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 _____	03/13/2023

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 Standard Survey: 3/13/23 Census: 64 Sample Size: 16 + 3= 19 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) follow a physician's order for parameters before administering Ex Order 26. 4B1 medication, b.) sign the Ex Order 26. 4B1 to confirm a resident's Ex Order 26. 4B1, placement and patency was done and Ex Order 26. 4B1 record was completed, and c.) execute a physician's order for a Ex Order 26. 4B1 medication for a resident with Ex Order 26. 4B1. This was found with 3 of 19 residents reviewed for professional standards of practice, Resident # 42, Resident # 271, and Resident # 67. Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The	F 658	Concern Tag- F658 SS -D Services Provided Meet Professional Standards F658 CFR(s): 483.21(b)(3)(i) Based on observation, interview, and record review, it was determined that the facility failed to a.) Follow a physician's order for parameters before administering Ex Order 26. 4B1 medication, b.) Sign the Electronic Treatment Administration Record (ETAR) to confirm a resident's Ex Order 26. 4B1,	3/31/23

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

Electronically Signed | 03/24/2023

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.

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F 658	Continued From page 1 practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or 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 well being, and executing a 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 with in 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." The deficient practice was evidenced by the following: 1. On 3/9/23 at 8:18 AM, the surveyor observed Licensed Practical Nurse # 1 (LPN #1) prepare to administer medication to Resident # 42. LPN # 1 referred to a list of residents on top of the medication cart. Each resident's name had the resident's *Ex Order 26. 4B1* written next to it. LPN # 1 said when she took the residents vital signs about 10 minutes prior the *Ex Order 26. 4B1* was [redacted] and the [redacted] was [redacted]. Two of the medications LPN # 1 administered required checking the *Ex Order 26. 4B1* prior to administering, those were *Ex Order 26. 4B1*, and	F 658	placement and patency was done and urine output record was completed, and c.) Execute a physician's order for a NJ Exec. Order 26:4.b.1 for a resident with insomnia. This was found with 3 of 19 residents reviewed for professional standards of practice, Resident # 42, Resident # 271, and Resident # 67. Based on observation, interview, and record review, it was determined that the facility failed to a.) Follow a physician's order for parameters before administering [redacted] medication, b.) Sign the Electronic Treatment Administration Record (ETAR) to confirm a resident's *Ex Order 26. 4B1*, placement and patency was done and *Ex Order 26. 4B1* record was completed, c.) Execute a physician's order for a [redacted] medication for a resident within *Ex Order 26. 4B1*. This was found with 3 of 19 residents reviewed for professional standards of practice, Resident # 42, Resident # 271, and Resident # 67 How the corrective action will be accomplished for any resident affected by deficient practice 1) LPN # 1 failed to follow physician's order for parameters before administering NJ Exec. Order 26:4.b.1 medication. LPN #1 took the *Ex Order 26. 4B1* less than an hour	

