STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315435	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT MONTCLAIR	**42 NORTH MOUNTAIN AVE MONTCLAIR, NJ 07042**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 40824 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00152419, NJ00160914, and NJ00162197 Survey Dates: 11/13/2023-11/15/2023 Survey Census: 62 Sample Size: 12 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of	F 552		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 552	Continued From page 1 proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Surveyor: 40824 Complaint #: NJ00152419 Based on record review, interviews, and facility policy review, the facility failed to notify the Responsible Party (RP) of a change in medical status and failed to ensure the RP's right to be informed and make decisions regarding medical care for one of one resident (Resident (R) 3) reviewed for resident rights. Specifically, the facility failed to notify the RP of R3's change in medical condition and did not give the RP the opportunity to make decisions regarding invasive medical care related to intravenous and subcutaneous hydration therapy. Findings include: Review of R3's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, indicated R3 was admitted to the facility on EX Order 26.4B1 with a primary diagnosis of EX Order 26.4B1. R3 was discharged from the facility on EX Order 26.4B1 Review of R3's "Admission Assessment," located in the EMR under the "Progress Notes" and dated NJ Exec. Order 26:4.b.1 at 9:49 PM, indicated that R3 had EX Order 26.4B1 access devices upon admission. Review of R3's "Laboratory Results," located in the paper chart and dated EX Order 26.4B1, revealed an order for EX Order 26.4B1	F 552	Concern. Tag 552 SS-D Informed/Make Treatment Decisions(s) Based on record review, interviews, and facility policy review, the facility failed to notify the Responsible Party (RP) of a change in medical status and failed to ensure the RP's right to be informed and make decisions regarding medical care for one of one resident (Resident (R) 3) reviewed for resident rights. Specifically, the facility failed to notify the RP of R3's change in medical condition and did not give the RP the opportunity to make decisions regarding NJ Exec. Order 26:4.b.1 medical care related t NJ Exec. Order 26:4.b.1 therapy. How the corrective action will be accomplished for any resident affected by deficient practice. Licensed nurses were reinserviced on notification of a responsible party for any change in medical status and change in condition. Licensed nurses were inserviced on informing residents and RPs so they can make informed decisions regarding invasive medical care including IV and Subcutaneous therapy	

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F 552	Continued From page 2 EX Order 26.4B1 Review of R3's "Order Summary Report," dated EX Order 26.4B1 and located in the EMR under the "Orders" tab, included orders to: have the intravenous (IV) nurse insert mid-line EX Order 26.4B1 therapy; observe the EX Order 26.4B1 insertion site at least every two hours and as needed; flush the EX Order 26.4B1 before, between, and after medications with EX Order 26.4B1 ; and change the NJ Exec. Order 26:4.b.1 to the EX Order 26.4B1 EX Order 26.4 after insertion and then weekly on Friday. Review of R3's "Procedure Note for Order #NJ Exec. Order 26:4.b.1," dated EX Order 26.4B1 PM, revealed a EX Order 26.4B1 was placed with EX Order 26.4B1 guidance to R3's NJ Exec. Order 26:4.b.1 extremity. There was no documentation indicating the nurse had notified the RP or obtained consent for the EX Order 26.4B1. Review of R3's "Order Summary Report," located in the EMR under the "Orders" tab and dated NJ Exec. Order 26:4.b.1 revealed an order for EX Order 26.4B1 (hour) every shift for NJ Exec. Order 26:4.b.1. It was documented that the order ended on EX Order 26.4B1 Review of R3's "Progress Notes," located in the EMR under the "Progress Notes" tab, dated NJ Exec. Order 26:4.b.1 at 2:15 PM, and signed by Licensed	F 552	R #3 is discharged back to the community. All licensed nurses obtained informed consent prior to any invasive procedures rendered to all residents. All residents with scheduled invasive procedures were reviewed, proper RP notification and consent were in place. All residents with change in medical condition were reviewed, proper RP notification were in place. 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 and educated on obtaining RP notification regarding change in medical condition, obtaining RP informed consent with any invasive medical care. Unit manager or designee will identify any new invasive procedures ordered in the daily clinical meeting and ensure proper RP notification and const are in place to ensure that residents and RPs are	

