STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. BUILDING _____ B. WING _____	C 04/05/2024

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F 000	INITIAL COMMENTS Complaint #s NJ160655, NJ168170, NJ171858, NJ172270 STANDARD SURVEY: 4/1-4/5/2024 CENSUS: 47 SAMPLE SIZE: 12 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure the resident's call light was readily accessible. The deficient pratice was identified for 1 resident (#34) of 9 reviewed for accommodation of need and evidenced by the following. On 4/01/24 at 10:05 AM and 04/02/24 9:20 AM the surveyor observed the resident [NJ Ex Ord] in bed with eyes open. The residents' speech was	F 558	F558 1. Resident #34 call light cord was placed within reach of the resident when in bed. 2. All residents have the potential to be affected by this deficient practice of not having the call light cord within reach. 3. All nursing staff was re-educated on call lights to ensure they are within reach of residents when they are in bed. DON/Designee will randomly check 4 resident rooms weekly for 12 weeks to	5/10/24

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

Electronically Signed | 04/22/2024

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F 558	Continued From page 1 NJ Ex Order 26.4. On both days the call light cord was tied to the right hand rail, hanging down, and resting on the floor. A review of the medical record revealed the following information. The Admission Record indicated the resident had NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The Quarterly Minimum Data Set (MDS) assessment tool indicated the resident had NJ Ex Order and NJ Ex Order 26.4b1. On 4/03/24 at 11:38 AM the surveyor interviewed Certified Nursing Assistant #1 (CNA #1) who confirmed the call bell should be within reach of the resident. On 4/03/24 at 11:39 AM the surveyor interviewed CNA #2 who was the regular CNA for the resident and had not been worked on 4/1/24 and 4/2/24. She stated she always puts the call bell in the resident's hand. On 4/03/24 at 1:26 PM the surveyor discussed the inaccessibility of the the call light cord for Resident #34 with the Director of Nursing and the Administration. On 4/04/24 at 10:26 AM the Administrator responded that nurses and CNAs were educated to check call bell placement more frequently. NJAC 8:39-27.1(a); 4.1	F 558	ensure call light cords are within reach of residents while they are in bed. 4. Administrator/Designee will randomly check 3 resident rooms weekly for 2 months to ensure call light cords are within reach of residents while in bed. 5. All findings will be presented for review at the next 2 QAPI meetings.	

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) assessment for 1 of 12 residents reviewed (Resident #34). The deficient practice was evidenced by the following. On 4/1/24 at 10:05 AM, the surveyor observed the resident in bed receiving NJ Ex Order 26.4b1 [redacted]. A review of the medical record revealed the following information. The Admission Record included diagnoses of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The Nursing Progress Note of NJ Ex Order 26.4b1 at 10:01 AM indicated the resident was transferred to the hospital for a planned NJ Ex Order 26.4b1	F 637	F637 1. Resident #34 had a significant change MDS assessment initiated on NJ Ex Order 26.2[redacted]. 2. All residents have the potential to be affected by this deficient practice of omitting the required assessments. 3. MDSC was re-educated on all required types of MDS assessments. DON/Designee will review 2 medical records weekly for 2 months to ensure all appropriate MDS assessments is being submitted. 4. Regional MDS/Designee will review 1 clinical record a week for 2 months to ensure all appropriate MDS assessments are being submitted. 5. All findings will be presented for review at the next 2 QAPI meetings.	5/10/24

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F 637	Continued From page 3 NJ Ex Order 26.4b1. The Nursing Progress Note of NJ Ex Order 26.4b1 at 10:39 AM indicated the resident was re-admitted to the facility after having had a NJ Ex Order 26.4b1. The tracking of completed MDS assessments listed a Discharge Return Anticipated on NJ Ex Order 26.4 (indicating when the resident was transferred to the hospital for NJ Ex Order 26.4b1), an Entry on NJ Ex Order 26.4 (indicating when the resident was readmitted from the hospital), and a Medicare - 5 Day on NJ Ex Order 26.4. On 4/3/24 at 10:20 AM, the surveyor interviewed the MDS Coordinator (MDSC) on the telephone. The MDSC explained that when the resident was readmitted with a new NJ Ex Order 26.4b1 on NJ Ex Order 26.4 he should have completed a SCSA assessment along with the 5 day MDS. He stated he made a mistake. On 4/3/24 at 1:41 PM the surveyor discussed the omission of a SCSA with the Administrator and the Director of Nursing (DON).	F 637		
F 640 SS=E	NJAC 8:39-11.2(i) Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.	F 640		5/10/24

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(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and

