STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Center	25 E Lindsley Road Cedar Grove, NJ 07009

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ00184015 Based on interviews, medical record reviews, and review of other pertinent facility documents on 03/06/2025, it was determined that the facility failed to thoroughly investigate an allegation of staff-to-resident physical abuse between a Certified Nursing Assistant (CNA), Home Health Aide (HHA), and a resident (Resident #1). On 02/28/2025 at approximately 1:10 PM, Resident #1 verbalized that their skin was bruised due to rough handling by two staff members during transfer that morning. The accused CNA continued to care for residents with no additional supervision after 1:10 PM on 02/28/2025 and on 03/04/2025 before the facility's investigation was complete. Interviews with the Director of Nursing (DON) on 03/06/2025 and Clinical Lead for New Jersey (CLNJ) on 03/07/2025 revealed that the facility did not conduct a thorough investigation into the abuse allegation. Interviews with the DON on 03/06/2025 and CLNJ on 03/07/2025 revealed that the facility did not follow its abuse policy. The facility's failure to follow their abuse policy, thoroughly investigate, and remove the accused staff from duty after an accusation of physical abuse by staff placed all residents under the care of CNA #1 at risk for abuse. These failures created the likelihood of serious physical and emotional harm, or impairment, and resulted in an Immediate Jeopardy (IJ) situation. The Immediate Jeopardy was identified and was reported to the DON on 03/06/2025 at 6:39 PM. The DON was presented with the IJ template that included information about the issue. The IJ began on 02/28/2025 and continued through 03/07/2025 when the facility submitted an acceptable removal plan. On 03/13/2025, the surveyor verified the implementation of the facility's removal plan during an onsite revisit. The facility implemented their removal plan which included: On 03/07/2025 Resident #1 was assessed by the Registered Nurse (RN) and no new injuries were observed. On 03/07/2025 Resident #1 was interviewed by the RN Supervisor and felt safe at the center. CNA #1 was placed on administrative leave on 03/07/2025 pending the outcome of the investigation. Residents with Brief Interview for Mental Status (BIMS) scores of ten and above were interviewed to ensure that they felt safe and had not experienced or witnessed abuse. Residents that expressed concerns had an investigation initiated. This was completed on 03/07/2025. (continued on next page)

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

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Residents with a BIMS below 10 had head to toe skin checks completed. No new skin injuries were identified. This was completed on 03/07/2025. The DON and Administrator were re-educated by the RN Market Clinical Lead on the abuse policy on 03/06/2025. The Director of Social Work and Social Service Specialist were re-educated by the RN Market Clinical Lead on the abuse policy on 03/07/2025. Staff that were currently employed were re-educated by the DON, Assistant Director of Nursing, Educator, non-clinical department heads, RN Supervisor and/or Market Clinical Advisor on the abuse policy on 03/06/2025 and 03/07/2025. The Hospice Social Worker was re-educated by the RN Supervisor on the abuse policy on 03/07/2025. This deficient practice was identified for 1 of 3 residents (Resident #1) and was evidenced by the following: Review of the facility policy titled OPS [Operations] 300 Abuse Prohibition, with an effective date of 07/01/2013, a review date of 10/24/2022, and a revision date of 10/24/2022, PAGE: 1 of 8, under POLICY included, The Center will implement an abuse prohibition program through the following: Screening of potential hires; Training of employees (both new employees and ongoing training for all employees); Prevention of occurrences; Identification of possible incidents or allegations which need investigation; Investigation of all incidents and allegations; Protection of patients during investigations; and Reporting of incidents, investigations, and Center response to the results of their investigations. Under Federal Definitions: the policy revealed Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. Willful, as used in this definition of abuse means the individual must have acted deliberately not that the individual must have intended to cause injury or harm. Under PROCESS this policy revealed, 6.1.2 The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. The PROCESS section of the facility policy also revealed, 7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following. 7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on: 7.7.1 whether abuse or neglect occurred and to what extent; and 7.7.4 interventions to prevent further injury. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Facility Reportable Event (FRE) (document used by healthcare facilities to report incidents) was submitted to the New Jersey Department of Health (NJDOH) by the facility's DON. The FRE was submitted on 02/28/2025, with a Date of Event, of 02/28/2025 and a Time of Event of 1:10 PM. The FRE revealed that on 02/28/2025 at about 1:10 PM, Resident #1 verbalized that a bruise on their skin was caused by rough treatment by their assigned CNA during a transfer that morning. The FRE revealed that the following interventions were implemented after the event: skin assessment to check for bruising, family notification, physician notification, hospice nurse notification, and investigation initiated. According to the admission Record (AR) Resident #1 was admitted to the facility with diagnoses which included but were not limited to sepsis, unspecified organism; metabolic encephalopathy; acute kidney failure, unspecified; type 2 diabetes mellitus without complications; unspecified systolic (congestive) heart failure; anemia, unspecified; and encounter for palliative care. According to the Minimum Data Set (MDS), an assessment tool dated 12/26/2024, Resident #1 had a BIMS score of 8 out of 15, which indicated that Resident #1's cognition was moderately impaired. The MDS revealed that Resident #1 was dependent on helpers for self-care activities. The MDS also revealed that Resident #1 was dependent on two or more helpers to roll left and right, move from sitting to laying, move from laying to sitting, and move from sitting to standing. A review of Resident #1's Care Plan (CP) initiated on 12/15/2024 revealed under Focus, that Resident #1 requires max assistance for ADL [activities of daily living] care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, toileting [.]. Under Interventions, Resident #1's CP included, Monitor for SOB [shortness of breath], fatigue and/or change in condition. Adjust ADL tasks accordingly and encourage resident/patient to pace him/herself during ADL activity. The CP interventions initiated on 12/15/2025 also revealed Monitor for pain. Attempt non-pharmacological interventions to alleviate pain and document effectiveness. Administer pain medication as ordered and document effectiveness/side effects. A review of Resident #1's Progress Notes (PNs) dated 02/28/2025 at 2:52 PM written by Licensed Practical Nurse (LPN) #1 revealed: Resident reported he/she was roughed up by the 2 CNA's during transfer with the total lift this morning. The resident complained of lower back pain for which he/she was medicated with good effect. Head to toe assessment done together with unit manager, no skin issues noted. During a telephone interview on 03/06/2025 at 12:29 P.M., LPN #1 stated that she and Unit Manager (UM) #1 conducted a check of Resident #1's skin on 02/28/2025. LPN #1 stated that the skin check was performed because at approximately 1:00 P.M. Resident #1 complained of rough treatment during a transfer with a Hoyer Lift (a mechanical device that helps caregivers safely transfer patients with limited mobility. Hoyer is a brand name often used as a generic term to refer to any type of mechanical patient lift) that morning. During the same interview LPN #1 stated that the CNA assigned to Resident #1 that day continued to care for the rest of her assigned residents, but Resident #1 was removed from the CNA's assignment. LPN #1 stated that if she became aware of an abuse accusation about a staff member, she would notify her manager. LPN #1 stated that if the UM was not present, she would change the assignment of the staff members accused of abuse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/06/2025 at 12:57 P.M., Home Health Aide (HHA) #1, who was also accused of rough treatment by Resident #1, stated that she routinely cared for Resident #1. HHA #1 stated that the last day she provided care to Resident #1 was 02/28/2025. During a follow-up telephone interview on 03/07/2025 at 12:46 P.M., HHA #1 stated that on 02/28/2025 she stopped caring for residents at 1:00 P.M., then was off for the weekend (03/01/2025 and 03/02/2025). HHA #1 stated that she did not perform resident care on 03/04/2025 because she went to the office for education. HHA #1 stated that she resumed care of residents on 03/05/2025 but was not assigned to Resident #1. During an interview on 03/06/2025 at 1:14 P.M., CNA #1, who was accused of rough treatment by Resident #1, stated that Resident #1 was usually one of the residents assigned to her. CNA #1 stated that on 02/28/2025 she and a HHA provided morning care to Resident #1. CNA #1 stated that at that time Resident #1 requested to be manually lifted rather than placed in the Hoyer Lift. CNA #1 stated that it was the first time she knew of the resident complaining about the Hoyer Lift and other than that, Resident #1 was fine during morning care. CNA #1 stated that Resident #1 returned from activities at approximately 12:30 or 1:00 P.M. that day, made a complaint of rough treatment, and was then removed from CNA #1's assignment. CNA #1 further stated that she continued to care for other residents that day until she left work at 2:30 P.M. A review of a facility document Witness Statement/Interview Documentation Form, completed by CNA #1 and dated 2/28/25 was reviewed. The document revealed: I was assigned to [Resident #1] this morning with [his/her] Hospice Aide. We attended to [him/her] around 10:30 A and put [him/her] in the wheelchair using the Total Lift. At about 1:10 the Unit Manager asked us to put [him/her] back on the bed to assess [his/her] skin. The Hospice Aide and I put [him/her] back in the bed using the lift we were instructed. After the Manager finished the skin assessment, she told us that the resident reported that we were [NAME] (rough) with her when we use the lift to get [him/her] up this morning. During an interview on 03/06/2025 at 2:02 P.M., UM #1 stated that Resident #1 required total care. UM #1 stated that in the afternoon of 02/28/2025 she overheard Resident #1 say that his/her whole body was bruised. UM #1 stated that at that time she and LPN #1 conducted a full body assessment and did not observe any marks. UM #1 stated that the assessment was documented, and notifications were made to Resident #1's Physician and family. UM #1 stated that on 03/01/2025 Resident #1 had no injuries, and still had no injuries on the day this interview was conducted. During the same interview, UM #1 stated that HHA #1 had already left work for the day when Resident #1 made the accusations of rough treatment. UM #1 stated that Resident #1 was removed from CNA #1's assignment until she finished work at 2:30 P.M. that day. UM #1 stated that the process after an abuse accusation was to complete an incident report, investigate, and make notifications. UM #1 stated that if the abuse accusation was substantiated the accused staff would have been sent home while the investigation was completed. UM #1 further stated that if it was determined that there was abuse, she would have suspended the CNA. A review of the facility document Witness Statement/Interview Documentation Form, completed and signed by UM #1, dated 2/28/25 was reviewed. The document revealed: [Resident #1] was brought to the nurses station from activities around 1250p [12:50 P.M.]. I asked [him/her] to stay there for a few minutes til [until] I get [his/her] aide to put [him/her] in bed. At about 110pm [1:10 P.M.] resident alleged that [his/her] whole body is bruised because the CNAs were rough when they used the lift to get [him/her] up this morning. I then instructed the CNAs to put her back to bed to be assessed which they did. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/06/2025 at 2:30 P.M. the DON stated that when residents made allegations of injuries or abuse, the facility staff responded right away. The DON stated that the process was to interview the resident, review the chart, and get statements from staff. The DON stated that if it was believed or there was a strong suspicion that there was possible abuse or neglect, the staff member would have been sent home for the duration of the investigation. A review of CNA #1's electronic timecard revealed that CNA #1 worked on 02/28/2025 from 6:31 A.M. to 2:50 P.M. The timecard revealed that CNA #1 did not work from 03/01/2025 to 03/03/2025. The timecard further revealed that CNA #1 worked on 03/04/2025 from 6:34 A.M. to 2:29 P.M. During the same interview the DON stated that after the accusation of rough treatment was made by Resident #1 on 02/28/2025, CNA #1 was not sent home and that in general she would have needed to check with the other residents assigned to a CNA who was accused of abuse. The DON stated that part of an investigation was interviews with other residents. The DON stated that interviews with other residents were not done. The DON stated that other residents in CNA #1's assignment were not interviewed because she determined that there was no abuse. The DON further stated that her investigation was completed on 03/04/2025 at 12:38 P.M. when she emailed a FRE follow-up to the NJDOH. On 03/06/2025 at 4:28 P.M., a follow up interview was conducted with the DON regarding the facility policy OPS 300 Abuse Prohibition. The DON stated that the term removed from duty, in this policy meant sent home. The DON stated that the facility employee should have been sent home on the day they were accused of abuse. The DON further stated that there was no increased supervision of CNA #1 while she cared for other residents after the accusation of abuse was made against her. Also, during the follow-up interview the DON stated that if the facility's abuse policy wasn't followed residents could be injured, have emotional distress, get withdrawn, and their physical wellbeing could suffer. An interview was conducted with the CLNJ on 03/07/2025 at 11:22 A.M. The CLNJ stated that it was the expectation that an abuse investigation included: interview of the accused staff and other staff; an interview of the resident who made the accusations; and interviews of other residents. During the same interview, the CLNJ stated that it was the expectation that an employee accused of abuse was immediately placed on leave meaning that they were removed from the premises while the investigation was continued. The CLNJ stated that an investigation was considered complete when the abuse is substantiated or is unsubstantiated. The CLNJ further stated that allowing the accused staff member to continue to care for other residents was not in line with the facility's abuse policy. N.J.A.C.:8.39-4.1 (a) (5)