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F 552	Continued From page 3 Practical Nurse (LPN2), indicated EX Order 26.4B1 EX Order 26.4B1 in place, was refusing EX Order 26.4B1 medications, and was receiving EX Order 26.4B1. There was no documentation that staff had notified the RP of R3's status. Review of R3's "Laboratory Results," located in the paper chart and dated EX Order 26.4B1 revealed an order to start EX Order 26.4B1. Review of R3's "Care Plan," located in the EMR under the "Care Plan" tab, indicated that R3 had difficulty communicating related to a EX Order 26.4B1 EX Order 26.4B1 required staff to anticipate and meet all needs. A NJ Exec. Order 26:4.b.1 problem related to EX Order 26.4B1 diet and EX Order 26.4B1 appetite was also care planned. Interventions, dated EX Order 26.4B1, included NJ Exec. Order 26:4.b.1 EX Order 26.4B1) and an EX Order 26.4B1 EX Order 26.4B1. Review of R3's "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab and with an Assessment Reference Date (ARD) of EX Order 26.4B1 indicated R3 had a "Brief Interview for Mental Status (BIMS)" score of EX Order 26.4B1 out of 15, indicating R3 was EX Order 26.4B1. Additionally, it was recorded R3 required NJ Exec. Order 26:4.b.1 with eating; had diagnoses includin EX Order 26.4B1 ; had a history of EX Order 26.4B1 and had EX Order 26.4B1 resident. Review of R3's "Progress Notes," located in the EMR under the "Progress Notes" tab, dated	F 552	making informed decisions prior to any invasive procedures. Unit Manager or designee will identify any new change in status and medical condition in daily clinical meeting and ensure that resident or RP are informed about change in status or medical condition. 11 – 7 supervisor or primary nurse will identify new orders for invasive procedure/s through 24 hour chart check and ensure that proper notification was completed and notify UM or designee. Supervisor from all shifts will identify new orders for any invasive procedure and alert the DON and ADON through the 24 hour report. 24 hour report and progress notes will be reviewed in the daily clinical meeting to ensure that RP was informed of change in medical condition and a verbal consent was obtained to follow invasive medical care/ treatment. Audits will be monitored for completion by the Administrator and will be reviewed in the monthly QA. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended as indicated. Adverse findings will be immediately addressed.	

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F 552	Continued From page 4 NJ Exec. Order 26:4.b.1 at 2:26 PM, and signed by the Nurse Practitioner (NP), revealed R3 was resting comfortably in bed with EX Order 26.4B1 running, her labs were reviewed, and EX Order 26.4B1 were changed. It was documented that the NP spoke with staff nurses regarding R3's status. There was no documentation that the RP had been notified of R3's status. Review of R3's "Order Summary Report," dated NJ Exec. Order 26:4.b.1 through NJ Exec. Order 26:4.b.2 and located in the EMR under the "Orders tab, revealed R3 continued to receive EX Order 26.4B1 from EX Order 26.4B1 through EX Order 26.4B1. It was documented R3 received EX Order 26.4B1) at EX Order 26.4B1 from EX Order 26.4B1 through EX Order 26.4B1 EX Order 26.4B1 from EX Order 26.4B1 through EX Order 26.4B1 and EX Order 26.4B1 starting on EX Order 26.4B1 Review of R3's "Orders," located in the EMR under the "Orders" tab and dated EX Order 26.4B1 revealed an order for R3 to receive EX Order 26.4B1 he order was created by Registered Nurse (RN3) on EX Order 26.4B1. Review of R3's "Progress Notes," located in the EMR under the "Progress Notes" tab, dated NJ Exec. Order 26:4.b.1 at 2:11 PM, and signed by the Social Services Director (SSD), revealed, ". . . IDCP (Interdisciplinary Care Plan) team met with R3's [family member] . . . via phone conference to provide an update and go over R3's plan of care. R3 is on NJ Exec. Order 26:4.b.1 she has a appetite, is , and EX Order 26.4B1. R3 tends to EX Order 26.4B1 and at times EX Order 26.4B1 She	F 552	How the concern will be monitored and title of person responsible for monitoring. Supervisor from all shifts will identify new orders for any invasive procedure and alert the DON and ADON through the 24 hour report. Supervisor from all shifts will identify change in medical condition through rounding and nurse report and notify RP, DON, and ADON. 11 – 7 Supervisor or primary nurse will identify new orders for invasive procedure from the 24 hour chart check and alert the Unit Manger or odesignee to ensure that the RP notification was done and consent was obtained prior to an invasive procedure. 24 hour report and progress notes will be reviewed in the daily clinical meeting to ensure that RP notification regarding change in medical condition. Director of Nursing or designee will perform a monthly audit of 5 charts to monitor that RP notification is done with any medical changes. Director of Nursing or designee will perform a monthly audit of 5 charts to monitor that proper notification of residents or RPs are conducted prior to any invasive procedures.	

