

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arbor Glen Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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: 315036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arbor Glen Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Complaint # 406965Based on interviews and record review and review of pertinent facility documentation, the facility failed to ensure that the physician was notified in a timely manner of a resident's change in condition for 1 of 3 residents reviewed for transfer to the hospital (Resident #1). This deficient practice was evidenced by the following:On 11/10/25 at 9:30 AM, the surveyor reviewed Resident #1's closed medical record. A review of Resident #1's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; congestive heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs) chronic obstructive pulmonary disease (aka COPD, a group of lung diseases that cause airflow obstruction and breathing difficulties) and obstructive sleep apnea (a sleep disorder where the airway repeatedly collapses or becomes blocked during sleep, leading to pauses in breathing).A review of Resident #1's electronic Progress Notes (PN) included the following note written by the Unit Manager dated 6/30/25, which was listed as a late entry and times were not in chronological order: 8:00 am In bed asleep during rounds. Slow to respond. Would opens his/her eyes when called but would go back to sleep. VS:BP-159/85, P-97, T-97.9, O2 sat-91%. Seen by the Respiratory Therapist and assessed for respiratory status. O2 saturation monitored. Unable to be fed/eat for breakfast and lunch. Medication not given due to lethargy. O2 at 3L/min continuous. Head of bed elevated at all times. No respiratory distress noted. Kept comfortable. 1:30 pm- Daughter came in. She is very concerned of Resident #1's current status. Not able to eat and take his/her medication. She wanted Resident #1 to be sent back to the hospital for further evaluation. Resident #1's physician made aware and gave orders for the resident to be sent to ER for evaluation. daughter took Resident #1's personal stuff with her.2:15pm- Called ambulance for transportation.3:00 pm- Picked up by ambulance via stretcher with O2 at 3l/min. daughter made aware that Resident #1 was just picked up. will go to the ER2pm- daughter visited. Given update of Resident #1. daughter is very concerned.Further review of Resident #1's PN indicated that on 6/30/25 at 11:39 AM the nurse documented that 3 medications were not given because resident was not opening his/her mouth. Further review of Resident #1's closed medical record included the following notes written by the respiratory therapist dated 6/30/25:10:13 AM (Respiratory Treatment Note) RCP received patient in bed with oxygen via nasal cannula at 5LPM however patient was not wearing oxygen underneath his/her nose. Patient had nasal cannula on his/her head so patient was technically on room air. RCP did pulse oximeter check to find SpO2 was 67%. Patient lethargic and not responsive. RCP obtained oxygen tank and oxygen non-rebreather mask and placed oxygen non-rebreather mask on patient at 15LPM over nasal cannula at 5LPM. RCP adjusted nasal cannula and placed it underneath patient's nose with non-rebreather mask on top. RCP stayed in the room and obtained/monitored vitals. SpO2 increased to 98% while on non-rebreather. HR 85/min and RR 18/min. Patient lethargic and not responsive to questions/commands. Patient unable to do incentive spirometry at this time. RCP informed nursing manager and nurse of patient's condition. Nursing manager and nurse came in the room to monitor patient. RCP left the room and informed director of rehab regarding patient's condition. Speech therapist and occupational therapist also came in the room to assess patient and informed the director of Rehab regarding patient's condition.When RCP returned to check on patient approximately 5 minutes later RCP received patient on oxygen via nasal cannula at 5LPM. Nursing manager informed RCP that nurse removed non-rebreather. RCP rechecked vitals to find: SpO2 92%, HR 87/mi and RR 18/min on oxygen via nasal cannula at 5LPM. Patient stable at this time. Nursing supervisor and nurse are going to continue to monitor patient. 11:05 AM (Progress Note) Patient unable to do incentive spirometry Patient lethargic and not responsive. Unable to follow commands. Patient is on 5 liters of oxygen via nasal cannula. Nurse and nursing supervisor informed. On 11/10/25 at 10:05 AM, the surveyor interviewed the Registered Nurse/Supervisor (RN/S) regarding the process for a resident that had a change in condition and specifically an episode of desaturation and was lethargic and not taking medications. The RN/S stated that the resident would be placed on oxygen with a non rebreather mask and monitor the pulse oximeter. If the resident improved, then the resident would be monitored and the physician would be notified. The RN/S stated that if the resident did not improve then the resident would be sent immediately to the emergency room. The RN/S stated that if a resident was lethargic, she would assess the vital signs and blood sugar and notify the physician for additional orders and/or to be sent to the hospital for evaluation. On 11/10/25 at 10:23 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) regarding change in condition. The ADON/IP stated that an</p>		