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F 658	Continued From page 2 Ex Order 26. 4B1. One medication required checking the Ex Order 26. 4B1 and Ex Order 26. 4 prior to administering, that was Ex Order 26. 4B1, according to physician's orders. There was no NJ Exec. Order 26:4.b.1 in the medication cart. LPN # 1 gave the resident the Ex Order 26. 4B1 and the Ex Order 26. 4B1. When LPN #1 was done she went to the nurses station and asked the Unit Manager (UM) to help her retrieve the Ex Order 26. 4B1 from the "back up" supply. The UM assisted LPN #1 and at 8:43 AM LPN # 1 administered the Ex Order 26. 4B1 to Resident # 42. On 3/9/23 at 9:15 AM, the surveyor asked LPN # 1 if it was her normal routine to take all of the resident's vital signs and then administer all of the resident's medication, even those with parameters ordered by the physician. LPN # 1 described her routine as follows; "I come in at 7 AM, count narcotics, get report, make rounds to prioritize who to give medication to first, who is demanding, who is more acute, then I take vital signs between 7:30 and 8." The surveyor asked if she ever took vital signs a second time. LPN # 1 stated "Yes, if it's been more than an hour since I took their vital signs and they have parameters I take their vitals again before I give the medicine." On 3/9/23 at 9:40 AM the surveyor reviewed the medical record of Resident # 42 which revealed the following: An admission record with diagnoses which included Ex Order 26. 4B1	F 658	before administering medication. LPN #1 was counselled and was re in serviced regarding following a physician's order. Vital signs will be taken before administering medication following medication parameters. LPN #1 was observed during medication administration pass on 3/14/23. Vital signs were taken before administering medications with parameters (example; Ex Order 26. 4B1). Nurse LPN#1 competed and pass the Competency of Medication pass on medication administration 0n 3/14/23. LPN#1 was able to: a) Demonstrate correctly by checking orders with parameters before preparing the medications. b) Vital signs was taken, reviewed and documented in EMAR. c) Medication was administered right after the Ex Order 26. 4B1 and Ex Order 26. 4 were taken. Resident #42 was assessed and Ex Order 26. 4 and pulse was within normal limits. All residents with medication parameters was reviewed and assessed. No other residents was affected with this deficient practice. 2) Resident #271 had physician orders for Ex Order 26. 4B1 placement and patency every shift, provide Ex Order 26. 4B1	

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F 658	Continued From page 3 An order summary report with physician's orders that read: *Ex Order 26. 4B1* Give 1 tablet by mouth one time a day for [redacted] hold for *Ex Order 26. 4B1* less than [redacted]. *Ex Order 26. 4B1* Give one tablet by mouth one time a day for [redacted] hold for [redacted] less than [redacted]. *Ex Order 26. 4B1* Give 1 tablet by mouth two times a day for *Ex Order 26. 4B1* Take with food. Hold for [redacted] less than [redacted] or *Ex Order 26. 4B1* [redacted] less than [redacted]. On 3/9/23 at 1:45 PM the surveyor spoke with the Administrator, the Director of Nursing, and the Regional Nurse. The surveyor explained the concern with LPN #1 not following physician's orders or standards of practice to take the resident's vital signs upon administering medication with parameters ordered by the physician. The surveyor asked if they knew why LPN # 1 said she would take the resident's vital signs again if it had been one hour since she had taken them and they had parameters. The surveyor requested the facility's policy and procedure for medication administration. On 3/13/23 at 9:30 AM the surveyor reviewed the facility's policy and procedure titled " Administering Medication Using Electronic System (PCC)" that was provided by the Regional Nurse. There was no mention in the policy and procedure about following parameters. There was no mention of taking vital signs again if it had been one hour since the vital signs had been taken last and there were parameters ordered. The surveyor spoke with the Regional Nurse and the Director of Nursing about their policy and procedure for parameters. The Regional Nurse	F 658	*Ex Order 26. 4B1* care every shift, and document *Ex Order 26. 4B1* every shift. The February 2023 and March 2023 ETAR revealed there were several dates that the nurse did not document on the treatment record that the *Ex Order 26. 4B1* placement and patency every shift, *Ex Order 26. 4B1* every shift, and document *Ex Order 26. 4B1* every shift was done 1. *Ex Order 26. 4B1* placement and patency for dates of 2/16/23 night shift, 2/18/23 day shift, 3/2/23 night shift, 3/6/23 evening shift, 3/7/23 evening shift and 3/8/23 evening shift. 2. Provide *Ex Order 26. 4B1* care every shift for dates of 2/16/23 night shift, 2/18/23 day shift, 3/6/23 evening shift, 3/7/23 evening shift and 3/8/23 for evening shift. 3. Document *Ex Order 26. 4B1* every shift for dates of 2/16/23 night shift, 2/18/23 day shift, 2/21/23 day shift, 3/2/23 night shift, 3/6/23 evening shift, Licensed nurses who failed to check the placement and patency of *Ex Order 26. 4B1* [redacted], failed to provide *Ex Order 26. 4B1* care every shift and failed were counselled and re in-service on documentation after providing care, treatment and documentation of total output in each shift. Resident # 271 with *Ex Order 26. 4B1* placement was assessed with no significant changes. All residents with *Ex Order 26. 4B1* was reviewed and assessed to ensure nurses are documenting accordingly	

