STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Family of Caring Healthcare at Tenafly, LLC	133 County Road Tenafly, NJ 07670

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of pertinent facility documentations on 3/3/26 and 3/10/26, it was determined that the facility failed to completely and accurately document Physician Orders (PO) and medication administration of insulin for Resident #1 in accordance with current professional standards and practices.This deficient practice was identified for 1 of 4 residents (Resident #1) reviewed for documentation as follows: A review of Resident #1's admission Record (AR), an admission record summary, revealed the resident was admitted to the facility with diagnoses which included but were not limited to fracture of right femur, muscle weakness, type 2 Diabetes Mellitus (DM) with diabetic chronic kidney disease, heart failure, hypertension, and repeated falls. A review of the resident's Progress Notes (PN) entry dated 07/22/2025 at 4:28 PM signed by the nurse indicated the resident was alert and oriented to person, place, and time (AAOx3) upon initial assessment.A review of the resident's Order Summary Report (OSR), a list of physician's orders, active orders as of 07/23/2025, revealed the resident had orders for the following:-Admelog SoloStar Solution Pen-injector 100 unit/ml (milliliter) (insulin lispro), a phone order, inject as per sliding scale: if 0-70 = 0 call MD/NP; 71-199 = 0; 200-299 = 1; 300-400 = 2; 401-999 call MD/NP for insulin order, subcutaneously before meals for DM eat within 15 minutes of using the medication. Watch for hypoglycemia sx [symptoms] including headache/hunger/sweating - with order date of 07/22/2025 and start date of 07/23/2025.-Humalog Kwikpen Subcutaneous Solution Pen-injector 100 unit/ml (insulin lispro), a prescriber written order, inject as per sliding scale: if 0-149 = 0 units; 150-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-500 call MD, subcutaneously before meals and at bedtime for DM - with order date 07/23/2025 and start date of 07/23/2025. -Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine), a phone order, inject 16 unit subcutaneously at bedtime for DM do not use if it looks cloudy. Watch for hypoglycemia symptoms including headache/hunger/sweating - with order date of 07/22/2025 and start date of 07/22/2025. -Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine), a phone order, inject 22 unit subcutaneously at bedtime for DM. Do not use if it looks cloudy. Watch for hypoglycemia symptoms including headache/hunger/sweating - with order date of 07/23/2025 and start date of 07/23/2025.-Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine), a prescriber written order, inject 10 unit subcutaneously at bedtime for DM. Do not use if it looks cloudy. Watch for hypoglycemia symptoms including headache/hunger/sweating - with order date of 07/23/2025 and start date of 07/23/2025. There were no further POs for insulin. A review of the resident's Medication Administration Record (MAR) with date range of 7/1/2025-7/31/2025 revealed the following:-Lantus SoloStar Solution Pen-Injector 100 unit/ml (Insulin Glargine) inject 16 unit subcutaneously at bedtime for DM with a Start Date of 9:00 PM and a D/C [discontinue] Date of 07/23/2025 1:52 PM. The Licensed Practical Nurse (LPN) #1 documented code 9 under the Tue 22. The MAR indicated under its Chart Codes (CC), code 9 = Other/See Progress Notes.A review of the resident's PN dated 07/22/2025 at 8:17 PM revealed LPN #1 documented awaiting RX delivery. -Admelog SoloStar Solution Pen-injector 100 unit/ml (Insulin Lispro) inject 4 unit subcutaneously one time only for DM (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

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Family of Caring Healthcare at Tenafly, LLC	133 County Road Tenafly, NJ 07670

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for 1 Day; Start Date of 07/22/2025 9:30 PM and a D/C Date of 07/23/2025 5:05 PM. The MAR revealed the medication entry was initialed by LPN #1 under Tue 22 with a check mark and a time of 2203, indicating the medication was administered and timed at 10:03 PM on July 22.This medication entry was not reflected in the resident's OSR nor documented in the resident's PN. -Admelog Solution 100 unit/ml (Insulin Lispro) inject 7 unit subcutaneously one time only for DM until 07/23/2025 5:59 AM with a Start Date 07/23/2025 0230 [2:30 AM]. The MAR was initialed by Registered Nurse (RN) #1 at 2:47 AM under the Wed 23.This medication entry was not reflected in the resident's OSR.A review of a 07/23/2025 PN at 2:10 AM revealed RN #1 received a PO for 7 units x1 dose but failed to document the type of insulin. -Admelog SoloStar Solution Pen-injector 100 unit/ml (insulin lispro) inject as per sliding scale: if 0-70 = 0 call MD/NP; 71-199 =0; 200-299 =1; 300-400 =2; 401-999 call MD/NP for insulin order, subcutaneously before meals for DM eat within 15 minutes of using the medication. Watch for hypoglycemia sx [symptoms] including headache/hunger/sweating - with a Start Date 07/23/2025 7:30 AM and D/C Date of 09/09/2025 5:46 PM. The MAR revealed under Wed 23, BS (blood sugar) 341 at 11:30 AM, a check mark with LPN #2 initials and the number 2, indicating 2 units of insulin were given. The MAR further revealed under Wed 23 at 4:30 PM LPN #3 documented BS of 400 and code 9, indicating Other/See Progress Notes. A review of a 07/23/2025 PN revealed at 12:37 PM, LPN #2 documented primary nurse and pt's daughter by bedside alerted this nurse that pt's sugar has been running high and over 400mg/dl since last night and during lunch. made MD aware but still awaiting for response. made endocrinologist - Dr [NAME] aware but was told thatdoctor [sic] was away and would come back after 1pm. unable to connect with any MD. extra 2 units of admelog was given for now, with closer monitoring with blood sugar. daughter by bedside and pt agreed to plan. will continue with plan of care.A review of a 07/23/2025 PN revealed at 1:55 PM, LPN #2 documented called back pt's endo Dr [NAME] regarding high blood sugar of 466mg/dl. as per office, Dr. [NAME] came back but currently seeing other patient, office told this writer that this writer needs to wait until Dr [NAME] gets a chance to call me back. this writer made office staff aware that pt's blood sugar has been high and its urgent to connect with Dr [NAME] but office staff continuously said that this writer needs to wait. no time frame given. made MD aware. obtained new order to increase lantus to 22u nightly. gave another 2u for blood sugar coverage. pt denies discomfort. VSS, pt continues to be alert and oriented. clinical team made aware.A review of a 07/23/2025 PN revealed at 4:58 PM, LPN #3 documented, NEW ORDERS; change meds lispro sliding scale 150- 200 2 units, 200-250 4 units, 250 - 300 6 units, 300-350 8 units, and lantus; d/c current lantus and decrease to 10 units.A review of a 07/23/2025 PN revealed at 5:03 PM, LPN #3 documented that orders were received and follow through.A review of a 07/23/2025 PN revealed at 10:20 PM, LPN #3 documented Resident #1 reported uncontrolled blood sugar ranging 400s or higher off and on for the past day. The PN revealed the MD was made aware and ordered 8 units to be given prior to dinner. Insulin given. The PN further revealed Blood sugar read 402 @ 2102 [9:02 PM]. Lantus and 8 units of coverage given .There was no PO on Resident #1's OSR nor order entry on Resident #1's MAR for this medicaiton. On 03/10/26 at 10:34 AM, the surveyor interviewed LPN #1. LPN #1 confirmed she entered code 9 and documented in the 7/22/2025, 8:17 PM PN awaiting pharmacy delivery related to the 16 units of Lantus at bedtime PO. LPN #1 further said she was not able to give the Lantus as we have to wait for the delivery. When asked if she called the doctor, LPN #1 stated she let the RN supervisor know. The RN supervisor called the resident's MD [medical doctor] and the MD ordered a one time dose of the short acting insulin. If a medication is not yet received from pharmacy, the protocol is to document this in the PNs. The MD would be notified and this would also be documented. There was no PN indicating the medication was not received nor the MD was notified. The surveyor was unable to interview LPN #2 or LPN #3.On 03/10/26 at 11:17 AM, the surveyor interviewed the DON regarding LPN #2's documentation on 7/23/2025 at 12:37 PM. The DON stated that LPN #2 was referring to the 11:30 AM sliding scale order of 2 units Admelog that was given for the resident's BS of 341. On 03/10/26 at 11:50 AM, the surveyor interviewed the RN Supervisor.The RN supervisor stated she (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cannot exactly remember Resident #1's BS on 7/22/2025 or calling the MD. She further stated she was unable to document at the time because there were a lot of orders to carry out and she assumed the nurse would document in the PNs. On 03/10/26 at 12:57 PM, the surveyor interviewed the DON regarding the 7/23/2025,10:20 PM PN and the MAR. DON stated LPN #2 documented the insulin given in the PN as a late entry. The DON affirmed that the documentation did not coincide or reflect timely in the resident's MAR. On 03/10/26 at 1:13 PM, the surveyor interviewed the resident's MD. The MD stated if there was no medication yet the nurses always called me and normally would give the BS result. I do not remember the exact blood sugar result but it was more than 400 plus. I do not remember the nurse's name but they absolutely called me. The insulin order I gave at that time was based on the patient's sliding scale from the medication list from the hospital; the nurses called me when the patient was admitted to the facility. A review of a facility policy titled Charting and Documentation revised on 10/2025 revealed, under Policy Statement, All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Under Policy Interpretation and Implementation revealed 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.N.J.A.C.8:39-35.2(d)6