STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D35008	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR MANOR	403 CLAREMONT AVENUE 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) COMPLETE DATE
R 000	Initial Comments Complaint #: NJ 00174109 Census: 24 Sample: 3 THE FACILITY IS NOT IN COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE N.J.A.C. 8:37 STANDARDS FOR LICENSURE OF DEMENTIA CARE HOMES.	R 000		
R 016	8:37-1.1(b) Purpose and Scope This chapter is promulgated for the purpose of establishing interim licensing standards for dementia care homes in the State of New Jersey to ensure that they are maintained and operated in such a manner that will protect the health, safety and welfare of its residents and at the same time preserve and promote a home-like atmosphere appropriate to such facilities. This STANDARD is not met as evidenced by: Complaint #: NJ00174109 Based on interview and review of residents' records and pertinent facility documents, it was determined that the facility Administrator failed to implement its policy and procedure on [redacted] assessment and Care Plan (CP) on admission for 1 of 3 residents reviewed, Resident #1 as evidenced by the following: On 5/30/24 at 10 a.m., the surveyor reviewed Resident#1's medical record (MR) which revealed Resident #1 was admitted to the facility on	R 016		

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R 016	Continued From page 1 NJ Ex Order 26. 4B1 [redacted]. The progress notes (PN) dated NJ Ex Order 26.4(b) at 2:30 p.m., and on NJ Ex Order 26.4(at 2:15 p.m., written by a Registered Nurse (RN) documented that the resident was NJ Ex Order 26. 4B1 to person only. Further surveyor review of the resident's PN dated from NJ Ex Order 26.4(b) through NJ Ex Order 26.4(b)(, written by a RN documented on 21 occasions that the resident requested to go home to NJ Ex Order 26. 4B1 [redacted] and did not NJ Ex Order 26.4(b)(1) on the following dates: NJ Ex Order 26. 4B1 [redacted]. However, there was no documented evidence that the NJ Ex Order 26.4(b)(1) assessment was completed on admission, and CP developed with intervention(s) to prevent the resident from NJ Ex Order 26. 4B1 on NJ Ex Order 26. 4B1 . At 11:15 a.m., during interview with Co-owner/RN #1 and the Director of Nursing (DON)/RN #2, both stated that the resident was in NJ Ex O , and that he/she refused to disclose his/her whereabouts to the family and facility. In addition, Co-owner/RN #1, acknowledged that the resident's NJ Ex Order 26. 4B1 assessment was not completed on admission and also confirmed that no care plan was developed to address the resident's NJ Ex Order 26. 4B1 [redacted]. Refer to 8:37-3.1 (a)(12)	R 016		
R 365	8:37-3.1(a)(12) Resident Rights Every resident of a dementia care home shall	R 365		

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R 365	Continued From page 2 have the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident. This STANDARD is not met as evidenced by: Complaint #: NJ 00174109 Based on interview and review of residents' records and pertinent facility documents, it was determined that the facility failed to provide a safe environment for 1 of 3 residents reviewed for [NJ Ex Order 26.4(b)(1)] Resident #1. This deficient practice was evidenced by the following: On 5/30/24 the Department of Health (DOH) investigated a Reportable Event Report (RER) received on [NJ Ex Order 26.4(b)] which occurred on [NJ Ex Order 26. 4B1]. The RER revealed, "On [NJ Ex Order 26. 4B1], approximate time of [NJ Ex Order 26. 4B1] ... can not be NJ Ex Order 26.4(b)(1) and inside and [NJ Ex Order 26.4(] the building. Staff went around [NJ Ex Order 26.4(b)(] him/her in the [NJ Ex Order 26.4(b)(1)] including ... Incident was reported to the [NJ Ex Order 2] at 5:14 p.m., by ... Resident has always has the ideation of going back to [NJ Ex Order] where he/she [NJ Ex Order 26.4(b)(1)] and visit his/her family" On 5/30/24 at 10 a.m., the surveyor reviewed Resident#1's medical record which revealed Resident #1 was admitted to the facility on [NJ Ex Order 26. 4B1]. The progress notes (PN) dated [NJ Ex Order 26.4(] at 2:30 p.m., and on [NJ Ex Order 26.4(] at 2:15 p.m., written by the same Registered Nurse (RN) #3 documented that the	R 365		

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R 365	Continued From page 3 resident was NJ Ex Order 26. 4B1 to NJ Ex Order 26.4(b)(1) The PN dated from NJ Ex Order 26. 4B1 written by RN #1, RN #2 and RN #3 documented on NJ Ex Order 26. 4B1 that the resident requested to go home to NJ Ex Order 26. 4B1 and did not want to be at the facility on the following dates: on NJ Ex Order 26. 4B1 [redacted]. The PN dated NJ Ex Order 26.4(b)(1) at 11:15 a.m., written by RN #3 documented that staff reported the resident was trying to NJ Ex Order 26.4(b)(1). However, there was no documented evidence to show that NJ Ex Order 26. 4B1 assessment was completed and no CP initiated with intervention(s) to prevent the resident from NJ Ex Order 26. 4B1. On NJ Ex Order 26. 4B1 at 11:15 a.m., the surveyor interviewed the facility's Co-owner/RN #1 and the Director of Nursing (DON)/RN #2 regarding the NJ Ex Order 26. 4B1 which occurred on the above date. RN #1 stated that she received a telephone call on NJ Ex Order 26. 4B1 to inform her that Resident #1 was NJ Ex Order 26.4(b) RN #1 stated that she viewed the camera footage on NJ Ex Order 26. 4B1 at approximately 12:30 p.m., she observed the physical therapist leaving the premises through the back gate instead of the front entrance. She stated that the back gate was locked so the physical therapist went to knock on the kitchen door for a staff member to let him out through the back gate. In addition, RN#1 stated that Resident #1 was observed at the kitchen door standing with a walker and the physical therapist then NJ Ex Order 26.4(b) the resident NJ Ex Order 26.4(b)(1) into the courtyard. RN #1 stated a kitchen Aide (KA) then opened the	R 365		

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R 365	Continued From page 4	R 365		

back gate from the inside of the building for the physical therapist to leave. RN #1 explained that either the KA forgot to lock the gate from the inside or the gate did not latch properly when the physical therapist exit the back gate. RN #1 stated that the [redacted] after the physical therapist left from the gate.

During continued interview, RN#1 stated that Resident #1 was in [redacted] but was not sure of the resident's [redacted] because the resident refused to disclose his/her [redacted] to anyone including the resident's family.

The timeline provided by RN#1, dated [redacted] revealed Resident #1 [redacted] from the facility on [redacted] at 12:30 p.m., but the facility staff was not aware that the resident was missing until 3:30 p.m., during round. A total of [redacted].

At 11:45 a.m., the surveyor interviewed the KA who stated that the physical therapist came through the kitchen door and asked to be let out through the back gate. The KA stated that she unlocked the gate from the inside for the therapist but could not recall if she locked the gate after the therapist went through the gate or not. The KA explained that she did not physically go outside to ensure the back gate was properly latched and also did not recall seeing Resident #1 [redacted]. The KA stated she was the only one in the kitchen at the time and was busy preparing lunch for the residents.

The [redacted] note provided by RN #1 later, dated [redacted] and [redacted], indicated that the resident was [redacted] and with complaint about [redacted] in [redacted] and that he/she [redacted]. The

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R 365	Continued From page 5 surveyor did not observe documented evidence of intervention(s) put in place to address the resident's risk of [NJ Ex Order 26. 4B1] and to ensure the resident was safe during his/her stay at the facility. The surveyor reviewed the facility policy titled, "Notice of Resident Rights" no date, which revealed, 12). "A safe and decent living environment ..." On 5/30/24 at 12:18 p.m., the surveyor requested a removal plan from the Co-owner RN #1 for failure to ensure Resident #1's safety while resided at the facility and failure to complete an [NJ Ex Order 26. 4B1] assessment and CP to address the resident's [NJ Ex Order 26. 4B1] risk. On 6/3/24, the surveyor received a revised removal plan from the facility via email and the removal plan was acceptable.	R 365		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
D35008		7/21/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR MANOR	403 CLAREMONT AVENUE 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 R0016 Reg. # 8:37-1.1(b) LSC	Correction Completed 06/30/2024	ID Prefix R0365 Reg. # 8:37-3.1(a)(12) LSC	Correction Completed 06/30/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 5/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			