STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2023

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 19106 Based on observation, interview, and record review it was determined that the facility failed to provide indwelling urinary catheter care in a manner to prevent the spread of infection to a resident with a history of urinary tract infection (UTI). The deficient practice was identified for 1 of 1 resident (Resident #7) reviewed for indwelling urinary catheter care and was evidenced by the following. On 11/14/23 at 10:37 AM, the surveyor observed Resident #7 awake in bed. The resident's large (overnight) urinary drainage bag was observed placed in a black privacy bag hanging on the bed frame. The surveyor inspected the resident's bathroom on 11/14/23 at 10:37 AM and again on 11/15/23 at 9:38 AM and observed a small (daytime) urinary drainage bag with uncapped tubing open to air stored in a plastic bag which hung from a handrail next to the toilet. On 11/15/23 at 9:38 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to Resident #7. The CNA confirmed the urinary drainage bag was uncapped and open to air. She stated the tubing should be capped. She further stated I don't know anything about it when asked whose drainage bag it was. On 11/15/23 at 9:45 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) in charge of the unit. The LPN confirmed the presence of an uncapped small urinary drainage bag in the resident's bathroom. She stated of the four residents sharing the bathroom, only one resident, Resident #7, had an indwelling urinary catheter. She stated she would educate the CNA as to why the tubing needed to be capped. A review of the electronic medical record revealed the following information. The resident was admitted to the facility with the diagnoses of retention of urine and UTI. The November 2023 Treatment Administration Record included a 10/25/23 physician's order for the use of an indwelling urinary catheter. The 10/31/23 Admission Minimum Data Set (MDS), an assessment tool used to guide the care of the resident, included in Section H that the resident used an indwelling urinary catheter and in Section I that the resident had a current UTI. (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: 315164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2023

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/23 at 1:15 PM, the surveyor discussed the concern of the uncapped indwelling urinary drainage bag with Director of Nursing (DON), the Licensed Nursing Home Administrator, and the Day to Day Manager. The DON provided the surveyor with the facility's policy for Urinary Catheter Care, revised October 2010. General Guideline #1 included the directive to maintain a closed drainage system. NJAC 8:39-19.4(a)5

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34033 Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to a.) acquire, accurately administer and document a medication (Polysaccharide Iron complex) from 10/7/23 until surveyor inquiry on 11/16/23 for one (1) of five (5) residents, (Resident #50), observed during the medication administration observation, b.) administer medications in a timely manner to five (5) residents, (2 sampled residents :Resident #23 and #53 and 3 unsampled Residents #1, #2 and #3) by one (1) of two (2) nurses observed administering morning medications on 11/16/23 and c.) accurately document the administration of an as needed (PRN) medication (Tylenol) for one (1) of nine (9) residents, (Resident #44), reviewed for medication management. 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. The deficient practices were evidenced by the following: REFER TO F759 1. On 11/16/23 at 9:37 AM, during the morning medication administration pass, the surveyor, in the presence of another surveyor, observed the Licensed Practical Nurse (LPN) preparing seven (7) medications which included one 150 milligram (MG) capsule of Polysaccharide Iron Complex (an iron supplement) for Resident #50. The LPN stated that he was unable to find the Polysaccharide Iron Complex capsule in the medication cart and would have to check with the Charge Nurse/LPN (CN/LPN) or call the physician. On 11/16/23 at 9:55 AM, the surveyors observed the CN/LPN join the LPN at the medication cart and assisted the LPN in searching the medication cart for the Polysaccharide Iron Complex capsules. The CN/LPN stated that she was unable to find the Polysaccharide Iron Complex capsules and would have to check why it was not available. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/16/23 at 10:08 AM, the LPN had completed administering the morning medications to Resident #50 which included six (6) of the seven (7) medications that had an administration time of 9 AM. The surveyors had not observed the LPN administer the Polysaccharide Iron Complex according to the PO. The LPN signed the electronic medication administration record (EMAR) indicating the number five (5) which corresponded with Hold/see Progress Notes for the administration of the Polysaccharide Iron Complex. The surveyor reviewed the medical record for Resident #50. A review of the resident's Admission Record (AR) revealed diagnoses which included fracture of right femur, anemia and deficiency of other specified B group vitamins. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 10/13/2023, reflected the resident had a brief interview for mental status (BIMS) score of 11 out of 15, indicating that the resident had a moderately impaired cognition. In addition, the MDS revealed in section A1110 for Language that the resident spoke another language and required an interpreter. A review of the Order Summary Report revealed a physician's order (PO) dated 10/7/23 for Polysaccharide Iron Complex capsule 150 MG, Give 1 capsule by mouth one time a day for supplement. A review of the nursing Progress Notes (PN) dated 11/16/23 at 10:58 AM completed by the CN/LPN indicated that MD called made aware of AM medication being administered late. On 11/16/23 at 1:30 PM, the surveyor interviewed the LPN who stated that he was an agency nurse and that this was his first day at the facility. The LPN stated that he was given an orientation handout that morning but was unsure who had given it to him. The LPN added that the CN/LPN was working on locating the Polysaccharide Iron Complex capsules and had called the physician. On 11/16/23 at 1:38 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the CP was in the facility this morning and gave out Med Pass information to the nurses. On 11/16/23 at 1:44 PM, the surveyor interviewed the CP who stated that she had given an in-service information handout on Medication Pass that morning to the nurses who were doing the medication pass because there were agency nurses. A review of the Medication Pass in-service information handout provided by the CP reflected that under Miscellaneous Situations: Missing Medications: If a medication is not found on the med cart, notify another nurse to first check the backup supply. If not available from back up, notify the physician for further orders, such as stat delivery from pharmacy and a one-time order to administer later in the day. Follow up with the surveyor to let them know how the problem was resolved. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/16/23 at 1:16 PM, the surveyor interviewed the CN/LPN who stated that she was the not the usual Unit Manager (UM) and was acting as the CN for that day. The CN/LPN stated that the Polysaccharide Iron Complex was technically an over the counter (OTC) medication and was a house stock medication to be provided by the facility. The CN/LPN added that she could not find the Polysaccharide Iron Complex capsules and thought they were on order, so she had called the provider pharmacy and requested 20 capsules to be delivered. The CN/LPN explained that the facility could order any OTC but that the order could take a couple days to come in so during the interim they requested a small amount of the OTC medication be delivered from the provider pharmacy so that it would be available to the resident. At that time, the surveyor, with the CN/LPN, reviewed a Fax Log dated 11/16/23 and timed for 10:29 AM that she had completed so that the facility would receive the Polysaccharide Iron Complex in the next delivery from the provider pharmacy. The CN/LPN also stated that the 3 PM to 11 PM shift would administer the medication because she had also called the physician and obtained a PO to administer the medication late. The CN/LPN could not speak to why the medication was not available for the 9 AM medication pass. At that time, the CN/LPN reviewed the electronic PO for the Polysaccharide Iron Complex and stated that the start date for the PO was 10/7/23. The CN/LPN also reviewed an electronic Progress Note (EPN) which indicated that the pharmacy was contacted with regard to delivering the Polysaccharide Iron Complex but could not speak to whether the medication was delivered. On 11/16/23 at 1:48 PM, the surveyor interviewed the Director of Nursing (DON) who stated that she was aware that the Polysaccharide Iron Complex capsules were not available during the medication pass and had called the provider pharmacy. The DON added that the provider pharmacy had never delivered any Polysaccharide Iron Complex capsules for Resident #50 because it was an OTC medication. The DON then explained that she had checked with their supplier and the Polysaccharide Iron Complex was out of stock. The DON then stated that she would have to investigate what the nurses were administering since the EMAR indicated that the medication was administered and why there was no follow up when the medication was not administered and documented as awaiting delivery or called pharmacy. A review of the October EMAR for Resident #50 revealed that the Polysaccharide Iron Complex had a start date of 10/7/23 and on 10/13, 10/16 and 10/31 the medication was not administered and had a chart code of the number nine (9) entered for the 9 AM administration which indicated Other/See Progress Notes. In addition, on 10/21/23 there was a chart code of the number five (5) which indicated Hold/see Progress Notes. Further review of the EMAR revealed that the medication was administered on 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/14, 10/15, 10/17/10/18, 10/19, 10/20, 10/22, 10/23, 10/24, 1025, 10/26, 10/27, 10/28, 10/29, and 10/30. A review of the corresponding EPN regarding the PO for Polysaccharide Iron Complex 150 MG revealed the following: 10/13/23 at 10:23 Pharmacy to deliver 10/21/23 at 08:25 on order 10/31/23 at 10:06 AM meds not available (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the November EMAR for Resident #50 revealed that Polysaccharide Iron Complex was not administered at 9 AM on 11/1, 11/2, 11/3,11/6, 11/8, 11/9 and 11/10 and had a chart code of the number nine (9) which indicated Other/See Progress Notes. Further review of the EMAR revealed that the medication was administered on 11/4, 11/5, 11/7, 11/11, 11/12, 11/13, 11/14 and 11/15. A review of the corresponding EPN regarding the PO for Polysaccharide Iron Complex 150 MG revealed the following: 11/1/23 at 9:37 Pending delivery from pharmacy; MD notified regarding missing dose. 11/2/23 at 11:15 on order 11/3/23 at 10:27 On order. MD notified of missed dose. No new orders at this time. 11/6/23 at 10:32 Med on order. Pending pharm delivery. 