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F 658	Continued From page 4 and the Director of Nursing said they didn't have a specific policy and procedure for parameters. The Regional Nurse stated "because every nurse knows that they take the vitals when they give the med if there are parameters." 2. The surveyor reviewed the medical records for Resident #271 that revealed the following: According to the Order Summary Report, Resident #271 had physician orders for *Ex Order 26. 4B1* and patency every shift, provide *Ex Order 26. 4B1* care every shift, and document *Ex Order 26. 4B1* every shift. The February 2023 and March 2023 ETAR revealed there were several dates that the nurse did not document on the treatment record that the *Ex Order 26. 4B1* and patency every shift, *Ex Order 26. 4B1* every shift, and document urine out put every shift was done on the following dates: 1. *Ex Order 26. 4B1* and patency for dates of 2/16/23 night shift, 2/18/23 day shift, 3/2/23 night shift, 3/6/23 evening shift, 3/7/23 evening shift and 3/8/23 evening shift. 2. Provide *Ex Order 26. 4B1* care every shift for dates of 2/16/23 night shift, 2/18/23 day shift, 3/6/23 evening shift, 3/7/23 evening shift and 3/8/23 for evening shift. 3. Document NJ Exec. Order 26:4.b.1 every shift for dates of 2/16/23 night shift, 2/18/23 day shift, 2/21/23 day shift, 3/2/23 night shift, 3/6/23 evening shift, 3/7/23 evening shift, and 3/8/23 evening shift.	F 658	according to physician's order. No residents were affected of this deficient practice. On 3/8/23 at 11:10 AM, the surveyor observed Resident #67 in their room fully dressed and seated in their wheelchair. The resident stated they had Ex Order 26. 4B1 at home, was sent to the hospital and was now at the facility for rehabilitation. The resident stated he/she was a little tired today, and hadn't been sleeping. The resident further stated he/she had a consultation recently with the Nurse Practitioner (NP) who had ordered him/her a *Ex Order 26. 4B1*. The resident stated they had received a *Ex Order 26. 4B1* that night, but the next night when he/she asked for the *Ex Order 26. 4B1* the nurse stated the resident did not have an order for a *Ex Order 26. 4B1*. Progress Notes reflected a Nurse Practitioner Progress Note dated NJ Exec. Order 26:4.b at 2:18 PM, revealed a History and Physical note indicating the resident had been seen by the NP and the medications were reviewed, but there was no new medication orders for a *Ex Order 26. 4B1* reflected. A review of the Order Summary Report for February 2023 did not reflect an order for any medication used as a *Ex Order 26. 4B1*. Nurse who failed to enter the order in PCC was no longer employed. 2) Resident # 67 was assessed by an RN and a *Ex Order 26. 4B1* was reordered by NP and was administered to resident #67 on NJ Exec. Order 26:4.b	