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F 552	Continued From page 5 enjoys drinking, [sic] but needs assistance. R3's medications and orders were reviewed and RP is familiar with her medication administration . . ." Review of R3's "Progress Notes," located in the EMR under the "Progress Notes" tab, dated [redacted] at 9:35 AM, and signed by the Registered Dietitian (RD), revealed that R3 continued with [redacted] appetite, required a [redacted] diet, [redacted] twice daily were provided, laboratory results were reviewed, [redacted] were reviewed with [redacted] noted, and [redacted] were being received. Review of R3's "Progress Notes" located in the EMR under the "Progress Notes" tab dated [redacted] at 12:14 AM by RN1 stated, ". . . In bed during shift. . . [redacted] . . ." Review of R3's "Progress Notes," located in the EMR under the "Progress Notes" tab, revealed no documentation R3's RP had been notified of R3's laboratory test results that resulted in physician orders, had been notified and consented to the placement of the [redacted], had been notified of changes in R3's [redacted], or had been notified and consented to the [redacted] During an interview on 11/14/23 at 8:39 AM, R3's RP stated she was the Power of Attorney for R3. The RP stated the facility put [redacted] in R3's [redacted] to help her [redacted] and the [redacted] was causing her [redacted] as evidenced by her being [redacted] The RP stated she had not given consent for the [redacted] and the facility had not notified her "about anything." The RP	F 552	DON will present audit results and trends in the monthly QA meeting to identify issues and ensure resolution of issues. Provide ongoing in-service and education to all nurses to obtain a verbal or written consent for any change in medical condition and invasive medical procedures. Audits will be reviewed in the Quarterly Quality Assurance and Performance Improvement Meeting. Dates when concern will be completed. 12/30/23.	

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F 552	Continued From page 6 also stated that she had concerns with her family member [NJ Exec. Order 26:4.b.1]. During an interview on 11/14/23 at 10:18 AM, the Assistant Director of Nursing (ADON) stated his expectation was for the charge nurse to notify the physician, resident, and family member if indicated regarding resident changes in condition or changes in medications. During an interview on 11/14/23 at 4:47 PM, NP stated that she recalled R3 having a [EX Order 26] appetite, and she started [EX Order 26.4B1] to keep R3's EX Order 26.4B1 and her EX Order 26.4B1 The NP stated R3 had also been [EX Order 26.4B1] medications [EX Order 26.4B1], pocketing food, and she felt R3 needed to be started on EX Order 26.4B1 during her stay at the facility. The NP stated the EX Order 26.4B1 were completed and [EX Order 26.4B1] were started on an unknown date, but R3's [EX Order 26.4B] EX Order 26.4B1 so they started [EX Order 26.4B1]. The NP stated she did not recall speaking with the family/RP regarding the EX Order 26.4B1, but if she did, she would have entered a progress note. Additionally, the NP stated that typically the facility nurses notified the family/RP, but sometimes she would notify the RP if family was at the bedside or at the facility. The NP stated her expectation was for the facility staff to notify the RP if they were not already aware. During an interview on 11/15/23 at 8:28 AM, the SSD stated that she had a care conference with the RP on 01/20/22 at 2:00 PM and R3's plan of care was discussed including medications as of that time, EX Order 26.4B1, EX Order 26.4B1, [EX Order 26] appetite, and the need for [EX Order 26.4B1] The SSD stated at the time of the	F 552		

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F 552	Continued From page 7	F 552		

care conference, the Nurse Practitioner had not yet changed orders from EX Order 26.4B1 therapy to EX Order 26.4B1 therapy.

During an interview on 11/15/23 at 11:51 AM, RN1 stated R3 would only drink EX Order 26.4B1 had EX Order 26.4B1, and she remembered they could not get an EX Order 26.4B1 so they had to do EX Order 26.4B1" RN1 stated Usually the NP or physician would call the family to let them know there had been a status change. R3 confirmed that she had not notified the RP of R3's changes but confirmed that either the nurse or the NP should have made the RP aware of any medication changes.

During an interview on 11/15/23 at 5:32 PM, the Director of Nursing (DON) stated the facility did not have a specific policy addressing informed consent; however, they did have policies related to RP notification of laboratory results and acute condition changes. Additionally, the DON confirmed that staff did not document any attempts to communicate with the RP regarding R3's change in status or medication changes. The DON stated that her expectation was for either the charge nurse or the Nurse Practitioner/Medical Doctor to notify the RP of any changes in condition, specifically notifying her of the need for EX Order 26.4B1 and the change to EX Order 26.4B1.

Review of the facility's policy titled, "Acute Condition Changes- Clinical Protocol," revised October 2010, revealed, ". . . If necessary, the Physician will order diagnostic tests or evaluate the resident . . . As needed, the Physician will discuss with the staff and resident and/or family the benefits and risks of diagnosing and

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F 552	Continued From page 8 managing the situation in the facility or via hospitalization . . . The staff will monitor and document the resident's progress and responses to treatment, and the Physician will adjust treatment accordingly . . . At the next visit, the Physician will review the status of the condition change and document his/her evaluation, including the significance of the acute situation . . ." NJAC 8:39-4.1 (a)	F 552		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Surveyor: 40824 Complaint #: NJ00160914 Based on interviews, record reviews, and policy review, the facility failed to notify the physician of laboratory results for one of one (Resident (R) 2) residents reviewed for laboratory services. Specifically, the facility failed to notify the physician of R2's EX Order 26.4B1 .	F 773	Concern. Tag F773 Lab services Physician order/ notify of results. Based on interviews, record reviews, and policy review, the facility failed to notify the physician of laboratory results for one	12/30/23

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F 773	Continued From page 9 Findings include: Review of the facility's policy titled, "Charting and Documentation," revised April 2008, revealed, ". . . All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record . . . Documentation of procedures and treatments shall include care-specific details and shall include at a minimum . . . Notification of family, physician or other staff . . ." Review of the facility's policy titled, "Acute Condition Changes- Clinical Protocol," revised October 2010, revealed, ". . . If necessary, the Physician will order diagnostic tests or evaluate the resident directly . . . As needed, the Physician will discuss with the staff and resident and/or family the benefits and risks of diagnosing and managing the situation in the facility or via hospitalization . . ." Review of R2's "Admission Record," located in the electronic medical record (EMR)" under the "Profile" tab, indicated R2 was admitted to the facility on EX Order 26.4B1 with a EX Order 26.4B1 [redacted] R2 was discharged from the facility on EX Order 26.4B1 Review of R2's "Care Plan," dated NJ Exec. Order 26:4.b.1 2 and located in the EMR under the "Care Plan" tab, indicated that R2 required NJ Exec. Order 26:4.b.1 with bathing/showering, dressing, personal hygiene, toileting, and transferring from one surface to another and NJ Exec. Order 26:4.b.1 with bed mobility. It was recorded R2 had an EX Order 26.4B1 and to obtain and monitor NJ Exec. Order 26:4.b.1 as ordered and	F 773	of one (Resident (R) 2) residents reviewed for laboratory services. Specifically, the facility failed to notify the physician of R2's EX Order 26.4B1 results. How the corrective action will be accomplished for any resident affected by deficient practice. Licensed nurses were reinserviced on facility policy regarding notification of ordering physician of abnormal lab results Licensed nurses were provided education on documentation of Physician notification regarding abnormal lab result and change in treatment. R # 2 was discharged back to the community. All residents with NJ Exec. Order 26:4.b.1 results were reviewed, proper Physician notification were in place. 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 and educated on prompt notification of the ordering physician or any medical	

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F 773	Continued From page 10 report the results to the physician and follow up as indicated. Review of R2's "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab and with an Assessment Reference Date (ARD) of EX Order 26.4B1 revealed R2 had a "Brief Interview for Mental Status (BIMS)" score of EX Order out of 15, indicating R2 was EX Order 26.4B1. Additionally, it was recorded R2 had an EX Order 26.4B1 EX Order 26.4B1 Review of R2's "Order Recap Report," located in the EMR under the "Orders" tab, revealed an order dated EX Order 26.4B1 to collect a EX Order 26.4B1 EX Order 26.4B1. Review of R2's "Treatment Administration Record (TAR)," dated EX Order 26.4B1 and located in the EMR under the "Orders" tab, revealed staff collected a EX Order 26.4B1 Review of R2's "Lab Results Report," located in the EMR under the "Results" tab, revealed the EX Order 26.4B1 was collected on EX Order 26.4B1 and results were reported on EX Order 26.4B1. The lab report was documented as being reviewed by Registered Nurse (RN) 3 and included a "flagged" result, indicating an EX Order 26.4B1 with EX Order 26.4B1. The colony count was recorded as greater than NJ Exec. Order 26:4.b.i for EX Order 26.4B1, with EX Order 26.4B1, one plus protein (normal reference range: negative), EX Order 26.4B1 EX Order 26.4B1), EX Order 26.4B1 EX Order 26.4B1 plus (3+) (normal reference range: negative), EX Order 26.4B1	F 773	professional of any abnormal results. Licensed nurses were educated to use shift to shift report to alert the incoming nurse to follow up any pending laboratory results. Unit manager/designee or primary nurse will check lab results in PCC before the end of the morning shift and notify the ordering Physician or medical professional of any abnormal results. Unit manager/designee or primary nurse will document abnormal lab results and new Physician orders in the nurse's progress notes and 24 hour report. 11 – 7 supervisor and/or primary nurse will identify new laboratory orders through 24 hour chart check and alert the Unit Manger or designee follow up on lab results including urinalysis, stat labs or any other lab services. Director of Nursing or designee will perform a monthly audit of 5 charts to monitor prompt Physician or medical professional notification with abnormal labs including urinalysis. Audits will be monitored for completion by the Administrator in the monthly QA meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315435	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT MONTCLAIR	42 NORTH MOUNTAIN AVE MONTCLAIR, NJ 07042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 11 EX Order (normal reference range: 0-5), EX Order 26.4B1 (normal reference range: 0-3), and bacteria NJ Exec. Order 26:4.b.1 (normal reference range: negative). There was no documentation that the nurse practitioner (NP) or physician had been notified of the EX Order 26.4B1 results. Review of R2's "Progress Notes," dated EX Order 26.4B1 at EX Order 26.4B1 and located under the "Progress Notes" tab of the EMR, revealed, ". . . Patient is to transfer this am [sic] to [facility name withheld] . . . NP ... aware, recommends informing the transfer receiving facility she recommends running a EX Order 26.4B1 and EX Order 26.4B1 on [R2], as that as what was to be done today if she did not transfer . . ." During an interview on 11/14/23 at 3:02 PM, the Assistant Director of Nurses (ADON) confirmed that a NJ Exec. Order 26:4.b.1 was collected for R2 on NJ Exec. Order 26:4.b.1 with results received by the facility on NJ Exec. Order 26:4.b.1. Upon review of the "Lab Results Report," it was revealed that RN3 reviewed the EX Order 26.4B1 with EX Order 26.4B1 on NJ Exec. Order 26:4.b.1. Review of R2's "Progress Notes" with the ADON confirmed that RN3 had not reported the lab results to the physician or the NP. The ADON stated that his expectation and the protocol of the facility was for the afternoon shift nurse (3:00PM-11:00PM) to review lab results received, enter a progress note, and call the MD or NP with the results. During an interview on 11/14/23 at 4:33 PM, the NP stated that she recalled R2 having orders for a EX Order 26.4B1 NJ Exec. Order 26:4.b.1) on NJ Exec. Order 26:4.b.1. The NP confirmed that staff had not notified her of the results and that she had not	F 773	plan can be amended as indicated. Adverse findings will be immediately addressed. How the concern will be monitored and title of person responsible for monitoring. Director of Nursing or designee will perform a monthly audit of 5 charts to monitor proper Physician notification for all abnormal lab results. DON will present audit results and trends in the monthly QA meeting to identify issues and ensure resolution of issues. Dates when concern will be completed. 12/30/23	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT MONTCLAIR	**42 NORTH MOUNTAIN AVE MONTCLAIR, NJ 07042**

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F 773	Continued From page 12	F 773		

realized until the resident was discharged on [redacted] that the results had not been reviewed. The NP stated that the normal protocol was for the nurse on duty at the facility to call her or the physician with any abnormal results, and then she would provide an order for [redacted] if appropriate and enter a progress note in the EMR. After further review of R2's progress notes, the NP stated she recalled realizing on [redacted] that the [redacted] from [redacted] had not been addressed and gave recommendations to ADON on [redacted] at 10:30 AM (see progress note dated [redacted] at 10:30 AM) for a repeat [redacted] once R2 was transferred to the new facility.

During an interview on 11/15/23 at 11:51 AM, RN1 confirmed she had not provided care to R2; however, the current process regarding reporting of [redacted] results was for the desk nurse to notify the MD/NP and make a progress note.

During an interview on 11/15/23 at 12:30 PM, RN2 confirmed that the current process for reviewing lab results was for the lab results to be checked on the afternoon shift, call the physician/NP with abnormal labs, document any new orders in EMR, and enter a progress note with who was notified. RN2 stated the family/responsible party should be notified as well.

During an interview on 11/15/23 at 4:35 PM, the Director of Nurses (DON) confirmed that the current process for handling laboratory results was for the charge nurse to review laboratory results that were received on their shift, and if the results were normal, the nurse might wait to

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F 773	Continued From page 13 notify the physician/NP during the next shift. The DON stated if results were abnormal, then the nurse should notify the physician/NP immediately. The DON confirmed that RN3 did not document that she had notified the provider but should have. Additionally, the DON stated that the facility did not have a specific policy for notifying the physician/NP of laboratory results; however, policies were provided titled, "Acute Condition Changes- Clinical Protocol" and "Charting and Documentation" for reference of the expectations regarding nursing notifying physicians of resident concerns. NJAC 8:39-13.1 (d)	F 773		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060719	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT MONTCl	42 NORTH MOUNTAIN AVE MONTCLAIR, NJ 07042

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S 000	Initial Comments Surveyor: 25306 Complaint #: NJ00152419, NJ00160914, and NJ00162197 Survey Dates: 11/13/2023-11/15/2023 Survey Census: 62 Sample Size: 12 The facility is 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: Surveyor: 25306 Complaint #: NJ00152419, NJ00160914, and NJ00162197 Based on review of pertinent facility	S 560	Concern. S560 Mandatory Access to care. 8:39-5.1(a) Mandatory Access to Care	12/30/23

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

Electronically Signed | 12/08/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 7 of 21 day shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and 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 CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 3 weeks of staffing from 02/12/2023 to 02/18/2023 and 10/29/2023 to 11/11/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below:	S 560	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 interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey for 7 of 21 day shifts as follows: This deficient practice had the potential to affect all residents. One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties .As per the "Nurse Staffing Report" completed by the facility for the 3 weeks of staffing from02/12/2023 to 02/18/2023 and 10/29/2023 to11/11/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: 1.For the week of staffing from02/12/2023 to 02/18/2023, the facility was deficient in CNA staffing for residents on 3 of 7day shifts as follows:	

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	060719	A. BUILDING: _____ B. WING _____	C 11/15/2023

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S 560	Continued From page 2 1. For the week of staffing from 02/12/2023 to 02/18/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -02/13/23 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs. -02/15/23 had 5 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/18/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. 2. For the 2 weeks of staffing prior to survey from 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -10/30/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -10/31/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -11/04/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -11/05/23 had 5 CNAs for 63 residents on the day shift, required at least 8 CNAs.	S 560	-02/13/23 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs.-02/15/23 had 5 CNAs for 63 residents on the day shift, required at least 8 CNAs.-02/18/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. 2.For the 2 weeks of staffing prior to survey from 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for resident on 4 of 14 day shifts as follows:-10/30/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs.-10/31/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs.-11/04/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.-11/05/23 had 5 CNAs for 63 residents on the day shift, required at least 8 CNAs. 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,	

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S 560	Continued From page 3	S 560	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. No resident was negatively 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. 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. The Administrator or designee will review staffing /schedules weekly for 4 weeks and monthly for 3 months to ensure adequate staffing for all shifts. Corporate staffing Director will monitor staffing needs daily to ensure facility is compliance with staffing requirements.	

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S 560	Continued From page 4	S 560	Staffing Coordinator was educated on communicating any shifts that do not meet the required minimum direct care staff to resident ratios to the DON or ADON to fill open positions through bonuses or other form of incentives. 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. 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315435	A. Building B. Wing	12/11/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT MONTCLAIR	42 NORTH MOUNTAIN AVE MONTCLAIR, NJ 07042

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 F0552 Reg. # 483.10(c)(1)(4)(5) LSC	Correction Completed 12/08/2023	ID Prefix F0773 Reg. # 483.50(a)(2)(i)(ii) LSC	Correction Completed 12/08/2023	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

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 11/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
060719 Y1	Y2	12/11/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT MONTCLAIR	42 NORTH MOUNTAIN AVE MONTCLAIR, NJ 07042

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 12/08/2023	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
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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	
11/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: D7ND12