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F 640	Continued From page 5 approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to complete and submit electronically the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within 14 days of completing the resident's assessment and in accordance with the Center's for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. This deficient practice was identified for 14 residents sampled (Resident #11, 16, 22, 26, 27, 33, 36, 39, 50, 117, 9, 30, 45, and #41) and reviewed for resident assessment. According to the Long-Term Care RAI 3.0 User's Manual Version 1.18.11, updated October 2023, the MDS is a comprehensive tool and a federally mandated process for clinical assessment of all residents. It must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. This deficient practice was evidenced by the following: On 4/3/24, at 2:35 PM, the survey team reviewed the facility task that included residents' MDS assessments, which was triggered under the survey facility task as "MDS record over 120 days old." 1. Resident #11's medical record review in the Electronic Health Record (EHR) reflected an Annual MDS (AMDS) with an Assessment Reference Date (ARD) of	F 640	F640 1. Resident #11 MDS assessment was submitted [redacted] Resident #16 MDS assessment was submitted [redacted] Resident #22 MDS assessment was submitted [redacted] Resident #26 MDS assessment was submitted [redacted] Resident #27 MDS assessment was submitted [redacted] Resident #33 MDS assessment was submitted [redacted] Resident #36 MDS assessment was submitted [redacted] Resident #39 MDS assessment was submitted [redacted] Resident #50 MDS assessment was submitted [redacted] Resident #117 MDS assessment was submitted [redacted] Resident #9 MDS assessment was submitted [redacted] Resident #30 MDS assessment was submitted [redacted] Resident #45 MDS assessment was submitted [redacted] Resident #41 MDS assessment was submitted [redacted] 2. All residents have the potential to be affected by this deficient practice of not completing and submitting MDS assessments in a timely manner. 3. MDSC was re-educated on completing and submitting MDS assessments in a timely manner.	

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F 640	Continued From page 6 [redacted], was due to be transmitted to CMS no later than [redacted]. However, the AMDS was not submitted to CMS and still in progress. 2. Resident #16's medical record review in the EHR reflected a Quarterly MDS (QMDS) with an ARD of [redacted] was due to be transmitted to CMS no later than [redacted]. However, the QMDS was not submitted to CMS and still in export ready. 3. Resident #22's medical record review in the EHR reflected a QMDS with an ARD of [redacted], was due to be transmitted to CMS no later than [redacted]. However, the QMDS was not submitted to CMS and still in progress. 4. Resident #26's medical record review in the EHR reflected a QMDS with an ARD of [redacted], was due to be transmitted to CMS no later than [redacted]. However, the QMDS was not submitted to CMS and still in progress. 5. Resident #27's medical record review in the EHR reflected a QMDS with an ARD of [redacted], was due to be transmitted to CMS no later than [redacted]. However, the QMDS was not submitted to CMS and still in progress. 6. Resident #33's medical record in the EHR reflected a Significant Change MDS (SCMDS) with an ARD of [redacted], was due to be transmitted to CMS no later than [redacted]. However, the SCMDS was not submitted	F 640	DON/Designee will review 3 assessments weekly for 2 months to ensure all MDS assessments is being submitted on time. 4. Administrator/Designee will review 2 assessments a week for 2 months to ensure all MDS assessments are being submitted on time. 5. All findings will be presented for review at the next 2 QAPI meetings.	

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F 640	Continued From page 7	F 640		

to CMS and
still in progress.

7. Resident #36's medical record review in the EHR reflected a QMDS with an ARD of [NJ Ex Order 2] was due to be
transmitted to CMS no later than [NJ Ex Order 2]. However, the QMDS was not submitted to CMS and still in progress.

8. Resident #39's medical record review in the EHR reflected a QMDS with an ARD of [NJ Ex Order 2] was due to be
transmitted to CMS no later than [NJ Ex Order 2]. However, the QMDS was not submitted to CMS and still in progress.

9. Resident #50's medical record review in the EHR reflected a QMDS with an ARD of [NJ Ex Order 2], was due to be
transmitted to CMS no later than [NJ Ex Order 2]. However, the QMDS was not submitted to CMS and still in progress.

10. Resident #117's medical record review in the EHR reflected an Admission/5Day MDS with an ARD of [NJ Ex Order 26], was due to be transmitted to CMS no later than [NJ Ex Order 2]. However, the Admission/5Day MDS was not submitted
to CMS and still in progress.

On 4/3/24 at 10:18 AM, the survey team interviewed the MDS coordinator on the telephone. He stated, "The Admission/5 Day MDS should not be "in progress." An MDS with an ARD of [NJ Ex Order 26] should be completed by [NJ Ex Order 2] and submitted per MDS regulations 14 days later."

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On 4/3/24 at 1:38 PM, another surveyor discussed with the License Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Representative concerns about Resident #117's late completion and submission.

11. The surveyor reviewed the medical record for Resident #9.

A review of the MDS submissions revealed that there was a Quarterly MDS submission dated [NJ Ex Order 26.4] "in progress" which was 33 days overdue for submission. The last MDS submission was dated [NJ Ex Order 26.4b] indicating that the MDS was over 120 days old.

12. The surveyor reviewed the closed medical record for Resident #30.

A review of the MDS submissions revealed that there was a Quarterly MDS submission "in progress" dated [NJ Ex Order 26.4] which was 32 days overdue for submission. The last MDS submission was dated [NJ Ex Order 26.4b] indicating that the MDS was over 120 days old.

13. The surveyor reviewed the closed medical record for Resident #45.

A review of the electronic Progress Notes (ePN) revealed that the resident was admitted to the hospital on [NJ Ex Order 2].

A review of the MDS submissions revealed that there was a discharge return anticipated "in

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progress" dated [NJ Ex Order 2] which was 41 days overdue.

On 4/3/24 at 2:13 PM, the survey team met with the facility Administrative team to review the MDS submissions that were "in progress." The Regional Director of Operations (RDO) stated that the previous MDS Coordinator had not been working for a while for a personal reason and then had resigned which caused a backup in submissions. The RDO added that currently the MDS submissions were being done by an agency. The RDO also stated that he had not realized how far behind the MDS submissions were.

14. Resident #41's medical record review in the EHR reflected a QMDS with an ARD of [NJ Ex Order 26.4], which was due to be transmitted to CMS no later than [NJ Ex Order 2]. However, the QMDS was not submitted to CMS and is still in progress.

On 4/3/24 at 2:22 PM, the survey team discussed the late MDS assessments in [NJ Ex Order 26.4b1] with the LNHA, Regional Director of Operations, RN/DON, and incoming DON. The Regional Director of Operations stated that they were ready to outsource hiring and training a new nurse for the MDS position. He added that during that time in [NJ Ex Order 26.4b1], the MDS Coordinator was sick and resigned in [NJ Ex Order 26.4b1].

On 4/4/24 at 10:45 AM, the facility offered no further information other than MDS completions and late submissions due to a lack of staffing.

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F 640	Continued From page 10 On 4/4/24 at 1:25 PM, the survey team met with the facility Administrative team. There was no further documentation provided by the facility regarding the MDS late submissions. On 4/5/24 at 9:19 AM, the surveyor reviewed the facility policy and procedure titled Timeframe for Completion of the MDS, revised June 2023, reflected "To complete the standardized resident assessment instrument...according to federal and state regulatory requirements."	F 640		
F 641 SS=D	NJAC 8:39 - 11.1 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, accurately for 2 of 12 residents reviewed (Resident #41, and #116). The deficient practice was evidenced by the following: 1. On 4/2/24 at 11:14 AM, the surveyor observed Resident #41 sitting in the wheelchair, who returned from the activity room, and was wheeled by the staff.	F 641	F641 1. Resident #41 MDS had his/her section C and D completed [NJ Ex Order 26.4b] for the ARD [NJ Ex Order 26.4b]. Resident # 116 is no longer a resident of the facility. 2. All residents have the potential to be affected by this deficient practice of not completing an accurate assessment. 3. MDSC, SW, DOR, and Dietitian were re-educated on completing accurate assessments. DON/Designee will review 3 assessments weekly for 2 months to ensure all MDS assessments are accurately assessed.	5/10/24

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F 641	Continued From page 11 The surveyor reviewed Resident #41's hybrid (combination of paper and electronic) medical record as follows: The Admission Record (an admission summary) documented that Resident #41 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 . The resident's most recent Annual MDS (AMDS) assessment, dated NJ Ex Order 26.4b1, reflected that Resident #41 had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, indicating NJ Ex Order 26.4b1 . The AMDS with an ARD of NJ Ex Order 26.4b1 Section D Resident Mood Interview (PHQ-9), signed by the MDS Coordinator (MDSC)/Registered Nurse (RN) on NJ Ex Order 26.4b1, revealed the assessment record written in a paper copy of "Section C NJ Ex Order 26.4b1 Patterns" was given and done by the Social Worker (SW). The document revealed that the interview with the handwritten date of "NJ Ex Order 26.4b1" was done five (5) days before the ARD of NJ Ex Order 26.4b1. On 4/3/24 at 10:03 AM, the surveyor interviewed the MDSC/RN over the phone, who left the position on NJ Ex Order 26.1. The MDSC/RN revealed that he was completing all sections except K, the dietitian, part of Section O, and GG, the rehab, while sections C, D, E, & Q for the SW. If the SW cannot complete it that day, he will put sections C, D, E, and Q in MDS. The interview process for PHQ-9 should be done within a 7-14-day lookback period on the ARD. On 4/4/24 at 10:08 AM, the surveyor interviewed SW regarding the assessment process of PHQ-9. The SW stated she did the assessment early on	F 641	4. Regional MDSC /Designee will review 2 assessments a week for 2 months to ensure all MDS assessments are accurately assessed. 5. All findings will be presented for review at the next 2 QAPI meetings.	

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F 641	Continued From page 12	F 641		

NJ Ex Order 26.4b1 before the ARD of NJ Ex Order 26.4b1 because she didn't realize that she couldn't do it earlier than the ARD date.

2. The surveyor reviewed Resident #116's hybrid medical record, who no longer resided in the facility, which revealed.

The AR documented that Resident #116 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 .

The resident's most recent AMDS assessment, dated NJ Ex Order 2, reflected that Resident #116 had a BIMS score of NJ out of 15, indicating NJ Ex Order 26.4b1 . Section O Special Treatments, Procedures, and Programs revealed that Resident #116, the NJ Ex Order 26.4b1 , was "Not assessed/no information."

The electronic NJ Ex Order 26.4b1 record indicated Resident #116 received the NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1 and the NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1 . Both were given in the community (historical).

On 4/4/24 at 10:14 AM, the team of surveyors met with the administration. The director of operations stated that the MDSC/RN did not capture the NJ Ex Order 26.4b1 because it was not in the electronic medical record as yet. The surveyor showed the administration that the NJ Ex Order 26.4 was historical and should be documented in section O of the AMDS assessment.

NJAC 8:39 - 11.1

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F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record record review it was determined that the facility failed to consistently assess a resident's vital signs and NJ Ex Order 26.4b1 prior to leaving and when returning from the NJ Ex Order 26.4b1. The deficient practice was identified for 1 of 1 resident, #117, reviewed for NJ Ex Order 26.4b1 and services and is evidenced by the following. On 4/1/24 at 10:01 AM, the surveyor observed the resident seated in a side chair in their room. The resident stated they go to the NJ Ex Order 26.4b1 NJ times a week. The resident stated the Certified Nurse Assistant (CNA) gets the resident ready and brings the resident down to meet the NJ Ex Order 26.4b1. The resident stated the nurse does not assess the resident before leaving or when returning from the NJ Ex Order 26.4b1. 04/2/24 at 1:15 PM, the surveyor observed the resident in their room talking with the CNA. At 1:30 PM the CNA brought the resident out of the room and into the hallway. The Licensed Practical Nurse (LPN) inquired if the resident had their NJ Ex Order 26.4b1, the resident replied, and the CNA brought the resident into the elevator. The LPN did not assess the resident's vital signs or assess the NJ Ex Order 26.4b1	F 698	F698 1. Resident #117 is no longer a resident in the facility. 2. All hemodialysis residents have the potential to be affected by this deficient practice of not assessing their vital signs and access site prior to leaving for dialysis and upon returning from dialysis. 3. All nurses were re-educated on assessing residents vital signs and access site prior to leaving for dialysis and upon returning from dialysis. Nursing Supervisor/Designee will randomly check 2 residents on dialysis weekly for 2 months to ensure their vital signs and access site prior to leaving for dialysis and upon returning from dialysis. 4. DON/Designee will randomly check 1 resident on dialysis weekly for 2 months to ensure their vital signs and access site prior to leaving for dialysis and upon returning from dialysis. 5. All findings will be presented for review at the next 2 QAPI meetings.	5/10/24

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F 698	Continued From page 14	F 698		

NJ Ex Order 26.4b1 .

A review of the medical record revealed the following information.

The Admission Record indicated the resident was admitted in NJ Ex Order 26.4b1 with diagnoses including, but not limited to, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 2 .

The NJ Ex Order 26.4 Admission Minimum Data Set (MDS) assessment tool coded the resident to have NJ Ex (the Brief Interview for Mental Status (BIMS) scored NJ Ex of a possible 15).

The Order Recap Reports for NJ Ex Order 2 and NJ Ex Ord included physician orders for NJ Ex Order 26.4b1 times a week on NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1, blood pressure every shift on NJ Ex Order 26.4b1, and monitor NJ Ex Order 26.4b1. There were no orders for vitals signs and assessment of the NJ Ex Order 26.4b1 to be performed prior to leaving for the NJ Ex Order 26.4b1 or upon returning from the NJ Ex Orde.

The electronic Nursing Progress Notes from the day of admission through NJ Ex Order 2 revealed that of 30 days of visits to the NJ Ex Order 26.4b1, nurses documented 1 day (NJ Ex Order 26.4) for both pre and post NJ Ex Order 26.4 assessments. Nurses documented on 5 days for post NJ Ex Order 26.4 assessments.

On 4/3/24 at 8:27 AM the Director of Nuring (DON) provided the surveyor with the Dialysis policy and procedure, reviewed June 2023. Step 4 of Process Pre-Dialysis Care instructed staff to assess/evaluate the access site prior to transport to dialysis facility. Step 1 of Process

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F 698	Continued From page 15 Post-Dialysis Care instructed staff to assess the site upon return to the facility. On 4/3/24 at 9:42 AM the surveyor interviewed the Infection Preventionist (IP). She stated nurses should document pre and post [redacted] assessments of the patient in the electronic Nursing Progress Notes. On 4/3/24 at 1:38 PM the surveyor discussed with the Administrator and DON concerns regarding inconsistent nurse documentation of assessments of the [redacted] and vital signs when the resident leaves for and returns from the [redacted]. On 4/4/24 at 10:28 AM the Administrator responded that nursing was educated to do pre/post vitals and [redacted] checks and to document them in the electronic Nursing Progress Notes. NJAC 8:39-27.1(a); 2.9	F 698		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and	F 711		5/10/24

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F 711	Continued From page 16 §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) assure that the physician responsible for supervising the care of residents signed and dated monthly physician's orders. This deficient practice was observed for 3 of 12 residents reviewed (Resident #41, #58 and #45), b.) document Physician Progress Notes (PPN) at least every 60 days with alternating Nurse Practitioner (NP) visits for 1 of 12 residents reviewed (Resident #45), and c.) document physician progress notes that reflect the physician's decisions about the continued appropriateness of the resident's current medical regimen for 1 of 12 resident reviewed (Resident #28). The deficient practices were evidenced by the following: 1. On 4/2/24 at 11:14 AM, the surveyor observed Resident #41 sitting in the wheelchair, returning from the activity room, wheeled by the staff. The surveyor reviewed Resident #41's hybrid medical records (paper and electronic). According to the Admission Record (an admission summary), Resident #41 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 [redacted]	F 711	F711 1. Resident #41 monthly medication review was signed by the Physician on NJ Ex Order 2[redacted] Resident # 58 monthly medication review was signed by the Physician om NJ Ex Order 26.4[redacted] Resident # 45 is no longer in the facility. Resident # 28 physician monthly progress note was completed on NJ Ex Order 2[redacted] 2. All residents have the potential to be affected by this deficient practice of not having the monthly medication review signed by the Physician 3. All Physicians were reeducated on the requirement to review and sign the monthly medication review and on the requirement of monthly visits. DON/Designee will randomly check 5 residents charts monthly for 6 months to ensure the physician are visiting their residents and documenting the visits and that monthly medication review is being completed. 4. Administrator/Designee will randomly check 3 residents charts monthly for 6 months to ensure the physician are visiting their residents and documenting the visits and that monthly medication review is being completed. 5. All findings will be presented for review at the next 2 QAPI meetings.	

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The surveyor reviewed the Order Summary Report (OSR) for Resident #41 which revealed the physician did not sign and date the monthly OSR for NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b [redacted], and NJ Ex Order 26.4b1.

On 4/2/24 at 1:11 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) and stated that the physician comes to the facility every other day and should sign the monthly orders electronically using their password.

2. The surveyor observed Resident #58 awake and NJ Ex Or [redacted] in bed on 4/1/24 at 10:00 AM.

The surveyor reviewed the medical record of Resident #58 which revealed the following information.

The resident was admitted in NJ Ex Order 26.4b1 with diagnoses including, but not limited to, NJ Ex Order 26.4b1 [redacted].

The NJ Ex Order 26.4b1 Clinical Physician Orders including the following statement: "Next Order Review NJ Ex Order 26.4b1 - 63 Days Overdue".

A further review of the hybrid medical failed to reveal the physician had signed monthly physician orders for NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

On 4/03/24 at 2:34 PM the Administrator confirmed that the resident had no monthly physician's orders signed.

On 4/04/24 at 10:00 AM the Administrator stated

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the physician has frequently visited residents and has his own log in for the electronic medical enabling him to sign monthly orders electronically, however, no reason was given for why the physician did not sign monthly orders for NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

3. The surveyor reviewed the closed medical record for Resident #45.

A review of the resident's Admission Record (a summary of information about the resident) revealed diagnoses that included but were not limited to NJ Ex Order 26.4b1, NJ Ex Orde and NJ Ex Order 26.4b1.

A review of the Order Review History revealed that monthly physician orders (PO) were electronically signed by the primary physician for the months of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. There was no other monthly PO signed by the primary physician.

A review of the electronic Progress Notes (ePN) revealed that the latest entry of a "Physician Note" by the primary physician was dated NJ Ex Order 26.4 as a "Late Entry." The next primary physician entry was dated NJ Ex Order 26.4b1.

On 4/3/2024 at 2:13 PM, the survey team met with the facility Administrative team. The Regional Director of Operations (RDO) stated that the physicians documented electronically. The RDO added that some physicians had their own computer software and transferred their reports to the facility electronic progress notes.

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The RDO stated that he was unaware that the physician progress notes were not entered.

4. On 4/2/2024 at 12:30 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #28.

A review of the resident's AR revealed diagnoses that included but were not limited to NJ Ex Order 26.4b1 NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1

A review of the progress notes in the EMR revealed that the latest entry of a "Physician Note" by the attending physician was dated NJ Ex Order 26.4b1 as a "Late Entry" with a created date of NJ Ex Order 26.4b1. There were no further entries of "Physician Note" by the attending physician between that date and NJ Ex Order 26.4b1. Further review of the progress notes revealed that the "Physician Note" with dates of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 were also "Late Entry" with a created date of NJ Ex Order 26.4b1 for each.

On 4/3/2024 at 2:13 PM, the survey team met with the facility administrative team. The Director of Nursing (DON) stated he was unaware of missing progress notes and did not know why there were missing progress notes and that the attending physician comes to the facility monthly.

On 4/4/24 at 10:08, the survey team met with the

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administrative team. The RDO stated that he had reached out to the physicians regarding signing their physician orders and entering their progress notes. The RDO added that the physicians have been to the facility and communicate with the nurses frequently but had not documented. The RDO also stated that each physician has their own login to the electronic computer system that the facility uses. The RDO added that he had been checking from time to time that the physicians were documenting and was giving them a courtesy reminder. The RDO stated that the physicians were to do recapitulations and sign the monthly PO at the beginning of the month and complete progress notes when they performed their visits.

On 4/4/24 at 1:25 PM, the survey team met with the administrative team. There was no further documentation provided by the facility.

A review of the facility policy dated as reviewed June 2023, titled "Medication Orders" provided by the Licensed Nursing Home Administrator revealed "The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders." Further review of the policy revealed under "Supervision by a Physician" that "1. Each resident must be under the care of a Licensed Physician authorized to practice medicine in this state and must be seen by the Physician at least every sixty (60) days." In addition, "4. Physician Orders/Progress Notes must be signed and dated every thirty (30) days. (Note: This may be changed to every sixty (60) days after the first ninety (90) days of the resident's admission, provided it is approved by the Attending Physician and the Utilization Review Committee.)"

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F 711	Continued From page 21	F 711		
F 726 SS=E	NJAC 8:39-23.2(b)(d) Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726		5/10/24

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F 726	Continued From page 22 Based on interview and record review it was determined that the facility failed to ensure that 5 of 5 licensed nurses were assessed to have the required competencies to meet the care needs of residents residing at the facility. The deficient practice is evidenced as follows. On 4/04/24 at 10:44 AM the surveyor requested from the Director of Nursing (DON) 5 randomly selected nurses' annual nurse competencies. Later that day the DON provided 5 Nursing Performance Appraisals for the 5 nurses. The Appraisals did not address specific nursing tasks. Many of the Appraisals covered non-care areas, such as "demonstrates knowledge of resident's bill of rights, completing the 24 hour report, maintaining residents' dignity, responding to residents' calls for assistance, ensures safety of personal possessions, willing to work under supervision, knowledge with carrying out daily nursing tasks, applies restraints according to manufacturers instruction and plan of care, and carry out proper infection control techniques." The Appraisals that addressed nursing tasks failed to list the specific required steps required to complete the task competently. On 04/04/24 at 12:28 PM the DON confirmed that nurse competencies were not done for any of the nurses employed at the facility. The DON stated that going forward nurse competencies will be completed for all nurses. On 4/05/24 at 9:48 AM the Administrator confirmed there were no nurse competencies performed by facility administration except for the Medication Pass Observation which is performed by the facility's Consultant Pharmacist.	F 726	F726 1. Annual nursing competencies was initiated on 4/16/24 2. All residents have the potential to be affected by this deficient practice of not assessing the competence of the nurses. 3. HR Director was re-educated on the need for annual competencies for all nursing staff. DON/Designee will randomly audit 3 nursing files a month for 3 months to ensure competencies evaluations are being done. 4. Administrator/Designee will randomly audit 3 nursing files a month for 2 months to ensure competencies evaluations are being done. 5. All findings will be presented for review at the next 2 QAPI meetings.	

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F 726	Continued From page 23 On 4/5/24 the Administrator provided the surveyor with the Staff Performance Evaluation Policy, reviewed June 2023. The second guideline of the policy indicated "an employee should receive a performance evaluation that includes satisfactory demonstration of applicable competencies."	F 726		
F 757 SS=D	NJAC 8:39- 9.3 Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, review of the electronic medical record and other pertinent medical	F 757	F757 1. Resident #28 had his/her [redacted]	5/10/24

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F 757	Continued From page 24 records, the facility failed to ensure that 1 of 5 residents reviewed for unnecessary medications (Resident #28) was free of an unnecessary medication by failing to follow the Consultant Pharmacist (CP) recommendations and failing to provide adequate diagnosis, indications and documentation supporting the use of a medication. The deficient practice was evidenced by the following: On 4/2/2024 at 12:30 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #28. The resident's EMR reflected a physician's order dated NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 [redacted] with directions give one (1) capsule by mouth every twenty-four (24) hours as needed NJ Ex Order 26.4b1. The resident's EMR reflected documentation from the CP dated NJ Ex Order 26.4b1 that reflected a request to "clarify NJ Ex Order 26.4[redacted]." On 04/2/2024 at 1:17 PM the surveyor interviewed the Director of Nursing (DON). The surveyor requested information on how the CP recommendations are addressed. Additionally, the surveyor requested copies of the printed CP recommendation from NJ Ex Order 26.4b1 and any physician notes addressing the recommendation. On 04/3/2024 at 9:20 AM the DON provided CP documentation entitled "Therapeutic Suggestions" for Resident #28 for NJ Ex Order 2[redacted]. It reflected three recommendations from the CP.	F 757	discontinued on NJ Ex Order 26.4[redacted] 2. All residents have the potential to be affected by this deficient practice of having unnecessary medication. 3. Nurses were re-educated on the potential risk of having unnecessary medication. Nursing Supervisor/Designee will randomly audit 3 residents medication list a week for 3 months to ensure residents are free from unnecessary medications. 4. DON/Designee will randomly audit 2 residents medication list a week for 2 months to ensure residents are free from unnecessary medications. 5. All findings will be presented for review at the next 2 QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. BUILDING _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	111-115 GATES 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) COMPLETION DATE
F 757	Continued From page 25	F 757		

One recommendation indicated "Please comment on the effectiveness of NJ Ex Order 26.4b1 and the clinical rationale for use. It is usually given routinely to be effective". The documentation also reflected a handwritten signature on the line titled 'accepted' which the DON identified as the signature of the attending physician dated NJ Ex Order 2. The word 'continue' was handwritten on the line labeled reason for not accepting. The DON did not provide any further documentation from the attending physician.

On 04/03/2024 at 10:40 AM the surveyor reviewed the physician's progress notes section of the resident's EMR. The surveyor did not observe any physician progress notes present in the EMR between the dates of NJ Ex Order 26.4b1 through NJ Ex Order 26.4b1 that addressed the use or indication for NJ Ex Order 26.4 nor a response to the CP recommendation.

On 04/4/24 at 9:15 AM the surveyor reviewed electronic progress notes and nursing notes for documentation indicating the resident experienced NJ Ex Order 26.4b1 . The surveyor did not observe documentation reflecting either condition.

On 04/4/24 at 12:24 PM the surveyor interviewed the attending physician (MD) by telephone. The MD stated that he recalled seeing the resident at the facility and that the resident had an order for NJ Ex Order 26.4. The MD stated the resident had a diagnosis of NJ Ex Order 26.4b1. The MD stated this was a medication the resident used at home. The MD stated he did not recall changing the NJ Ex Order 26.4 order to an 'as needed' order NJ Ex Order 2 and could not provide a rationale for NJ Ex Ord use. The MD stated he did not recall seeing the CP

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	315363	A. BUILDING _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 26 recommendation sheet for the [NJ Ex Order 26.4b1] visit. On 4/4/24 at 12:47 PM The surveyor interviewed the CP by telephone. The CP stated that she recalled the recommendation to the physician to address the use of [NJ Ex Order 26.4] as a [NJ Ex Ord]. The CP stated that when making recommendations, the facility is usually responsive and tries to have the concern addressed at that time. Recommendations for the MD are addressed as best as possible. The CP stated that she looks in the medical record for progress notes for responses to recommendations that were not immediately addressed. The surveyor reviewed the resident's admission record (an admission summary) which did not reflect diagnoses of NJ Ex Order 26.4b1 [redacted] or NJ Ex Order 26.4b1 [redacted]. The surveyor reviewed the manufacturer prescribing information (PI) for [NJ Ex Order 26.4]. The PI reflected indications and usage of NJ Ex Order 26.4b1 [redacted] in adults and NJ Ex Order 26.4b1 [redacted] in adults. The PI reflected recommended dosage for [NJ Ex Order 2] in adults as [NJ Ex Order 26.4b] orally once daily and for [NJ Ex O] in adults as [NJ Ex Order 26.4b] orally once daily. N.J.A.C. 8:39-11.2(b), 8:39-29.3(a)1.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		5/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. BUILDING _____ B. WING _____	C 04/05/2024

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F 812	Continued From page 27 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, and b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 4/3/24 at 9:45 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following: 1. In the food preparation area, inside the ice machine, the surveyor observed a black colored build up along the seam and white colored matter inside the walls of the ice machine. The FSD stated that the dish machine was last cleaned about one month ago.	F 812	F812 1. The ice machine was cleaned and sanitized 4/5/24. The sprinkler heads nozzles was cleaned on 4/5/24. The grill knobs was cleaned on 4/5/24. The carton of expired milk was immediately discarded. The dented cans were immediately discarded. 2. All residents have the potential to be affected by this deficient practice. 3. All dietary staff were reeducated on cleaning of the ice machine, grill knobs, and sprinkler head nozzles. In addition, dietary staff was re-educated on disregarding expired food items and dented cans. FSD/Designee will randomly audit 2 times a week for 3 months to ensure cleanliness and that no expired food	

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	315363	A. BUILDING _____ B. WING _____	C 04/05/2024

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F 812	Continued From page 28 2. In the food preparation area, above the stove and grill cook tops, the surveyor observed 3 out of 5 sprinkler head nozzles and the pipes soiled with a brown colored substance. 3. In the food preparation area, the surveyor observed that 3 of 3 grill knobs were soiled with a brown colored substance, and 2 of 2 oven handles were soiled with a brown colored substance and the substance was able to be lifted with the tip of the FSD's pen. The FSD stated that the debris should have been cleaned. 4. In the standing refrigerator # 2, the surveyor observed a half opened half gallon carton of whole milk with an open date of 4/3/24 written on the carton. The stamped manufacturer expiration date was 4/1/24. 5. In the dry storage room, the surveyor observed two number 10 sized cans of diced peaches. One had a 1 inch sized dent on the upper lip and the second one had a 1.5 inch dent to the upper lip. The FSD stated that the dented cans should not have been on the shelf as they were in rotation for use. A review of the Dating and Labeling policy dated 1/24/17, revealed "Kitchen will assure food safety by maintaining proper dates and labels to all goods and ready to eat food products," "Foods marked with manufactures use by date may be used and stored until expiration date," and "Discard all foods that expire immediately." A review of the Dented Can policy, dated 11/2023, revealed "Unacceptable, dented canned goods will be reported and returned/discarded in a timely manner."	F 812	and/dented cans are in use. 4. Administrator/designee will do weekly audits for 3 months to ensure cleanliness and that no expired food and/dented cans are in use. 5. All findings will be presented and reviewed for the next 2 QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. BUILDING _____ B. WING _____	C 04/05/2024

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F 812	Continued From page 29 On 4/3/24 at 2:30 PM, the surveyor discussed the above concerns with the Administrator and Director of Nursing. NJAC 8:39-17.2(g)	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060702	A. BUILDING: _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	111-115 GATES AVENUE MONTCLAIR, NJ 07042

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S 000	Initial Comments 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		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.	S1410		5/10/24

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

Electronically Signed | 04/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060702	A. BUILDING: _____ B. WING _____	C 04/05/2024

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S1410	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure newly hired employees received the required [redacted]. The deficient practice was identified for 8 of 9 randomly selected employees who began their employment after the prevous standard recertification inspection. The details are as follows: On 4/3/24 the surveyor requested from the Director of Nursing (DON) the health files for 9 employees hired since the last standard recertification inspection. On 4/4/24 the surveyor reviewed the files. One staff person received [redacted]. Seven employees received a[redacted] On 4/04/24 at 1:40 PM the surveyor interviewed the DON and the Administrator informing them of the findings and requesting other types of screening methods that would meet the requirement, such as a Quantiferon blood test, a chest x-ray, or a screening questionnaire. The facility administration did not provide additional information regarding TB screening. On 4/05/24 at 9:51AM the surveyor reviewed the facility Employee Health Program Policy and Procedure, reviewed June 2023. Procedure Step 7 indicated "all new employees are required to be given a Mantoux test or provide doumentation of having test done. For employees with positive	S1410	S1410 1. The facility initiated the [redacted] testing for staff on 4/16/24. 2. All residents have the potential to be affected by this deficient practice of omitting the required 2 step Mantoux testing. 3. HR Director was re-educated on the process of 2 step Mantoux testing requirement. All employee files will be reviewed to ensure all employees have the 2 step Mantoux test. 4. The Administrator/Designee will audit 2 new hires a month for 3 months to ensure all employees have the 2 step Mantoux test. 5. All findings will be presented for review at the next 2 QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060702	A. BUILDING: _____ B. WING _____	C 04/05/2024

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MONTCLAIR CARE CENTER	111-115 GATES AVENUE MONTCLAIR, NJ 07042

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S1410	Continued From page 2 result, employee will be required to have chest x-ray."	S1410		

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
315363 Y1	A. Building B. Wing Y2	5/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	111-115 GATES AVENUE 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 F0558	Correction	ID Prefix F0637	Correction	ID Prefix F0640	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(f)(1)-(4)	Completed
LSC	05/10/2024	LSC	05/10/2024	LSC	05/10/2024
ID Prefix F0641	Correction	ID Prefix F0698	Correction	ID Prefix F0711	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.30(b)(1)-(3)	Completed
LSC	05/10/2024	LSC	05/10/2024	LSC	05/10/2024
ID Prefix F0726	Correction	ID Prefix F0757	Correction	ID Prefix F0812	Correction
Reg. # 483.35(a)(3)(4)(c)	Completed	Reg. # 483.45(d)(1)-(6)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	05/10/2024	LSC	05/10/2024	LSC	05/10/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/5/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060702		5/16/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	111-115 GATES 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 S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 05/10/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/5/2024	☐ 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
	315363	A. BUILDING **01** B. WING _____	**04/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	**111-115 GATES AVENUE** **MONTCLAIR, NJ 07042**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by CertiSurv, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/03/2024 and Montclair Care Center 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 Occupancies. Montclair Care Center is a two-story Type II Protected building that was built in 1966. The facility is divided into 6 smoke zones.	K 000		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6,	K 914		5/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. BUILDING **01** B. WING _____	**04/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	**111-115 GATES 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) COMPLETION DATE
K 914	Continued From page 1 which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure documentation of receptacle testing in patient care rooms in accordance with NFPA 99 (2012 Edition) Section 6.3.4. This deficient practice had the potential to affect all residents in the facility. The facility had a capacity of 64 beds and a census of 47 residents at the time of the survey. Findings included: On 04/03/2024 at 9:40 AM, the surveyor requested documentation to indicate that non-hospital grade electrical receptacles in patient care areas were being tested at intervals not exceeding 12 months as required by NFPA 99, Health Care Facilities Code. At that time, the Director of Maintenance (DOM) and Administrator stated the facility lacked documentation of inspections/testing of facility electrical receptacles in patient care areas. On 04/03/2024 at 9:50 AM, the DOM and Administrator reported the facility lacked a written environmental surveillance rounding policy to define expectations surrounding tension and polarity testing of electrical receptacles, including	K 914	K914 1. Receptacles testing for polarity and tension was initiated on 4/19/24. Documentation uploaded into epoc. 2. All residents have the potential to be affected by this deficient practice of not testing receptacles for polarity and tension. 3. Maintenance Director was educated on testing receptacles for polarity and tension. Receptacles testing for polarity and tension was added to the daily preventative maintenance room check being performed by the maintenance director. The maintenance director will provide a report of all tested receptacles which would include room or area tested, date tested, and results to the administrator on a monthly basis. Administrator/Designee will review the results of the reports with the Maintenance director weekly for 3 months to ensure the receptacles are being tested for polarity and tension. 4. Administrator/Designee will randomly audit 2 receptacles per unit 2 times a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. BUILDING **01** B. WING _____	**04/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	**111-115 GATES 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) COMPLETION DATE
K 914	Continued From page 2 the required interval of testing. The DOM and Administrator stated they were unaware that tension and polarity tests were not being documented. NJAC 8:39-31.2(c), 31.2(e), 31.2(i) NFPA 99	K 914	month for 3 months to ensure the receptacles are being tested for polarity and tension. 5. All findings will be presented for review at the next 2 QAPI (Quarterly) meetings.	

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)
315363	A. Building 01 - MAIN BUILDING 01 B. Wing	5/16/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	111-115 GATES AVENUE 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 K0914	Correction Completed 05/10/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO