 at 11:12 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the residents should have been offered all NJ Exec Order 26.4b1 including NJ Exec Ord and it should be documented in the resident's record. On 11/20/23 at 1:25 PM, the surveyor discussed	F 883	#16'smedical record, NJ Exec Order 26.4b1 A review of the resident's NJ Exec Order 26.4b1 history in the resident's electronic medical record revealed that there was no evidence that the resident had been offered or administered the NJ Exec Order 26.4b1. 2. The surveyor reviewed Resident #5's medical record, NJ Exec Order 26.4b1 . A review of the resident's NJ Exec Order 26.4b1 history in the resident's electronic medical record revealed that there was no evidence that the resident had been offered or administered the NJ Exec Ord . On 11/17/23 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6) who stated, "I don't know why NJ Exec Order 26.4b1 was not documented that it was offered on admission." How the corrective action will be accomplished for any resident affected by deficient practice. Both resident # 15 and resident #16 NJ Exec Ord . Clinical records were reviewed and confirmed that these 2 residents have no documentation that they were offered a NJ Exec Order 26.4b1. Both residents #15 and #16 were assessed. Resident #15 was offered a Ex Order 26.4B1 NJ Exec Order 26.4b1, an education material was given to patient and to family member. Risk and consequences were	

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F 883	Continued From page 37 with the US FOIA (b)(6) interim US FOIA (b)(6), US FOIA (b)(6) regarding the above concerns and no further information was provided. The surveyor reviewed the facility policy and procedure adapted from the Center for Disease Control (CDC) dated January 27, 2022. The facility policy stated, "All newly admitted, readmitted and current residents are to be offered a pneumococcal vaccine unless the immunization is medically contraindicated, or the resident has already been immunized." NJAC 8:39-19.4 (i)	F 883	discussed. Resident #16 was offered Ex Order 26.4B1 NJ Exec Order 26.4b1. Immunization records of all active residents were reviewed. Pneumonia vaccination were offered for those who have not received and for those who refused a pneumonia educational material was discussed to alert residents and to resident's representative. No other residents were affected of this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Licensed Nurses were in serviced on new revised policy and procedure of Pneumonia Vaccination, License Nurses were re in serviced on revised policy and procedure on immunization for Pneumonia Vaccination that each resident's representative receives education regarding the was	

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F 883	Continued From page 38	F 883	benefits and potential side effects of the immunization. Admission Coordinator will check the pneumonia vaccine in NJIIS website upon admission. Unit Manager or designee will audit 5 charts weekly X 90 days for 6 months and thereafter. Licensed Nurses were educated to enter records of immunization in PCC in the immunization tab. Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. Results of this audit and observation will be discussed in morning clinical meeting for immediate resolution. ADON/Designee will present findings in monthly QAPI and will be a part of quarterly QA. Dates when concern will be completed. 12/30/23	

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New Jersey Department of Health

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	060206	A. BUILDING: _____ B. WING _____	C 11/22/2023

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. 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 THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	Concern. S560- 8:39-5,1 (a) Mandatory Access to care. 8:39-5.1(a) Mandatory Access to Care S560 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by Based on observation, interview, and	12/30/23

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

Electronically Signed | 12/08/23

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S 560	Continued From page 1 Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.	S 560	review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 other Revised Statutes. (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. C. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the	

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S 560	Continued From page 2 (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the period of 10/29/2023 to 11/11/2023 for the 11/22/2023 Standard survey revealed the following staffing shortages. The facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -10/29/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -10/30/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -11/11/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. On 11/22/23 at 1:00 PM the surveyor informed	S 560	number of required direct care staff members shall rebounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the period of10/29/2023 to 11/11/2023 for the 11/22/2023Standard survey revealed the following staffing shortages. The facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -10/29/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -10/30/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. 11/11/23 had 6 CNAs for 56 resident son the day shift, required at least 7 CNAs. On 11/22/23 at 1:00 PM the surveyor informed thee Director of Nursing and the Licensed Nursing Home Administrator of the shifts when the minimum direct care staff to resident ratio was not met.	