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F 658	Continued From page 5 On 3/09/23 at 11:54 AM, the surveyor interviewed the Registered Nurse, Unit Manager (RN, UM) regarding blanks on the ETAR for above mentioned concerns. The RN,UM stated that these orders should have been signed for. The surveyor reviewed the policy titled "Charting and Documentation" dated 6/2022, which revealed that all observations, medications administered, services performed, etc., must be documented in the resident's clinical records. 3. On 3/8/23 at 11:10 AM, the surveyor observed Resident #67 in their room fully dressed and seated in their wheelchair. The resident stated they had [redacted] at home, was sent to the hospital and was now at the facility for rehabilitation. The resident stated he/she was a little tired today, and hadn't been sleeping. The resident further stated he/she had a consultation recently with the Nurse Practitioner (NP) who had ordered him/her a *Ex Order 26. 4B1*. The resident stated they had received a *Ex Order 26. 4B1* that night, but the next night when he/she asked for the *Ex Order 26. 4B1* the nurse stated the resident did not have an order for a *Ex Order 26. 4B1*. The surveyor reviewed the medical record for Resident #67. A review of the *Ex Order 26. 4B1* face sheet reflected that the resident was admitted to the facility in *Ex Order 26. 4B1* with diagnoses which included *Ex Order 26. 4B1* [redacted],	F 658	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. LPN 1 was supervised by the unit manager or designee for two weeks during med pass to ensure she is following physician's order for parameters before administering *Ex Order 26. 4B1* medication. . Monitoring has intended to accomplish that LPN 1 is following Facility policy on following physician's order for parameters before administrating [redacted] medication. Unit managers or designee on each floors has been monitoring and checking Nurses documentation to ensure that all [redacted] has been signed off by the nurses who are providing treatment. This monitoring is intended to accomplish any missing ETARs during the shift and to be corrected before the shift ends. Execute a physician's order for a [redacted] medication for the resident. Affected LPN who failed to carry out orders to the POS was counselled for not following proper protocol for executing physician's order. Both unit managers are responsible for checking to ensure the orders are	

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F 658	Continued From page 6 and repeated falls. A review of the admissions Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a *Ex Order 26. 4B1* [redacted] score of [redacted] out of 15, which indicated the resident is *Ex Order 26. 4B1*. A review of the Progress Notes reflected a Social Service Note dated [redacted] at 12:31 PM, revealed that Resident #67 had an *Ex Order 26. 4B1* [redacted] meeting which indicated the resident was having difficulty sleeping, and the NP was made aware to prescribe a *Ex Order 26. 4B1*. A further review of the Progress Notes reflected a Nurse Practitioner Progress Note dated [redacted] at 2:18 PM, revealed a History and Physical note indicating the resident had been seen by the NP and the medications were reviewed, but there was no new medication orders for a *Ex Order 26. 4B1* reflected. A review of the Order Summary Report for February 2023 did not reflect an order for any medication used as a *Ex Order 26. 4B1*. On 3/8/23 at 11:31 AM, the surveyor interviewed Resident #67's LPN # 2 who stated she was an agency nurse and this was her first time caring for the resident. LPN # 2 stated during her morning rounds the resident expressed they were having issues sleeping. LPN#2 told the resident she would follow up with their physician. LPN #2 stated she was currently reviewing the resident's medication orders in the computer and would contact the physician if needed.	F 658	acknowledged by the nurses. The intent by do this step is to make sure all orders are in the system and residents are getting their medications that are prescribed by their physician and for facility to follow professional standards. Licensed nurses Were re in- serviced regarding the policy and procedure on Administration of Medication by checking medication cautionary. Medications with parameters a blood pressure and pulse must be taken before administering education. Director of Nursing or designee will audit 5 charts weekly 4 weeks then monthly X 90 days and thereafter for medication parameters. Pharmacy consultant will observed 3 nurses monthly X 90 days and thereafter for medication administration focusing on medication parameters. All licensed nurses will be observed for medication administration competency upon hire and every year and as needed. Licensed nurses was re in serviced to check the placement and patency of suprapubic catheter, failed to provide suprapubic catheter care every shift and failed were counselled and re in-service on documentation after providing care, treatment and documentation of total output in each shift. Unit Manager or designee will audit 5 charts every week X 4 weeks and monthly x90 days for Omission of signatures in the (ETAR). Pharmacy Consultant or designee will review all charts monthly x 6 months and	

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F 658	Continued From page 7 On 3/8/23 at 11:36 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who was currently the transitional nurse Unit Manager (UM), because the previous UM was let go last Friday 3/3/23. The ADON stated he was very familiar with the residents on the Ex Order 26. 4B1 floor including Resident #67. The ADON stated the resident was soft spoken, awake and alert, and didn't ask for much. The ADON stated he would get report in the morning from the night nurse, and the nurse did not report anything in particular that morning regarding Resident #67, and that during his rounds Resident #67 did not make him aware of any concerns or issues either, including having trouble sleeping. On 3/08/23 at 11:46 AM, the surveyor and the DON reviewed Resident #67's physician's orders (PO) as well as their electronic Medication Administration Record (eMAR). The ADON acknowledged the resident did not have an order for a Ex Order 26. 4B1. Together the surveyor and the ADON reviewed the social service Progress Note from the IDCP meeting dated NJ Exec. Order 26:4B which revealed the NP was made aware to prescribe a Ex Order 26. 4B1. The ADON stated the NP comes Monday, Wednesday and Friday, but he would call the NP now to request an order. The ADON stated he had not attended the IDCP meeting, but the nurse who was present should have followed up on the request for a Ex Order 26. 4B1, especially since it was discussed at the meeting. On 3/08/23 at 12:15 PM, the surveyor interviewed the facility's Licensed Social Worker (LSW) who stated she met with residents upon admission to complete their initial assessment, advocate for them during their stay, and organized the care plan meetings. The LSW stated she was familiar	F 658	thereafter on nurse's omission of signatures in the (ETAR) and transcription of orders. Disciplinary action will be imposed following facility policy. Licensed nurses were re in serviced on Policy and Procedure for transcription of medication orders. A prescription of controlled substances will be faxed and called in to the pharmacy. A receiving nurse will enter the order to the Electronic Medical Record (Physician's Order). Unit manager or designee will audit 5 charts weekly x 4 weeks X 90 days for new orders in morning clinical meeting. ADON and designee will perform 24 hour daily x 4 weeks, then monthly x 90 days. Charts will be check to ensure all physician orders are being transcribed accordingly. Director of Nursing or designee will audit 5 charts weekly x 4 weeks then monthly X 90 days for transcription of new prescriptions. 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 as indicated. Adverse findings will be immediately	

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F 658	Continued From page 8 with Resident #67 because she was the resident's Ambassador, that an Ambassador was assigned to a group of rooms or residents and would oversee the resident's overall happiness with their stay. The LSW stated the resident had not expressed to her they were having trouble sleeping. A review of the LSW's notes revealed on [NJ Exec. Order 26:4.b.1] the resident had reported he/she was having trouble sleeping, the LSW stated but that's to be expected upon admission because of new setting and surroundings just coming from the hospital. The surveyor and LSW reviewed the IDCP meeting notes dated [NJ Exec. Order 26:4.b.1] which revealed the medication list and orders were reviewed, and included the resident had difficulty sleeping and the NP made aware to prescribe a [Ex Order 26. 4B1]. The LSW stated the nurse who was present at the meeting had been the ADON. The LSW stated all the staff present at the meeting would all be responsible for following up with the NP to ensure a [NJ Exec. Order 26:4.b.1] was ordered. The SW acknowledged based on the notes in the meeting, someone should have followed up with the NP to ensure a [Ex Order 26. 4B1] was ordered. On 3/8/23, at 1:29 PM, the surveyor interviewed the NP who stated she had been coming to the facility just over two years now, about three times a week. The NP stated she does not attend the IDCP meetings but the staff makes her aware of what's discussed. The NP stated she was familiar with Resident #67 and one of their main complaints has been not being able to sleep. The trouble sleeping was not new, they had trouble sleeping at home as well, they didn't want anything too strong so she wrote a physical prescription for the resident to receive [Ex Order 26. 4B1] [redacted] on [NJ Exec. Order 26:4.b.1] The NP further stated the facility called her today,	F 658	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. March 31, 2023	

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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**

(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 658	Continued From page 9 and said they had found the script still in Resident #67's medical chart and the prescription hadn't been filled. The NP stated when she saw the resident on [NJ Exec. Order 2] and the resident reported they had slept great, she assumed the resident had received the [Ex Order 26. 4B1] as ordered. The NP stated it was her process to review each resident's medication orders, and didn't notice the [Ex Order 26. 4B1] had not been ordered. The NP stated the facility informed her they had the script and they were going to fill it today. She was not aware the resident was still not sleeping well. On 3/9/23 the DON provided a copy of the original prescription dated [NJ Exec. Order 26.4] for Resident #67 for [Ex Order 26. 4B1]. On 3/9/23 at 9:51 AM, the surveyor re-interviewed the ADON, who stated he had called the NP who informed him, she had given the prescription for [Ex Order 26. 4B1] to the Director of Nursing (DON). The process should be the NP or nurse should have put the order into the computer, then they should fax it to the pharmacy, then ensure it was received by pharmacy. [Ex Order 26. 4B1] is a medication that we keep in the backup stock, if the UM had entered the order into the computer, then the procedure would be to use the backup stock if the medication was not received in time for the dose to be given. No one knew the order was written, because it was not in the computer so the resident did not receive the medication. The DON should have followed up, maybe asking how the resident slept. There was also nothing on the 24 hour report that should have reflected any new orders for a new medication, its up to the UM to keep that 24 hour report updated. The ADON was unable to produce a copy of the 24 hour report for that time period.	F 658		

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F 658	Continued From page 10 On 3/9/23 at 1:33 PM, the survey team met with DON and Licensed Nursing Home Administrator (LNHA). The DON stated she remembered the NP handed her the prescription for the [redacted] the DON then walked to the [redacted] floor gave the prescription to the UM and told her she needed to fax it to the pharmacy and it needed to be entered into the resident's eMAR, then she left the floor thinking the UM had completed the task. The DON acknowledged the nurse didn't enter the order into the eMAR and the resident didn't receive the medication. The DON stated the nurse should have faxed the prescription, because this medication was controlled, to pharmacy then entered the order into the computer then called the pharmacy to ensure the pharmacy received the prescription. The DON further stated when she followed up with the NP the next day the resident told the NP they had slept well, so nobody checked or ensured the medication was ordered and given to the resident. A review of the facility's "Physician Medication Orders" policy dated last reviewed 6/22, included...Placing medication orders: The Charge Nurse or Director of Nursing Services shall call-in the order for all prescribed medications... On 3/09/23 at 12:52 PM, the surveyors discussed the above concerns with the LNHA and DON. NJAC 8:39-11.2(b); 27.1(a)	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		3/31/23

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F 755	Continued From page 11 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 the facility failed to accurately document the administration of NJ Exec. Order 26:4.b.1 for one resident (Resident #14). This deficient practice was identified on 1 of 2 medication carts reviewed and evidenced by the following:	F 755	Concern F755- D Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	

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F 755	Continued From page 12 On 3/9/23 at 10:26 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN) inspected the [redacted] floor Cart Two. The surveyor and the LPN reviewed the narcotic medication located in the secured and locked narcotic box. When the narcotic medication inventory was compared to the to the corresponding declining inventory sheet, the surveyor identified Resident #14's *Ex Order 26. 4B1* tablets, a medication used for [redacted], did not match. The *Ex Order 26. 4B1* contained 22 tablets and the declining inventory sheet indicated there should be 23 tablets remaining. The LPN stated she had given Resident #14 a tablet prior to *Ex Order 26. 4B1* this morning. The LPN stated she should have signed and documented on the declining inventory sheet immediately after she removed the medication from inventory. On 3/09/23 at 10:45 AM, the surveyor interviewed the third floor Registered Nurse Unit Manager (UM/RN) who stated when the nurse removed the pill from the package, they then need to signs the declining inventory sheet at that time. Once the medication is administered then they sign the Medication Administration Record (MAR). Signing the declining inventory sheet indicated the medication was removed from inventory and then signing the MAR means the medication was administered to the patient. The UM/RN stated the LPN should have signed the declining sheet immediately after removing the medication from the card. On 3/9/23 at 1:43 PM, in the presence of the survey team and the Licensed Nursing Home Administrator the Director of Nursing stated the nurse should immediately sign for the medication	F 755	Based on observation, interview, and record review it was determined the facility failed to accurately document the administration of NJ Exec. Order 26:4.b.1 for one resident (Resident #14). This deficient practice was identified on 1 of 2 medication carts reviewed LPN reviewed the narcotic medication located in the secured and locked narcotic box. When the narcotic medication inventory was compared to the to the corresponding declining inventory sheet, the surveyor identified Resident #14's *Ex Order 26. 4B1* tablets, a medication used for [redacted], did not match. The blister pack contained 22 tablets and the declining inventory sheet indicated there should be 23 tablets remaining. The LPN stated she had given Resident #14 a tablet prior to *Ex Order 26. 4B1* this morning. The LPN stated she should have signed and documented on the declining inventory sheet immediately after she removed the medication from inventory. How the corrective action will be accomplished for any resident affected by deficient practice. Resident # 14 was assessed with no significant changes. Affected LPN was counselled regarding failure to document or signed the declining inventory sheets when *Ex Order 26. 4B1* was taken from the bingo card.	

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F 755	Continued From page 13 on the declining inventory sheet, after removing the medication from inventory. The declining inventory sheet was used for accountability of the medications and to ensure the resident received the medication when the nurse signed the MAR. A review of the facility provided policy "Controlled Substances" with a revised/reviewed date of 6/2022 did not address the facility process for the use of declining inventory sheets for medication reconciliation. NJAC 8:39- 29.2(d)	F 755	Corporate educator performed a competency on 3/14/23 to affected LPN regarding [NJ Exec. Order 26:4.b] medication. The LPN was observed that she will signed and documented on the declining inventory sheet immediately after medication was removed from the bingo card. All residents with orders and receiving Controlled substances were reviewed and narcotics were counted to match the declining inventory sheets to the actual medications left in the bingo cards. No other issues were found. LPN will be med passed once a week for 4 weeks to observed correct process is followed 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. Licensed nursing staff was in-serviced regarding the revised policy and procedure on Administration of Controlled Substances by documenting on the	

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F 755	Continued From page 14	F 755	declining inventory sheet immediately after the medication was removed. LPN will be monitored by the unit manager during the administration of narcotic medication to ensure she signs the declining inventory sheet at the time when the medication is being removed from the blister pack. Don or Adon will be responsible for monitoring the declining inventory sheet multiple times a day for 2 weeks to ensure the count matches the remaining tablets. Monitoring the declining sheet multiple times a day will intel any other discrepancies in timely manner or in real time this will help the facility further educate the nursing staff. Administrator and Don will have scheduled in-services to review policy on medication administration and declining inventory sheet 2 X month for all shifts to ensure proper procedure is followed by all nursing staff. Pharmacy Consultant or designee will observed 3 licensed nurses monthly X 6 months and thereafter for medication administration pass. Regional nurses or designee will review controlled declining forms weekly x 4 weeks and monthly x 6 months and thereafter to ensure facility policy and procedure on controlled medication administration is being followed accordingly. Audits will be monitored for completion by	

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F 755	Continued From page 15	F 755	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. March 31, 2023	

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
315435 Y1	A. Building B. Wing Y2	4/10/2023 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 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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 03/31/2023	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 03/31/2023	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	
3/13/2023	☐ 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
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FAMILY OF CARING HEALTHCARE AT MONTCLAIR	**42 NORTH MOUNTAIN AVE** **MONTCLAIR, NJ 07042**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 03/07/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/07/23 and was found to be in noncompliance 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 Healthcare at Montclair is a three-story building that was built in 1968. It is composed of Type II protected construction. The facility is divided into six smoke zones. The generator does 100 % of the building as per the Maintenance Director. The current occupied beds are 64 of 70. .	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	K 291		3/31/23

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

Electronically Signed | 03/24/2023

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.

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K 291	Continued From page 1 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 64 residents. Findings include: An observation on 03/07/23 at 10:51 AM revealed emergency lighting was not present at the emergency generator transfer switch located in the electrical room on the first floor. The Maintenance Director who was present at the time of the observation confirmed the emergency lighting was not present. NJAC 8:39-31.2(e) NFPA 99, 110 .	K 291	Concern Tag- K291 Emergency Lighting Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110 Standard For Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 64 patients. How the corrective action will be accomplished for any resident affected by deficient practice. The corrective action taken was to have a licensed electrician come and install an emergency light that would illuminate the generator panel in case of power loss. The light was installed on 3/15/23 before the survey team exited the building in accordance with the noted requirements. 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.	

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K 291	Continued From page 2	K 291	Measures to ensure were/will be put into place to assist this area of concern. Maintenance Director was re in serviced On emergency lighting that provides the emergency generator transfer switch. The light was installed and tested for operation in accordance with NFPA 110 Standard For Emergency Power Systems (2010 Edition) Sec.7.3. Maintenance Director and Designee will inspect proper operation of Emergency Generator transfer switch weekly x 90 days and thereafter. Regional Director of Maintenance or designee will inspect monthly x 6 months and thereafter to ensure the operation of the light continues in accordance with the required specifications. How the concern will be monitored and title of person responsible for monitoring. Results of findings will be discussed with the administrator in the morning meeting for immediate resolution. This will be included in monthly QAPI and this will be a part of quarterly Quality Assurance Program. Dates when concern will be completed. March 31, 2023	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		3/15/23

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K 345	Continued From page 3 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 64 residents. Findings include: An observation of the facility smoke detectors on 03/07/23 from 10:25 AM to 12:45 PM revealed smoke detectors were located in the corridors at the smoke barriers, in sleeping rooms, and other concealed areas throughout the building. A review of the untitled facility binder provided by the Maintenance Director contained inspection and testing reports for the fire alarm system for the calendar year 2021 and 2022. The facility fire alarm "Inspection and Testing Reports" dated 08/08/22 and 12/02/21 revealed no reference to a smoke detection sensitivity test. During an interview on 03/06/23 at 12:40 PM, the	K 345	Concern Fire K 345 SS- F Alarm System - Testing and Maintenance K345 CFR(s): NFPA 101 Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm And Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 64 residents. How the corrective action will be accomplished for any resident affected by deficient practice. The corrective action that took place was to schedule an inspection 3/15/23 with a qualified vendor. A full inspection will be conducted and maintained on a bi-yearly schedule. This was scheduled and completed with a	

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K 345	Continued From page 4 Maintenance Director contacted the fire alarm company who verified the fire alarm sensitivity testing was not completed on the fire alarm system and stated his company would send over a quote for the sensitivity testing. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	report. This has been included in the DOH book. This was done on March 15 2023. No 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. Measures to ensure were/will be put into place to assist this area of concern. Maintenance Director was re in-service to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm And Signaling Code (2010 Edition) Section 14.4.5.3.2. Administrator or designee will check maintenance schedule log to ensure smoke detection sensitivity are check very month X 4 months quarterly thereafter to ensure it is scheduled and completed every other year. Regional Maintenance Director will audit Facility Inspection and Sensitive Test every 6 months X 1 year and thereafter. How the concern will be monitored and title of person responsible for monitoring. Results of findings will be discussed with the administrator in the morning meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315435	A. BUILDING **01** B. WING _____	**03/13/2023**

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
K 345	Continued From page 5	K 345	for immediate resolution. This will be included in monthly QAPI and this will be a part of quarterly Quality Assurance Program. Dates when concern will be completed. March 15, 2023	

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 01 - MAIN BUILDING 01 B. Wing	4/10/2023

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 Reg. # NFPA 101 LSC K0291	Correction Completed 03/31/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 03/15/2023	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	
3/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO