STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315037	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Family of Caring at Teaneck LLC	1104 Teaneck Road Teaneck, NJ 07666

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #2666131Based on observation, interview, and record review, it was determined that the facility failed to: a.) transcribed a physician order to ensure that a resident receive treatment and care in accordance with professional standards of practice and facility policies and procedures and b.) ensure that an incident report was documented in the resident's electronic health record (EHR) timely for 1 of 21 residents (Resident #97) reviewed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 11/19/25 at 11:36 AM, during the initial tour, the surveyor interviewed Resident #97 in their room and observed the resident lying in bed with lower left (L) arm covered in bandages. Resident #97 stated they were in the hospital, was brought in the facility to get therapy. The resident further stated that there was an incident that during breakfast, the tea was knocked down onto resident's L arm and L abdomen. The resident stated that they did not have pain but it burns sometimes, and the nurse gave them something to help the pain and it was getting better. On 11/19/25 at 1:00 PM, the surveyor requested from the License Nursing Home Administrator (LNHA) all accidents and investigations for the last four months for Resident #97. On 11/20/25 at 1:00 PM, the LNHA provided a facility reportable event (FRE) investigation, dated 11/9/25. The surveyor reviewed the FRE investigation which revealed the facility staff reported the incident to the Department of Health (DOH) on 11/11/25. The FRE revealed on 11/9/25 at 8:10 AM, the Certified Nursing Assistant (CNA) and the License Practical Nurse (LPN) were assisting Resident #97 for breakfast. The resident requested for the tea to be heated up and the CNA returned with the tea and placed it on the overbed table which was in front of the resident. The LPN witnessed the resident reach for the oatmeal and accidentally spilled the tea over their L arm and abdomen. The LPN assessed the resident who presented with a reddened area measuring 4.5 cm (centimeters) x 1 cm to L arm and upper abdomen measuring 8 cm x 2.5 cm; treatment was rendered to L arm and abdomen immediately; physician and Resident Representative (RR) were made aware. The reddened areas presented as closed blisters on 11/11/25, and the resident denied pain. All staff were in-serviced not to heat up beverages in the microwave but to replace from the thermos that kitchen will provide. The facility staff determined a conclusion that the incident was an isolated accident. On 11/20/25 at 4:23 PM, the surveyor called the CNA who was assigned to Resident #97 during the incident. The CNA stated that she and the nurse pulled up the resident in bed for breakfast. She further stated that the resident asked for the tea to be heated because it was cold, and the CNA maybe heated it up in the microwave for 60 seconds. The CNA placed the tea on the tray and saw that there was no milk, turned to get the milk in another tray and then heard the resident yell, and saw the resident's arm with the water. The nurse was in the room by the bed and witnessed the incident. The CNA stated that she took the tray away and cleaned up after the incident, the RR was made aware. She further stated that the Director of Nursing (DON) provided in service about the incident. The surveyor reviewed the medical records of Resident #97, and revealed: A review of the admission Record (an admission summary) reflected diagnoses that included but not limited to type 2 diabetes mellitus without complications and malignant neoplasm of unspecified site of unspecified female breast. A review of the physician orders (PO) revealed: -11/11/25 order for Silver External Gel (Silver) apply to L arm/abdomen upper quadrant topically every day shift for skin redness/blisters that was discontinued on 11/11/25. -Silver External Gel (Silver) apply to L arm/abdomen upper quadrant topically every day shift for skin redness/blisters-Start Date11/12/25. -11/11/25 Cleanse L arm (lower) satellite wound with NS (normal saline), pat dry, apply Silvadene cream with cotton tipped wood applicator, and cover with tender band bordered gauze daily. one time a day for wound care. -11/11/25 Cleanse L upper abdominal area with NS, pat dry, apply Silvadene cream with cotton tipped