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S 560	Continued From page 3 the Director of Nursing and the Licensed Nursing Home Administrator of the shifts when the minimum direct care staff to resident ratio was not met.	S 560	How the corrective action will be accomplished for any resident affected by deficient practice. All efforts to hire facility Certified Nursing Aide(s) C.N.A will continue until there is adequate staff to serve all residents. Until the time, facility will utilize staffing agencies to fill any open spots in the schedule. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. Staffing records for 10/29/23 and 11/12/23 were reviewed No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. 1. Contracts with additional staffing agencies will be secured to supplement	

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S 560	Continued From page 4	S 560	facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. 2. The Administrator or designee will review staffing schedules weekly for 4 weeks and monthly for 3 months to ensure adequate staffing for all shifts. 3. Corporate staffing Director will monitor staffing needs daily to ensure facility is compliance with staffing requirements. Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. The results of these reviews will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060206	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFL	**133 COUNTY ROAD TENAFLY, NJ 07670**

(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
S 560	Continued From page 5	S 560	Dates when concern will be completed. 12/30/23.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315164 Y1	A. Building B. Wing Y2	12/31/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0690	Correction	ID Prefix F0755	Correction	ID Prefix F0759	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	12/30/2023	LSC	12/30/2023	LSC	12/30/2023
ID Prefix F0761	Correction	ID Prefix F0883	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. #	Completed
LSC	12/30/2023	LSC	12/30/2023	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/22/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060206 Y1	A. Building B. Wing Y2	12/31/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/30/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/16/23 and Family of Caring at Tenafly was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Family of Caring at Tenafly is a 2-story building that was built in 60s. It is composed of Type II (211) protected construction. The facility is divided into 6 smoke zones. The exterior 150 KW natural gas generator does 100% of the facility. The facility has 69 licensed beds currently at 55.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K 222		12/30/23

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

Electronically Signed | 12/08/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

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K 222	Continued From page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING 01 B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

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K 222	Continued From page 2 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of the US FOIA (b)(6) and US FOIA (b)(6) on 11/16/23, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 2 of 2 sets of sliding doors and was evidenced by the following. At 11:15 AM, the surveyor, US FOIA and US FOIA (b)(6) observed at the main entrance, that the two sets of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the doors could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. The sliding doors had signs indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors as stated on the signs. At the time of the observation, the surveyor interviewed the US FOIA and US FOIA (b)(6) and both stated that the (2) locksets (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency. The US FOIA (b)(6) was notified of the findings at the Life Safety Code Exit Conference on	K 222	Concern K222- Egress Doors CFR(s) NFPA 101 Based on observation and interview, in the presence of the US FOIA (b)(6) on11/16/23, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101,2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2and 19.2.2.2.6. This deficient An observation was made that on the 2 sets of doors at the main entrance had a Thumb-lock device. The current evacuation plan has the doors designated as an exit/egress route, but with the thumb -latch engaged this would not allow the doors to be opened. This is accordance with the requirements of NFPA 101 2012 edition, section 19.2.2.2.5.1, 192.2.2.5.2 and 19.2.2.2.6. How the corrective action will be accomplished for any resident affected by deficient practice. The maintenance director will remove the	

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	315164	A. BUILDING 01 B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

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K 222	Continued From page 3 11/16/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	thumb-latch from the two entrance doors. This will allow the doors to function as signs indicate on the doors, and allow exit and/egress according to evacuation route plan. Maintenance Director or Designee audited all entrance doors in facility to ensure the doors allow for proper egress. No residents were affected with this deficient practice How we identified other residents/areas that could potentially be affected. All residents have potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern. US FOIA (b)(6) was educated on reason for deficient practice and educated on how to audit exit doors for proper egress Maintenance Director or Designee will perform monthly audits for six months x 12 months and thereafter on all facility exit doors to ensure the doors allow for proper egress. Regional Maintenance Director will perform quarterly audits of all exit doors in the facility for a year to ensure the doors allow for proper egress.	