11/8/23 at 10:37 waiting for pharmacy There was no corresponding EPN found for 11/10/23. 11/10/23 at 9:00 Pending med delivery On 11/17/23 at 9:31 AM, the surveyor, in the presence of the survey team, interviewed the Unit Clerk (UC) who stated that he was responsible for the Central Supply of the facility which required keeping stock and ordering of the OTC medications that the facility provided. The UC explained that there was a list of the usual OTC medications that he ordered but the list could be added to. The UC further explained that if an OTC medication that was not on the list had to be ordered that sometimes it would take a couple days to receive and that the nurses were aware of that. The UC was unaware of the need to order Polysaccharide Iron Complex capsules. A review of the House Stock Medications list provided by the DON reflected that Polysaccharide Iron Complex 150 MG capsules were not on the list. On 11/17/23 at 10:40 AM, the surveyor interviewed the CN/LPN who stated that the Polysaccharide Iron Complex 150 MG capsules had been delivered on 11/16/23 and was able to show the surveyor the capsules in the medication cart. The CN/LPN added that one (1) capsule was missing from the delivery of 20 capsules because it had been administered that morning for the 9 AM dose. The CN/LPN also added that it was her mistake that the medication was not administered in the evening on 11/16/23 because she had not entered the PO to administer the medication as a one-time PO correctly in the electronic system. The CN/LPN stated that she had verbally told the 3 PM to 11 PM shift but had not electronically entered the PO correctly to prompt the medication nurse to administer the medication on 11/16/23. The CN/LPN acknowledged that the PO for Polysaccharide Iron Complex 150 MG was to be administered on 11/16/23 and that the resident had not received any doses on 11/16/23. The CN/LPN stated that the UM was currently not working and could not speak to the administration of the medication when it was not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/23 at 9:39 AM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that the facility policy does not speak to the process when a medication is not available. The DON added that the nurses should know that if a medication was not available that they have to find out why and let the physician know to get a PO to discontinue the medication or change to another medication. The DON stated that she was still investigating what the nurses had administered and why there was no follow up. The DON acknowledged that the Polysaccharide Iron Complex capsules were not available from 10/7/23 until 11/16/23 when the provider pharmacy delivered the medication. On 11/20/23 at 1:23 PM, the survey team met with the facility administrative team. The DON provided the surveyor with an Investigational Summary regarding the Polysaccharide Iron Complex. The DON stated that some of the nurses who signed as administering the Polysaccharide Iron Complex were agency nurses and was not able to contact every nurse. The DON added that the nurses that she had contacted had stated that they had administered the iron supplement but were unable to remember what iron medication or exact name they administered. The DON added that the nurses should have followed up when the medication was not available on 10/7/23. 2. On 11/16/23 at 9:26 AM, during the morning medication observation, the surveyor in the presence of another surveyor, observed the LPN preparing to administer medications to an unsampled Resident #1. The LPN attempted to obtain a blood pressure result for and was unable to get the BP machine to function. The LPN stated that he was going to skip to another resident. On 11/16/23 between 9:37 AM and 10:08 AM, during the morning medication administration observation, the surveyor in the presence of another surveyor, observed the LPN prepare and administer medications to Resident #50. On 11/16/23 at 10:12 AM, after the LPN completed the administration documentation for Resident #50, the surveyors interviewed the LPN regarding the names highlighted in red on the EMAR. The LPN stated that he just had to administer medications to the unsampled Resident #1 and was then complete with his morning medication pass. The LPN added that he would have to call the physician for the unsampled Resident #1 because the medications were going to be administered late and that was the reason why the name was highlighted in red. The LPN explained that the medications were due at 9 AM and he had one (1) hour before 9 AM and one (1) hour after 9 AM to administer the medications to be on time. The surveyors, with the LPN, again reviewed the EMAR which revealed five (5) resident names that were highlighted in a red color which included the unsampled Resident #1. The LPN stated that he thought the four (4) other residents that were highlighted in red just had monitoring information that he was able to document during his shift. The surveyors, with the LPN, then reviewed each of the five (5) residents that were highlighted in red (Residents #23, #53, and unsampled Residents #1, #2 and #3), and revealed that each resident had morning medications that were due for 9 AM that had not been administered yet. The LPN stated that the physician would have to be contacted for all the residents that had late medications. On 11/16/23 at 1:22 PM, the surveyors interviewed the CN/LPN who stated that she had called the physicians regarding the medications being administered late and there was no issue. The CN/LPN stated that this was the LPN's first day and knew that should not be an excuse, but she handled as much as she could. The CN/LPN stated that nothing unusual occurred this morning to make the medications late. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/16/23 at 1:30 PM, the surveyors interviewed the LPN who stated that he was an agency nurse, and this was his first day at the facility. The LPN also stated that he was late getting to the facility this morning since it was the first time coming to the facility and then had to get a login password for the electronic system and do a walk around which he explained meant that the CN/LPN showed him where things were available in the facility and which residents he was responsible for. In addition, the LPN stated that he thought he received an orientation information packet when he came to the floor but was unable to speak to who had given him the handout. The LPN stated that his shift started at 7 AM but knew he arrived after 7 AM but could not speak to what time he actually started his morning medication pass. On 11/16/23 at 1:48 PM, the surveyor interviewed the DON who stated that the usual process for a new agency nurse was an onboarding orientation which meant that they were given a packet that had to be completed before starting work. The DON thought the LPN had received an orientation packet. At that time the DON made a phone call and then stated that the LPN had not received or completed an orientation packet. The DON further explained that the LPN had received an in-service handout on Med Pass from the Consultant Pharmacist. The DON provided the surveyor with the facility Agency Employee & Temporary Staff Orientation Packet. On 11/20/23 at 11:15 AM, the surveyor interviewed the DON who stated that the orientation packet had not contained any information regarding the medication pass and that she would have to have the packet updated. The surveyor reviewed the EMAR for the five (5) residents that were highlighted in red, (Residents #23, #53, and unsampled Residents #1, #2 and #3), which revealed the following medications that were due at 9 AM on 11/16/23: -Resident #23 had a total of seven (7) medications timed for 9 AM which included: Centrum (a vitamin), Jardiance (a medication to lower blood sugar), Folibic (a combination of vitamins), Folic acid (a supplement), Toprol XL (a medication used to lower blood pressure), Spironolactone (a medication used to decrease fluid retention), and Vasotec (a medication used to lower the blood pressure). -Resident #53 had a total of ten (10) medications timed for 9 AM which included: Amiodarone (a medication used to prevent an arrythmia), Lipitor (a medication used to lower cholesterol), B complex (a vitamin), Protonix (a medication used to lower the acid in the stomach), Eliquis (an anticoagulant), Mucinex Extended Release (ER)(a medication used for cough), Midodrine (a medication used to increase the blood pressure), Tessalon [NAME] (a medication used to relieve persistent cough), Albuterol Nebulizer and Ipratropium nebulizer (medications used to help open the lungs). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Unsampled Resident #1 had a total of 14 medications timed for 9 AM which included: Norvasc, Aspirin Enteric Coated, Bacid (a probiotic), Lovenox injection (a medication used to prevent DVT), Hydrochlorothiazide (a medication used to prevent fluid retention), Elipta Inhaler (an inhaler to treat Chronic Obstructive Pulmonary Disease (COPD)), Losartan (a medication used to treat high blood pressure), Oxybutynin Extended Release for overactive bladder), Prednisone (a steroid used to decrease inflammation for COPD), Advair Inhaler, Colace (a stool softener), Mucinex ER, Labetalol (a medication used to treat high blood pressure) and Nystatin suspension (a medication used for oral fungus infection). -Unsampled Resident #2 had a total of seven (7) medications timed for 9 AM which included: Allopurinol (a medication used to lower uric acid levels) Norvasc, Multivitamin, Protonix, Wellbutrin extended release (XL) (an antidepressant), Ativan (an antianxiety) and Effexor (an antidepressant). -Unsampled Resident #3 had a total of four (4) medications timed for 9 AM which included: Lipitor, Prednisone, Vitamin D3, DuoNeb nebulizer (a combination medication used to treat COPD). On 11/21/23 at 12:59 PM, the surveyor interviewed the DON who stated that the managers on the floor should be checking the electronic dashboard to make sure medications were not administered out of the time compliance. The DON acknowledged that the medications were to be administered one hour before the time of administration or one hour after the administration time in order to be in compliance. The DON added that if a nurse was going to be late or there was an issue administering medications on time then the Unit Manager should step in and help out. The DON added that the CN/LPN was covering for the usual Unit Manager. On 11/22/23 at 9:20 AM, the surveyor interviewed the DON who stated that she had done an investigation regarding the medications being administered late. The DON stated that the physicians were notified and that there were no negative outcomes. The DON acknowledged that the LPN was aware that he had residents with overdue medications and were not administered in a timely manner and that the Unit Manger should have taken over if the LPN was starting late for medication administration or going to be late administering medications. A review of the Medication Pass in-service handout provided by the CP reflected General Rule: For medications scheduled at the times designated by facility policy (i.e., BIS at 9am and 5 pm), they must be administered up to one hour before and one hour after the scheduled time. A facility policy dated as revised 6/3/2323 for Administering Medications Using Electronic System (name redacted) reflected that Medications shall be administered in a safe and timely manner, and as prescribed. In addition, Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 49078 3. On 11/14/23 at 11:51 AM, the surveyor interviewed Resident #44. Resident reported pain in knee at times due to arthritis. Surveyor asked if she reported this to the staff or her doctor. The resident stated that her doctor was aware, and the staff gave the resident pain medication when it was needed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the medical record for Resident #44. On 11/20/23 at 09:58 AM, the surveyor reviewed the paper chart for physician's progress notes. A diagnosis of osteoarthritis (OA) was noted. The Physician's progress note dated 6/27/23 revealed that the resident's main complaint is knee pain and the resident had obesity with severe arthritis. On 11/21/23 at 12:12 PM, the surveyor reviewed the resident's electronic medical record, nurses/progress notes and electronic medication administration record (eMAR) for use of pain relief medications. There were two nurse progress notes that stated acetaminophen (Tylenol) was administered for pain as needed on 10/30/23 and 10/31/23. Upon reviewing the October eMAR for this resident, there was no electronic documentation for acetaminophen which was administration on 10/30/23 and 10/31/23. On 11/21/23 at 12:27 PM, the surveyor discussed the concern with the Director of Nursing (DON). The DON stated that she would look into this concern. On 11/21/23 at 1:00 PM, the DON provided a statement from medication nurse, that the nurse gave the acetaminophen but forgot to sign the administration of the medication in the October eMAR. NJAC 8:39-11.2(b), 29.2 (a)(d)

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NAME OF PROVIDER OR SUPPLIER: Family of Caring Healthcare at Tenafly, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34033 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 11/16/23, the surveyors observed two (2) nurses administer medications to five (5) residents. There were 28 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.1%. This deficient practice was identified for one (1) of five (5) residents, (Resident #50), that were administered medications by one (1) of two (2) nurses that were observed. The deficient practice was evidenced by the following: 1. On 11/16/23 at 9:37 AM, during the morning medication administration pass, the surveyor, in the presence of another surveyor, observed the Licensed Practical Nurse (LPN) preparing seven (7) medications which included one red colored tablet of One Daily (a multivitamin) (MVI) for Resident #50. The LPN stated that the MVI tablet was house stock meaning that the MVI was an over the counter (OTC) medication that was provided by the facility. On 11/16/23 at 9:52 AM, the surveyors observed the LPN attempting to administer six (6) of the seven (7) medications which included the red colored MVI tablet. Resident #50 was on the telephone speaking in another language and the LPN was unable to administer the medications. The LPN placed the medication cup containing the (6) medications on the resident's overbed table. At that time, the Charge Nurse/LPN (CN/LPN) joined the LPN in the resident's room and spoke to the resident and then spoke on the resident's phone. While the CN/LPN was speaking on the phone, the surveyor asked the LPN to review the medications that were in the medication cup that were ready to be administered to the resident. On 11/16/23 at 9:55 AM, the surveyors, with the LPN, reviewed the electronic medication administration record (EMAR) which revealed a physician's order (PO) dated 10/7/23 for One Daily/Minerals (Multiple Vitamins with Minerals) Give 1 tablet by mouth one time a day for Supplement. The surveyors with the LPN reviewed the house stock bottle in the medication cart that the LPN had removed the red colored MVI tablet from. The surveyors observed the LPN remove the red colored tablet of MVI from the resident's medication cup. The LPN stated that the red colored MVI tablet had not contained minerals. The LPN then stated that usually from his experience there was another house stock bottle that contained MVI with minerals but was unable to find one in his medication cart. The LPN stated that he would have to check with the CN/LPN. (ERROR #1) At that time, the surveyors observed the CN/LPN join the LPN at the medication cart and assisted the LPN in searching the medication cart for a house stock bottle containing MVI with minerals. The CN/LPN stated that the facility had a house stock of MVI with minerals and it was an orange or peach colored tablet. The CN/LPN verified that the red colored MVI tablet was not the MVI with minerals. The CN/LPN stated that she would obtain the house stock bottle of MVI with minerals. On 11/16/23 at 10:08 AM, the surveyors observed the CN/LPN give the LPN a house stock bottle of MVI with minerals that contained peach-colored tablets. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Family of Caring Healthcare at Tenafly, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the medical record for Resident #50. A review of the resident's Admission Record (AR) revealed diagnoses which included fracture of right femur, anemia and deficiency of other specified B group vitamins. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 10/13/2023, reflected the resident had a brief interview for mental status (BIMS) score of 11 out of 15, indicating that the resident had a moderately impaired cognition. In addition, the MDS revealed in section A1110 for Language that the resident spoke another language and required an interpreter. A review of the Order Summary Report revealed a physician's order (PO) dated 10/7/23 for One Daily/Minerals (Multiple Vitamins with Minerals) Give 1 tablet by mouth one time a day for Supplement. On 11/16/23 at 1:30 PM, the surveyor interviewed the LPN who stated that he was an agency nurse and that this was his first day at the facility. The LPN stated that he was given an orientation handout that morning but was unsure who had given it to him. On 11/16/23 at 1:38 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the Consultant Pharmacist (CP) was in the facility that morning and gave out Med Pass information to the nurses. On 11/16/23 at 1:44 PM, the surveyor interviewed the CP who stated that she had given an in-service information handout on Medication Pass that morning to the nurses who were doing the medication pass because there were agency nurses. A review of the Medication Pass in-service information handout provided by the CP reflected that The rights of med pass included Right Drug: Compare the pharmacy label/package to the MAR-the medication and strength must match exactly what is ordered. Example: multivitamin with minerals is NOT equivalent to a regular multivitamin or a multivitamin with iron. In addition, OTC (stock meds) are a common cause of medication errors due to the multiple different types and strengths. A review of the House Stock Medications list provided by the DON reflected that the facility provided Multivitamin with Minerals tablets. A review of the facility policy dated as revised 6/3/23 for Administering Medications Using Electronic System (name redacted) provided by the DON reflected that Medications must be administered in accordance with doctor's orders, including any required time frame and following medication cautionary. In addition, The individual administering medications must check the label THREE (3) times to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication. REFER TO F755 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 11/16/23 at 9:37 AM, during the morning medication administration pass, the surveyor, in the presence of another surveyor, observed the LPN preparing seven (7) medications which included one 150 milligram (MG) capsule of Polysaccharide Iron Complex (an iron supplement) for Resident #50. The LPN stated that he was unable to find the Polysaccharide Iron capsule in the medication cart and would have to check with the CN/LPN or call the physician. On 11/16/23 at 9:55 AM, the surveyors observed the CN/LPN join the LPN at the medication cart and assisted the LPN in searching the medication cart for the Polysaccharide Iron Complex capsules. The CN/LPN stated that she was unable to find the Polysaccharide Iron Complex capsules and would have to check why it was not available. On 11/16/23 at 10:08 AM, the LPN had completed administering the morning medications to Resident #50 which included six (6) of the seven (7) medications that had an administration time of 9 AM. The surveyors had not observed the LPN administer the Polysaccharide Iron Complex according to the PO. The LPN signed the EMAR indicating the number five (5) which corresponded with Hold/see Progress Notes for the administration of the Polysaccharide Iron Complex. The surveyor reviewed the medical record for Resident #50. A review of the resident's Admission Record (AR) revealed diagnoses which included fracture of right femur, anemia and deficiency of other specified B group vitamins. A review of the admission MDS, an assessment tool used to facilitate the management of care, with an assessment reference date of 10/13/2023, reflected the resident had a BIMS score of 11 out of 15, indicating that the resident had a moderately impaired cognition. In addition, the MDS revealed in section A1110 for Language that the resident spoke another language and required an interpreter. A review of the Order Summary Report revealed a PO dated 10/7/23 for Polysaccharide Iron Complex capsule 150 MG, Give 1 capsule by mouth one time a day for supplement. A review of the nursing Progress Notes dated 11/16/23 at 10:58 AM completed by the CN/LPN indicated that MD called made aware of AM medication being administered late. On 11/16/23 at 1:30 PM, the surveyor interviewed the LPN who stated that he was an agency nurse and that this was his first day at the facility. The LPN stated that he was given an orientation handout that morning but was unsure who had given it to him. The LPN added that the CN/LPN was working on locating the Polysaccharide Iron Complex capsules and had called the physician. On 11/16/23 at 1:38 AM, the surveyor interviewed the DON who stated that the CP was in the facility that morning and gave out Med Pass information to the nurses. On 11/16/23 at 1:44 PM, the surveyor interviewed the CP who stated that she had given an in-service information handout on Medication Pass that morning to the nurses who were doing the medication pass because there were agency nurses. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medication Pass in-service information handout provided by the CP reflected that under Miscellaneous Situations: Missing Medications: If a medication is not found on the med cart, notify another nurse to first check the back up supply. If not available from back up, notify the physician for further orders, such as stat delivery from pharmacy and a one-time order to administer later in the day. Follow up with the surveyor to let them know how the problem was resolved. On 11/16/23 at 1:16 PM, the surveyor interviewed the CN/LPN who stated that she was the not the usual Unit Manager and was acting as the CN for that day. The CN/LPN stated that the Polysaccharide Iron Complex was technically an OTC medication and was a house stock medication to be provided by the facility. The CN/LPN added that she could not find the Polysaccharide Iron Complex capsules and thought they were on order, so she had called the provider pharmacy and requested 20 capsules to be delivered. The CN/LPN explained that the facility could order any OTC but that the order could take a couple days to come in so during the interim the nurses would request a small amount of the OTC medication be delivered from the provider pharmacy so that it would be available to the resident. At that time, the surveyor with the CN/LPN reviewed a Fax log dated for 11/16/23 and timed for 10:29 AM that she had completed so that the facility would receive the Polysaccharide Iron Complex in the next delivery from the provider pharmacy. The CN/LPN also stated that the 3 PM to 11 PM shift would administer the medication because she had called the physician and obtained a PO to administer the medication when it arrived. The CN/LPN could not speak to why the medication was not available for the 9 AM medication pass. On 11/17/23 at 9:31 AM, the surveyor, in the presence of the survey team, interviewed the Unit Clerk (UC) who stated that he was responsible for the Central Supply of the facility which required keeping the stock and ordering of the OTC medications that the facility provided. The UC explained that there was a list of the usual OTC medications that he ordered but the list could be added to. The UC further explained that if an OTC medication that was not on the list had to be ordered and that would take a couple days to receive, and the nurses were aware of that. The UC was unaware of the need to order Polysaccharide Iron Complex capsules. A review of the House Stock Medications list provided by the DON reflected that Polysaccharide Iron Complex 150 MG capsules were not on the list. On 11/17/23 at 10:40 AM, the surveyor interviewed the CN/LPN who stated that the Polysaccharide Iron Complex 150 MG capsules had been delivered on 11/16/23 and was able to show the surveyor the capsules in the medication cart. The CN/LPN added that one (1) capsule was missing from the delivery of 20 capsules because it had been administered that morning for the 9 AM dose. The CN/LPN also added that it was her mistake that the medication was not administered in the evening on 11/16/23 because she had not entered the PO to administer the medication as a one-time PO correctly in the electronic system. The CN/LPN stated that she had verbally told the 3 PM to 11 PM shift but had not electronically entered the PO correctly to prompt the medication nurse to administer the medication on 11/16/23. The CN/LPN acknowledged that the PO for Polysaccharide Iron Complex 150 MG was to administer on 11/16/23 at a later time and that the resident had not received the 9 AM dose or any dose on 11/16/23. The PO for the Polysaccharide Iron Complex, although received on 11/16/23, was omitted. (ERROR #2) (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Progress Notes (PN) for dated 11/16/23 at 10:58 AM by the CN/LPN indicated MD called-made aware of AM medication being administered late. In addition, a PN dated 11/16/23 at 11:34 AM by the LPN indicated MD aware time to be changes. And a PN on 11/17/23 at 7:58 AM by the CN/LPN indicated Dr. (name redacted) contacted, updated, medication received. To start Polysaccharide Iron Complex Capsule 150 MG this am. A review of the November EMAR reflected that there was no administration of the Polysaccharide Iron Complex capsules on 11/16/23. Further review revealed that on 11/17/23 at 9 AM the Polysaccharide Iron Complex was administered. On 11/20/23 at 9:39 AM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that the facility policy does not speak to the process when a medication is not available. The DON added that the nurses should know that if a medication was not available that they have to find out why and let the physician know to get a PO to discontinue the medication or change to another medication. NJAC 8:39-11.2(b), 29.2(d)

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49078

Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in two (2) of four (4) medication carts inspected on 2 of 2 units. This deficient practice was evidenced by the following:

On [DATE] at 11:46 AM, the surveyor inspected South Cart 1 in the presence of the Unit Manager (UM) and observed one (1) vial Ultra Track test strips (testing strips used to check blood glucose levels with a blood glucose monitor) with no date documented on the vial when opened. The surveyor also observed one (1) box of Ipratropium/Albuterol (DuoNeb) nebulizer solution (an inhalant liquid used with a mechanical nebulizer to treat asthma), which contained one (1) open foil packet with two (2) vials. There was no date when opened observed on the foil packet or box.

On [DATE] at 11:55 AM, the surveyor interviewed the UM who stated that he could not find any dates when opened on the Ultra Track vial or the Ipratropium/Albuterol package. The surveyor with the UM reviewed the test strip manufacturer label and packaging which indicated discard remaining test strips 90 days after first opening date. The surveyor with the UM reviewed the manufacturer label for the Ipratropium/Albuterol nebulizer solution which indicated once opened they should be used within one (1) week of opening. The UM acknowledged that he was unsure of when the test strips or the DuoNeb were opened. The UM stated he would talk to the staff about dating medications when opened.

On [DATE] at 12:42 PM, the surveyor inspected North Cart 1 in the presence of the Licensed Practical Nurse (LPN) and observed one (1) box of Budesonide nebulizer solution (a steroid inhalant liquid used with a mechanical nebulizer to treat asthma) containing one (1) foil packet that was opened and contained three (3) vials that had no date when opened on the foil package or on the box.

At that time, the surveyor interviewed the LPN who stated there should be a date on the foil package when it is opened but did not see one on this package. The surveyor with the LPN reviewed the manufacturer label for the budesonide nebulizer solution which reflected once the foil pouch was opened, use ampules within 2 weeks.

On [DATE] at 10:57 AM, the surveyor interviewed Consultant Pharmacist (CP) by telephone. The CP stated she is the regular consultant and conducts unit inspections on a regular basis. The CP stated that she checks medication carts, for expired items and for items to be properly labeled. The CP also stated that any irregularities were documented and immediately reported to the staff and then put into a written report to the facility. The CP added that the staff will usually correct any issue right away.

On [DATE] at 11:15 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she spoke to the staff regarding dating when medications were opened, and the staff said they were unaware. The DON added that the staff should have known because they were dating medications when opened prior.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:32 PM, the surveyor interviewed the DON who stated that the CP had previously provided a handout to the nurses regarding Medications with shortened expiration dates. A review of the handout Medications with shortened expiration dates provided by the DON reflected under miscellaneous Test Strips Expires: 90 days after opening (or per manufacturer), under Nebulizer Inhalation Solutions DuoNeb (ipratropium bromide & albuterol) Date foil package or vial: Discard 7 or 14 days once removed from foil pouch, refer to manufacturer packaging, Pulmicort respules (budesonide) Date foil package or vial: Discard 14 days after opening foil package. NJAC 8:,d+[DATE].4(d)(g)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34421 Based on observation, interview, record review, and review of pertinent facility documentation it was identified that the facility failed to offer a resident the pneumonia (PNA) vaccination. This deficient practice was identified for 2 (two) of 5 (five) residents, (Resident # 5 and # 16), reviewed for vaccination status and was evidenced by the following: CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults [AGE] years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown: (last reviewed 9/21/23). 1. The surveyor reviewed Resident #16's medical record, who was over the age of [AGE] years old. A review of the resident's immunization history in the resident's electronic medical record revealed that there was no evidence that the resident had been offered or administered the PNA vaccination. 48781 2. The surveyor reviewed Resident #5's medical record, who was over the age of [AGE] years old. A review of the resident's immunization history in the resident's electronic medical record revealed that there was no evidence that the resident had been offered or administered the PNA vaccination. On 11/17/23 at 11:20 AM, the surveyor interviewed the Licensed Practical Nurse/Charge Nurse (LPN/CN), who stated, I don't know why Pneumonia Vaccine was not documented that it was offered on admission. On 11/17/23 at 11:43 AM, the surveyor interviewed the LPN # 1, who stated that this is her first time to work on the North Wing, and another LPN # 2 stated she has been working here for a year. LPN # 2 stated, The protocol on admission is we ask residents for vaccine information. We make sure to offer all vaccines and ask the doctor for orders if resident wants to receive them. On 11/20/23 at 9:40 AM, the surveyor interviewed the Regional Registered Nurse (RRN), who confirmed that the documentation for PNA vaccine being offered on admission was not documented in the progress notes. She stated, The company did away with the consent form but staff should document on the progress notes. On 11/20/23 at 11:12 AM, the surveyor interviewed the Infection Preventionist (IP), who stated that the residents should have been offered all vaccines, including PNA and it should be documented in the resident's record. On 11/20/23 at 1:25 PM, the surveyor discussed with the RRN, interim Director Of Nursing, Administrator and Regional Administrator regarding the above concerns and no further information was provided. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility policy and procedure adapted from the Center for Disease Control (CDC) dated January 27, 2022. The facility policy stated, All newly admitted , readmitted and current residents are to be offered a pneumococcal vaccine unless the immunization is medically contraindicated, or the resident has already been immunized. NJAC 8:39-19.4 (i)