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	315164	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

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K 222	Continued From page 4	K 222	Findings will be discussed with the administrator for immediate resolution. How the concern will be monitored and title of person responsible for monitoring. The Maintenance Director or Designee will review the results of the audits in the facility monthly QAPI meeting and this will be a part of Center quarterly Quality Assurance program. Dates when concern will be completed. 12/30/23.	
K 251 SS=F	Dead-End Corridors and Common Path of Travel CFR(s): NFPA 101 Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 11/16/23 in the presence of the US FOIA (b)(6) and US FOIA (b)(6), it was determined that the facility failed to provide corridors with proper exits. This deficient practice was evidenced for 1 of 6 exit/egress corridors observed by the following: At 11:00 AM, the surveyor, US FOIA (b)(6)	K 251	Concern. K 251 SS=F Dead End Corridors and Common Path of Travel CFR (s) NFPA101 Based on observation, interview and record review on 11/16/23 in the presence of the US FOIA (b)(6) it was determined that the facility	1/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 251	Continued From page 5 observed that the exit access corridor located on the ground floor was an approximately 71 ft. long dead end corridor leading to the Physical Therapy (PT) room. The PT room was provided with a non-exit door leading to the public way, but the door was not a standard size and required a step up to exit the building. The US FOIA (b)(6) both confirmed the dead end corridor exceeded 30' and residents were observed in the physical therapy room approximately 71' from the main exit of the facility. No further documentation indicating it is impractical and unfeasible to alter the current observed area. The US FOIA (b)(6) and US FOIA (b)(6) both confirmed they were aware of the dead end corridor regulations at the Life Safety Code exit conference on 11/16/23. NJAC 8:39-31.2(e)	K 251	failed to provide corridors with proper exits. This deficient practice was evidenced for 1 of 6exit/egress corridors observed by the following: At 11:00 AM, the surveyor, US FOIA (b)(6), observed that the exit access corridor located on the ground floor was an approximately 71 ft. Long dead-end corridor leading to the Physical Therapy (PT) room. The PT room was provided with a non-exit door leading to the public way, but the door was not a standard size and required a step up to exit the building. How the corrective action will be accomplished for any resident affected by deficient practice. The dead-end corridor is located in the lower -level of the facility, which is referred to as the Lobby Level. This lower level does not contain any patient sleeping rooms and is considered one zone for the purpose of the FSES equivalency request. The facility had an FSES completed by a third party contractor on January 22, 2024 No residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. The Life Safety Code deficiency cited by the surveyor does not impact the safety of the patients or the staff. This facility is classified healthcare occupancy throughout the entire building, and is fully	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

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K 251	Continued From page 6	K 251	protected with sprinklers. In addition, the lobby level is fully protected with hardwired smoke detectors. Measures to ensure were/will be put into place to assist this area of concern. The dead-end corridor would require extensive structural modification including moving walls, fire sprinkler, electric, plumbing, etc. The facility has requested a waiver based on a completed Fire Safety Evaluation System (FSES)equivalency. How the concern will be monitored and title of person responsible for monitoring. Outcome of findings will be discussed with Administrator and Regional Maintenance Director for immediate attention if needed. Dates when concern will be completed. 1/24/2024	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		12/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 7 materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/16/23, in the presence of the US FOIA (b)(6) and US FOIA (b)(6) it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring complete	K 363	Concern. K363 SS=F Corridor- Doors CFR(s): NFPA 101 An observation was made and interview on 11/16/23, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with requirements of NFPA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

(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
K 363	Continued From page 8 bedroom door closure for confinement of smoke/fire products was identified in 15 of 27 resident room (RR) doors observed and was evidenced by the following: During the building tour on 11/16/23 from 9:15 AM to 01:45 PM, the surveyor in the presence of the US FOIA (b)(6) toured the facility and observed the following compromised RR doors: RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order2 top door to frame gap RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order hardware issue RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order top door to frame gap RR Ex Order hardware issue At the time of observations, the surveyor interviewed the US FOIA (b)(6) who both confirmed the above findings. The US FOIA (b)(6) indicated the guide bar installed on the top of the doors allowed the doors to not be smoke resistant as the door was cut to provide the guide bar. The US FOIA (b)(6) were informed of the findings at the Life Safety Code exit conference on 11/16/23. NJAC 8:39-31.1(c), 31.2(e)	K 363	101, 2012 edition, section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5 This deficient practice was identified in 15 of 27 resident rooms. RR Ex Order2 top door to frame gap Ex Order2 top door to frame gap, Ex Order top door to frame gap, Ex Order2 top door to frame gap, Ex Order2 top door to frame gap, Ex Order top door to frame gap Ex Order2 top door tom frame gap, Ex Order top door to frame gap, Ex Order 26 hardware issue, Ex Order top door to frame gap, Ex Order top door to frame gap, Ex Order2 top door to frame gap, Ex Order2 top door to frame gap, Ex Order2 top door to frame gap, Ex Order2 top door to frame gap, Ex Order2 hardware issue NFPA 101, 2012 LSC Edition, Section 19.3.3, 19.3.6.3, 19.3.6.3.1, 19.3.6.5. How the corrective action will be accomplished for any resident affected by deficient practice. The facility will be installing an NFPA approved smoke seal around all frames at the mentioned corridor resident doors. This will be installed to provide a 20-minute smoke barrier as is required by NFPA regulations. The rooms listed below were remedied: Ex Order 26.4B1 No residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING 01 B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

(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
K 363	Continued From page 9 NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. The US FOIA (b)(6) was educated on the reason for the deficiency and how to audit the doors to ensure they had proper fire and smoke barriers The Maintenance Director or designee will audit 5 room daily for 30 days then monthly for 90 days and thereafter to ensure all resident room doors in the facility has a proper smoke barrier, according to the NFPA, is in place Maintenance Director or Designee will perform monthly inspections of all resident room doors for six months to ensure that the smoke seal is in good working order according to NFPA guidelines. This will be logged in a binder and signed off once a month. The Regional Maintenance Director will perform quarterly audits of resident room doors for a year to ensure the smoke seal is in place according to NFPA guidelines Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This	

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	315164	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

(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
K 363	Continued From page 10	K 363	plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. Results of this audit and observation will be discussed in morning clinical meeting for immediate resolution. ADON/Designee will present findings in monthly QAPI and will be a part of quarterly QA. Dates when concern will be completed. 12/30/23.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 11/16/23, in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter	K 911	Concern. K 911 SS=F Electrical System Essential Electrical System CFR9s) NFA 101 An observation was made after review of	1/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING 01 B. WING _____	11/22/2023

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K 911	Continued From page 11 6 and NFPA 110, 2010 Edition, Section 5.1.4. for one (1) of one (1) generators. This deficient practice was evidenced by the following: At 9:30 AM, the surveyor and US FOIA reviewed all the facility's generator documentation. The facility currently has one (1) exterior 150 KW (kilowatt) natural gas generator. The US FOIA (b)(6) could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The US FOIA confirmed there was no reliability letter available from the natural gas provider for the 150 KW natural gas generator for the facility to present to the surveyor. No additional information was received. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 11/16/23. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110,	K 911	the facilities generator documentation. The facility has 1 150 KW natural gas generator. A documented reliability letter from the gas provider was not found. NFPA 99, 2012 Edition Chapter 6 and NFPA110, 2010 Edition, Section5.1.4. How the corrective action will be accomplished for any resident affected by deficient practice. We are in contact with the provider to receive a letter of reliability. This will include gas delivery, a description that supports reliability. A statement that there is a low probability of interruption, a brief description that supports the statement regarding the low probability and a signature of technical personnel from the gas vendor. The facility contacted PSEG, the facility gas company; The facility obtained a reliability letter via PSEG website. The facility has also sent an email request for a specific reliability letter with a pending case number. No residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

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K 911	Continued From page 12 2010 Edition, Section 5.1.4.	K 911	Measures to ensure were/will be put into place to assist this area of concern. The US FOIA (b)(6) was educated on the reason for the deficiency and the need to have a reliability agreement letter from the provider in place The Maintenance Director or Designee will inspect the maintenance inspection book monthly for six months and thereafter to ensure that reliability agreement letter is in place. The Regional Maintenance Director will audit the maintenance inspection book quarterly for a year to ensure the reliability agreement letter is in place Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. Results of this audit and will be discussed in morning clinical meeting for immediate resolution. This will be brought to monthly QAPI and will be a part of quarterly Quality Assurance Program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	**11/22/2023**

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FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

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K 911	Continued From page 13	K 911	Dates when concern will be completed. 1/24/24.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		12/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING 01 B. WING	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

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K 918	Continued From page 14 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/16/23, in the presence of the US FOIA (b)(6) [redacted] a). it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and b). it was determined that the facility failed to ensure a remote manual stop station for (2) two of (2) two outside diesel generators, (1) one Onan generator (175 KW) and (1) Cummins (80 KW). providing emergency power to approximately 70% of Health Care facility, and 100% of the vent unit and were installed in accordance with the requirements of NFPA 110, 2010 edition, sections 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 2 of 2 generators by the following: a). At 9:45 AM, the surveyor reviewed all generator documentation for the monthly load testing for the exterior 150 KW facility generator. The 2023 generator log indicated the monthly load test was being completed, but the log did not provide any transfer times for the following dates: 10/31/23, 9/27/23, 8/30/23, 7/31/23, 6/30/23, 5/31/23, 4/11/23, 3/22/23, 2/24/23, 1/31/23, 12/30/22 and 11/30/22. An interview was conducted with the US FOIA (b)(6) [redacted] during document review and he stated currently, the required transfer times were not being logged on the provided generator log.	K 918	Concern. K 918 SS=F Electrical System Essential Electrical System CFR9s) NFA 101 It was determined that the facility failed to certify the time needed by the generator to transfer power to the building was within the 10-second time frame in accordance with NFPA 110, section5.6.5.6.and 5.6.5.6.1. The generator log did not have the transfer times noted on all monthly load tests. (b) It was observed that there was no manual remote stop station to prevent inadvertent or unintentional operation, that was located outside of the enclosure housing the prime mover for the current generator. NFPA 110, 2010 Edition, Section 5.6.5.6.and 5.6.5.6.1. How the corrective action will be accomplished for any resident affected by deficient practice. Going forward the Maintenance Director will time all transfer times when load test is conducted. These times will be noted in the generator log at all monthly load tests. A manual stop will be installed by a licensed electrician at least 6□ from main	

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	315164	A. BUILDING 01 B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 15 b). On 11/16/23 at 11:45 AM, the surveyor, US FOIA [redacted], observed the exterior 150 KW generator .The observations indicated that there was no remote manual stop station observed outside the area of the generator location. The generator was provided with a stop station, but it was on the generator cabinet above 3-cabinet vents. An interview was conducted during the time of the observation with the US FOIA (b)(6), who both stated and confirmed that the exterior generator was not provided with a remote manual stop station to prevent inadvertent or unintentional operation, that was located outside the area of the enclosure housing the prime mover for the current generator in service. The US FOIA (b)(6) [redacted] were informed of the findings at the Life Safety Code exit conference on 11/16/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	operating enclosure housing the prime mover for the current generator in service. NJ Ex Order 26.4b1 installed the remote generator stop button more than 6 feet away from the generator on Friday December 22, 2023. Project is completed and in working order. No residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. The US FOIA (b)(6) was educated on the reason of the deficiency and educated on how to time transfer tests during a load test and to ensure the remote manual stop is in place and functioning Maintenance Director or Designee will inspect the data generator logbooks monthly x 90 days then every 6 months and thereafter to ensure that transfer times have been documented and signed for. The manual stop will be tested once a	

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	315164	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 16	K 918	month for six months by the Maintenance Director or Designee and noted in the generator logbook with date, time and signature of tester. The Regional Maintenance Director will audit quarterly for a year the generator log book to ensure there are proper documented transfer times during load tests and will ensure the remote manual stop is in place and functioning Audits will be monitored for completion by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended when indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. Results of this audit and will be discussed in morning clinical meeting for immediate resolution. This will be brought to monthly QAPI and will be a part of quarterly Quality Assurance Program. Dates when concern will be completed. 12/30/23	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315164 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0222	12/30/2023	LSC	K0363	12/30/2023	LSC	K0911	01/24/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0918	12/30/2023	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	
11/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	R **05/30/2024**

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{K 000}	INITIAL COMMENTS An onsite revisit was conducted on 5/30/2024 regarding the facility's Plan of Correction for K251 that was originally cited on the Recertification survey of 11/22/2023. Family of Caring at Tenafly is in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Family of Caring at Tenafly is a 2-story building that was built in 60's. It is composed of Type II (211) protected construction. The facility is divided into 6 smoke zones. The exterior 150 KW natural gas generator does 100% of the facility. The facility has 69 licensed beds.	{K 000}		
{K 251} SS=F	Dead-End Corridors and Common Path of Travel CFR(s): NFPA 101 Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and interview on 05/30/2024 in the presence of facility management, it was determined that the facility failed to ensure dead end corridors did not exceed 30-feet in length in accordance with NFPA 101:2012 edition, Section 19.2.5.2. This deficient	{K 251}	Concern. K 251 SS=F Dead End Corridors and Common Path of Travel CFR (s) NFPA101	6/1/24

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

Electronically Signed | 06/14/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING 01 B. WING _____	R 05/30/2024

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{K 251}	Continued From page 1 practice had the potential to affect all residents utilizing Physical Therapy and was evidenced by the following: An observation of the ground floor Physical Therapy exit access corridor located on the ground floor at 10:30 AM, revealed that the exit corridor was approximately 71-feet in length without a designated exit from the far end of the corridor. Exit directional signs located in the corridor only directed the exit path to the main lobby exit. A review of the facility's posted evacuation plan revealed that the there was only one designated exit path from the corridor to the main lobby exit. In an interview, at the time of observation, the facility's U.S. FOIA (b)(6)) stated that there was an exit directional sign leading into the Physical Therapy room to an unacceptable exit arrangement but that sign was removed prior to the initial survey. This condition created a newly designated dead-end corridor and was not previously approved as a dead-end corridor. The facility's U.S. FOIA (b)(6) were notified of the deficient practice at the Life Safety Code Exit at 11:30 AM.	{K 251}	How the corrective action will be accomplished for any resident affected by deficient practice. The facility installed a new exit sign in the hallway at the entrance to the therapy gym. How we identified other residents/areas that could potentially be affected. The facility recognizes this deficient practice does have the potential to effect all patients and residents. Measures to ensure were/will be put into place to assist this area of concern. U.S. FOIA (b)(6) designee has been educated on the usage of the exit sign. How the concern will be monitored and title of person responsible for monitoring. Maintenance Director will monitor For function and placement monthly. Will be included in the QAPI Meeting quarterly for 1 year. Dates when concern will be completed. 6/1/24.	
K 252 SS=F	NJAC 8:39-31.2(e) Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less	K 252		6/1/27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	R **05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

(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
K 252	Continued From page 2 than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and interview on 05/30/2024 in the presence of facility management, it was determined that the facility failed to provide at least 2 acceptable exits, remote from on another for each floor or fire section in accordance with NFPA 101:2012 edition, Section 7.4, 7.5, and 19/2/5/4. This deficient practice had the potential to affect all residents utilizing Physical Therapy and was evidenced by the following: An observation at 10:30 AM revealed that the Ground floor Physical Therapy corridor was only provided with 1 acceptable exit, through the main lobby. The exit directional signs located in the corridor only directed the exit path to the main lobby exit. These were located outside the Physical Therapy room and outside the kitchen. Further observation revealed there was an exit from the kitchen to the loading dock area adjacent to the lobby exit which was through a hazardous area and not remote from the lobby exit. There was another exit from the Physical Therapy	K 252	Concern. K252 Life Safety Code Survey Based on observation, documentation review, and interview on 5/30/2024 in the presence of facility management, it was determined that the facility failed to provide at least 2 acceptable exits, remote from one another for each floor or fire section in accordance with NFPA 101:2012edition, section 7.4,7.5 and 19/5/4. An observation at 10:30am revealed that the ground floor Physical Therapy corridor was only provided With one acceptable exit, through the main lobby. The exit directional signs located in the corridor only directed the exit path to the main lobby exit. How the corrective action will be accomplished for any resident affected by deficient practice K252. #1 – Family of Caring at Tenafly is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING 01 B. WING _____	R 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

(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
K 252	Continued From page 3 room to the exterior but it was non-compliant. This exit was up 4 steps (2 straight and 2 to the left) and was provided with a short exit door measuring 32-1/2 inches in clear width and 66-1/2 inches tall. A review of the facility's posted evacuation plan revealed that the there was only one designated exit path from the corridor to the main lobby exit. In an interview, at the time of observation, the facility's U.S. FOIA (b)(6) confirmed the findings. The facility's U.S. FOIA (b)(6)U.S. FOIA (b)(6) were notified of the deficient practice at the Life Safety Code Exit at 11:30 AM. NJAC 8:39-31.2(e)	K 252	requesting a 3 year Time Limited Waiver to correct the non- compliant existing exit door in the Physical Therapy room as sited in K-252. #2- NJ Ex Order 26.4b1 [redacted] has been contracted by the facility to prepare plans to replace a non-compliant exit door in the existing Physical Therapy room with a new door which complies with all NFPA regulations on the first floor after approvals have been obtained from all entities. A-Planning Phase- June 20, 2024 – June 19, 2025. Architect, Securing Civil Engineering bids, select contracts. Submit to town/state for permits for the work outlined above. #3 – The facility will contract with a civil engineer to survey the site and produce drawings to install a walkway that will continue down to the driveway and meet the ADA compliance in regards to slope. This will be installed at a 12 feet to 1 foot slope maximum. B- Permits Phase – June 20, 2025 – September 19, 2025. Local – County permits and DCA approvals. #4 – This plan will provide compliance with a 2nd acceptable means of egress in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. C-Construction Phase – September 20,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	R **05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

(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
K 252	Continued From page 4	K 252	2025 –June 19, 2027. Complete Construction Project. Obtain CO at the completion of the project. #5 – No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. All staff were in-serviced on the communication system to alert residents and staff in the event of fire or other emergencies. All staff were in-serviced on emergency evacuation procedures and will include current and future employees. Maintenance Director/ designee will conduct Bi-monthly fire safety drills on 3 shifts including weekends for 36 months. Outside Contractor for Life Safety Company (JCM Fire Safety LLC) will conduct a fire drill every month x 3 years and thereafter. Regional Director of Maintenance or designee will conduct an evacuation drill every 3 months for 3 years and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING **01** B. WING _____	R **05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	**133 COUNTY ROAD** **TENAFLY, NJ 07670**

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K 252	Continued From page 5	K 252	bi-annually thereafter. The contracted architect will update Department of Health of progression on a quarterly basis while in remediation. How the concern will be monitored and title of person responsible for monitoring. Result and progress of the set project will be discussed quarterly with the administrator for the accomplishment and this will be a part of facility Quarterly Quality Assurance program. Reports will be sent by the contracted architect to DOH on the progress of the remediation on a quarterly basis to ensure that the project is being accomplished in the timeline set forth. Dates when concern will be completed. 06/01/27.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315164 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	6/28/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT TENAFLY, LLC	133 COUNTY ROAD TENAFLY, NJ 07670

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 Reg. # NFPA 101 LSC K0251	Correction Completed 05/30/2024	ID Prefix Reg. # NFPA 101 LSC K0252	Correction Completed 05/30/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO