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	12/10/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain an effective pest control program in 1 of 1 kitchen observed. The deficient practice was evidenced by the following: During the initial tour on 12/1/25 at 9:51 AM, the surveyor observed the dual conventional oven that had a stove and a grill on top. The Food Service Director (FSD) stated the stove and grill on top were being used to cook residents' food. The FSD stated the dual ovens in the bottom do not get used for cooking. The surveyor did not observe any signage that the dual ovens in the bottom were out of order or not to be used. The surveyor opened the dual ovens and observed inside four strips of glue board traps with dead roaches. The surveyor observed inside the first oven five dead roaches on one glue board, and seven dead roaches on another. The surveyor observed the second oven, which had two dead roaches on one glue board and seven dead roaches on the other glue board. On that same date and time, the FSD stated, We have a roach problem since last month, the roach trap gets changed every Monday when the pest control comes. The surveyor asked when the glue boards were changed last and the FSD responded when the pest company came last. The surveyor then asked how long it had been that the dual ovens have not been working. The FSD responded that the ovens did not work for three years since the FSD was at the facility. The surveyor requested for all the Pest Control Services reports for the last three months. On 12/1/25 at 10:26 AM, the FSD informed the surveyor that the local health department most recent inspection was on 10/2/24. The surveyor requested for the most recent inspection report. On 12/1/25 at 11:51 AM, the District Manager provided the Pest Control services reports which revealed below:-On 11/11/24, glue boards for roaches in target areas-kitchen, dishwash area.-On 11/10/25, glue boards for cockroaches in target areas-kitchen, dishwash area, utility room and storage area. At that same time, the surveyor requested from the License Nursing Home Administrator (LNHA) all the Pest Control reports and treatments for the last three months. The District Manager also provided the local health department inspection report dated 10/2/2024, which revealed one dead cockroach in kitchen where grease trap was located; Contact pest control to address asap (as soon as possible). On 12/2/25 at 9:30 AM, the LNHA stated, the pest control was called yesterday on 12/1/25 to spray the kitchen. The LNHA provided additional Pest Control services reports which further revealed below:-On 9/8/25 in the kitchen area, minor roach activity was observed on glue boards.-On 9/22/25, minor roaches captured observed on glue boards, liquid application done on surrounding areas.-On 10/13/25 (three weeks later), roaches were found underneath the prep area sink, glue boards, and liquid application to surrounding areas.-On 10/27/25, roaches in the kitchen dishwasher area caught on glue boards, applied roach gel bait, and spot treated.-On 11/10/25, observed moderate captures of roaches on glue boards in the dishwasher area, applied gel bait, and replaced glue boards and spot treated.-On 12/1/25 (three weeks later), treated the kitchen area back by ovens where roaches were in glue board, applied gel bait, and treated cracks and crevices around stove area. On 12/2/25 at 11:44 AM, the surveyor interviewed the Maintenance Director (MD) regarding the issue with roaches in the kitchen since the last inspection of the local health department from October 2024. The MD responded that the Pest Control come bi-weekly and stated, he was not aware the roach problem started since last year. The surveyor asked who was (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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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	responsible for Pest Control and he responded anyone can call the Pest Control Service. On 12/8/25 at 10:46 AM, the surveyor notified the LNHA of the above findings and concerns. The LNHA stated, I've not heard of this, roaches in the kitchen, until surveyor's inquiry. The LNHA also stated that the FSD did mention it to me about the no signage on the dual ovens and that the sign was placed for non functional oven after surveyor's inquiry. On 12/8/25 at 12:37 PM, the surveyor met with the LNHA in her office as per her request, in the presence of the District Manager. The surveyor asked the LNHA and the District Manager, if they read the reports of the Pest Control service in the past few months which revealed roach activities in the dishwater area, utility room, storage area, under the prep sink, and back ovens, the LNHA and District Manager did not responsd. The surveyor asked if the stove and the grill, on top of the dual ovens, were being used to cook residents' food and the District Manager confirmed, Yes. The District Manager also confirmed that there was no signage placed on the dual ovens to indicate not to use when the surveyor toured with him and the FSD. On 12/8/25 at 12:56 PM, the survey team met with the LNHA, the Clinical Lead (CL), and the surveyor notified them of the above findings and concerns since 10/2/24. On 12/9/25 at 11:57 AM, the survey team met with the LNHA, Director of Nursing (DON), the CL, and the LNHA stated that the provided Quality Assurance Evaluation completed by the District Manager for September of 2025, October 2025, and November 2025, which revealed no mention of the dual ovens not in working order. A review of the facility's Pest Control Policy dated 7/18/25, which revealed under Purpose, To ensure an environment free of insects and rodents. NJAC 8:39-31.5

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and review of facility documentation, it was determined that the facility failed to follow its Grievance/Concern Policy by failing to a.) thoroughly investigate a grievance filed by unsampled resident, b.) followed through the concerns of 1 of 1 resident during resident council meeting, and c.) notify the residents of the comprehensive resolution with regard laundry concerns identified during resident council meeting for 5 of 5 residents (Residents #23, #31, #42, #61, and #65). This deficient practice was evidenced by the following: On 12/2/25 at 10:00 AM, the surveyor reviewed the provided last three months Resident Council Minutes that was provided by the Licensed Nursing Home Administrator (LNHA) and revealed that on 10/14/25, there were seven members (residents) and two non-council members (Recreation Assistant and Food Service Director) in attendance. During the 10/14/25 Resident Council Meeting (RCM), Resident #23 had voiced concerns regarding the laundry process and clothing return. Further review of the 10/14/25 RCM revealed that there was an attached Departmental Response Form (DRF) for Resident #23's voiced concerns, and the response included in the DRF was that the Resident was given the facility's laundry process and reminded that the clothes were washed at the facility and delivered back to the appropriate resident in a timely manner. A review of the attached undated facility's Laundry Process revealed that all personal clothing items were to be collected by nursing staff and placed in the designated laundry chute (a vertical gravity-powered conduit designed to transport soiled linens from upper floors directly to a designated collection point, typically the laundry room) for cleaning. Once laundered, housekeeping staff will sort and return the cleaned items to the appropriate resident rooms. Housekeeping was responsible for labeling all personal clothing to ensure proper identification and return. Further review of the above facility's Laundry Process did not include information how often the personal clothing items were to be collected and returned in a week. On 12/4/25 at 10:33 AM, the surveyor met with Residents #23, #31, #42, #61, and #65 during RCM, and discussed the last three months council minutes. Resident #23 and Resident #65 informed the surveyor that the residents on 10/14/25 meeting wanted to know the laundry process because they were unsure of the pickup days and returned days for laundered personal clothing, and they were not provided a clear information, and was told that laundry was being picked up and it was downstairs. The five residents acknowledged that they were not satisfied with the resolution about the concerns with laundry services because they were not provided enough information. At that same time, Residents #23 and #65 both stated that there were times that their and other residents personal clothing were not picked up to be laundered for few days that was why they asked the facility's process for laundry. Resident #65 also added that other resident (who did not provide a name) had to use other resident's clothing because their clothing had not returned from laundry. All five residents confirmed that the concern with laundry still persisted and there were no definite answer as to how often the laundry pick up. All residents in the meeting thought that the laundry was being picked up every Monday and delivered back on Friday. Furthermore, Resident #65 stated that there was an incident also that they received other resident's clothes. Resident #65 further stated that they knew it was not their clothes because they saw other resident's name on the clothes provided to them. On 12/4/25 at 12:10 PM, the surveyor interviewed Certified Nursing Aide #1 (CNA #1), who informed the surveyor that it was CNAs responsibility to send the dirty clothes of the residents to laundry via chute but unaware how often they were being laundered. She further stated that at times other CNA forgot to send them down and when she saw them the following day she send them to the chute. On 12/4/25 at 12:15 PM, the surveyor interviewed CNA #2, who informed the surveyor that she thinks that the personal clothing of the residents were being laundered two times a week but unsure when. She further stated that she sent them to the laundry via chute. On 12/4/25 at 12:30 PM, the surveyor interviewed the Laundry Staff (LS), who informed the surveyor that she was the assigned staff for personal clothing of (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents in the facility. The LS stated that personal clothing of residents were laundered at the facility daily except weekends and returned to the residents the same day. She further stated that it was the responsibility of the CNA to ensure residents soiled personal clothing were picked up and sent to laundry via chute. She added that it was her responsibility to sent it back to residents clean and that she hung them to residents' closet. On 12/4/25 at 12:35 PM, the surveyor interviewed the Director of Housekeeping (DH) in the presence of LS. The surveyor notified the DH of the above concerns of the residents regarding laundry pick-up and delivery. The surveyor also asked the DH and LS if there were issues about it. The DH informed the surveyor that he remembered one resident complained about missing clothes and when he went and check he found out that the file of dirty clothes were inside resident's room. The DH further stated that the CNA had forgot to send it for laundry and filed up that was why the resident thought the clothes were missing. On that same date and time, the surveyor asked the DH if grievance was filed on behalf of the resident who had concerns with missing clothes. The surveyor also asked who the resident was, CNA, and when it happened, and the DH stated that he was unable to remember the name of the resident, what unit, who was the CNA, and other details. The DH further stated that he did not fill out a grievance form about the resident's concern because they found the dirty clothes. He added that he was unsure if grievance form should have been filled out and that the Administrator was not notified. On 12/8/25 at 12:55 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), the Clinical Lead (CL; also known as the regional director), and they were notified of the above findings and concerns with regard to residents' grievance regarding laundry services. At that same time, the surveyor also notified of the concern that the provided binder for grievance did not include information provided by the DH about missing clothes and the dirty clothing filed by the unsampled resident and no grievance was formulated. The LNHA acknowledged it should have been filed as a grievance the concern of unsampled resident that the DH communicated to the surveyor. On 12/9/25 at 11:56 AM, the survey team met with the LNHA, Director of Nursing (DON), and the CL, and the LNHA stated that we are educating the activity personnel about the facility's procedure and revising the process in responding to problems or concerns brought up by residents. The LNHA also stated that education will be provided also with regard to on how to report grievance, resolution, managing the grievance process, and on how to respond. A review of the facility's Grievance/Concern Policy that was provided by the DON with a review and revision date of 10/15/24, revealed that the patient/resident has the right to voice grievances to the Center or other agency or entity that hears grievances.All patients and/or their representatives may voice grievances/concerns and recommendations for changes. Service location leadership will investigate, document, and follow up on all concerns and grievances registered by any patient or patient representative. Social Service personnel will serve as patient advocates in the grievance/concern process. The Administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process.receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility.Process:.1.1 The right to file grievances orally (meaning spoken) or in writing. On 12/9/25 at 1:55 PM, the survey team met with the LNHA, DON, and CL for exit conference and there were no additional information provided by the LNHA. NJAC 8:39-4.1(a) 14, 15, 35

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure 2 of 21 residents (Residents #20 and #39) call bells were within reach, able to use to accommodate residents' needs, and follow facility's call light policy.This deficient practice was evidenced by the following: 1.On 12/8/25 at 11:01 AM, Surveyor #1 (S #1) in the presence of the Registered Nurse/Unit Manager #1 (RN/UM #1) entered Resident #39's room and both observed the resident lying in a low bed with a cane by their side. S#1 observed the resident's call bell wrapped up in a loop and clipped to the wall where the system was attached to the wall. The call bell was not within reach of the resident. S #1 asked RN/UM #1 if the resident could reach the call bell, and she replied no they cannot. RN/UM #1 moved the call bell and placed it on the bed next to the resident and explained to the resident that it should stay where they can reach it if needed. 2.On 12/8/25 at 6:56 AM, Surveyor #2 (S #2) was accompanied by Registered Nurse/Unit Manager #2 (RN/UM #2) during incontinence round in unit 2. Both S #2 and RN/UM #2 observed Resident #20 was lying on bed, awake, and agreed for incontinence check. S #2 observed the call bell on the floor and not accessible to the resident. RN/UM #2 immediately picked up the call bell on the floor and clipped it into resident's bed. RN/UM #2 stated that the call bell should not be on the floor and acknowledged that it was not within reach. On 12/8/25 at 12:55 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), the Clinical Lead (CL) for concerns above for Residents #20 and #39. S #1 asked if residents' call bells should always be within reach, and the CL stated yes, they should always be within reach. On 12/9/25 at 11:56 AM, the survey team met with the LNHA, Director of Nursing (DON), and the LNHA stated that education was done immediately yesterday about call bells. The LNHA further stated that education provided was to ensure call bells were within reach of the residents. A review of the facility's Call Lights Policy that was provided by the LNHA with a review and revision date of 7/15/25, revealed that patients will have a call light or alternative communication device at each patient's bedside.to allow patients to call for assistance when unattended.Process:.4. Staff will ensure the call light is within reach of the patient and secured as needed. 5. The call system will be accessible to patients while in their beds or other sleeping accommodations within the patient's room. On 12/9/25 at 1:55 PM, the survey team met with the LNHA, DON, and CL for exit conference and there were no additional information provided by the LNHA. NJAC 8:39-31.8 (c)(9)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Complaint # 406936Based on observation, interview, and record review it was determined that the facility failed to develop a comprehensive, person-centered care plan for 1 of 24 residents (Resident #98) reviewed for comprehensive care plans. This deficient practice was evidenced by the following: 1.On 12/9/25 at 9:04 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #98.A review of the admission Record (an admission summary) revealed that Resident #98 had diagnoses that included, but were not limited to; chronic kidney disease, peripheral vascular disease (a condition where blood vessels outside of the heart and brain become narrowed or blocked), hypertension (high blood pressure), and difficulty walking. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference date (ARD) of 8/12/24, indicated a Brief Interview Mental Status (BIMS) score of 12 out of 15, which indicated the resident had moderate cognitive impairment. In Section GG (Functional Abilities and Goals) of the MDS assessment indicated the resident needed substantial/maximal assistance with toileting hygiene. In Section H (Bladder and Bowel) of the MDS assessment, Resident #98 was coded as frequently incontinent and not on a toileting program. A review of the Care Area Assessment (CAA; a tool used to investigate issues triggered by MDS responses, to implement person centered care plans for residents) indicated a care plan (CP) for urinary incontinence (loss of bladder control) would be initiated. A review of the physician's order dated 8/24/24, indicated toilet before and after meal, before going to bed and as needed every shift for comfort care. A review of the resident's CP revealed there was no CP and interventions related to (r/t) the resident's urinary incontinence and/or toileting. On 12/9/25 at 10:16 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Clinical Lead (CL) about care planning. The DON stated CP were initiated by the unit managers and the nurse supervisors. The DON explained ADL (activities of daily living) care including incontinence care and toileting were part of the basic CP for residents. At that time, the surveyor notified the DON and the CL of the concern that the MDS assessment was triggered for a CP to be initiated and there was no CP for urinary incontinence and/or toileting for Resident #98. The DON and the CL reviewed the resident's CP in the EMR and could not find a CP related to urinary incontinence and toileting. The DON stated the EMR would be reviewed to provide any additional information. On 12/9/25 at 11:57 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the DON, and the CL of the above concern that there was no CP r/t urinary incontinence and toileting for Resident #98. On 12/9/25 at 1:20 PM, the LNHA, the DON, and the CL met with the surveyors. The DON stated the CP had one intervention that included to support toileting, which was found in the Enhanced Barrier Precaution (EBP) CP. Review of the CP and intervention documented Protective Personal Equipment would be worn .to support toileting. There was no additional documentation r/t toileting or urinary incontinence care. The surveyor asked if the CAA of the MDS triggered for a CP to be done would it be expected for there to be documented in the resident's CP. The DON replied yes. There was no additional information provided to the surveyor. A review of the facility's Person-Centered Care Plan Policy with a last revised date of 10/24/22, under Policy indicated: A comprehensive, individualized CP will be developed within seven days after completion of the comprehensive assessment.and review and revise the CP after each [MDS] assessment.CP includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments.The interdisciplinary team, in conjunction with the patient and/or patient representative, as appropriate, will establish the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors r/t the effectiveness of the plan of care.Documentation will show evidence of.patient's goals and preferences.Development of care planning interventions for all CAAs triggered by the MDS; and Rationale for not care planning for a specific triggered CAA . NJAC 8:39-27.1(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, it was determined that the facility failed to update and revise the comprehensive care plan of a resident. This deficient practice was identified for 2 of 24 residents reviewed, Resident #9 and Resident #33.The deficient practice is 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. 1.Surveyor #1 reviewed the electronic medical record (EMR) for Resident #33. A review of the resident's admission Record (AR; an admission summary) reflected that the resident was re-admitted to the facility with diagnoses which included but not limited to, essential hypertension (high blood pressure) and major depressive disorder (a mood disorder causing persistent sadness, loss of interest and hopelessness that significantly impairs daily life). A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/13/25, had a Brief Interview Mental Status (BIMS) score of 7 out of 15, which indicated the resident has severe cognitive impairment. Section I of the QMDS revealed section Psychiatric/Mood Disorder which reflected a diagnosis of Psychotic disorder (other than schizophrenia), and that the resident was not coded for schizophrenia or bipolar disorder. A review of the resident's comprehensive Care Plan (CP), dated 11/21/25, revealed, under the focus area, entries reflecting, diagnoses of cognitive loss/dementia, psychiatric disorders and psychosis. A review of the resident's Order Summary Report (OSR), revealed an order to monitor behaviors every shift for bipolar, orders for quetiapine, (an antipsychotic medication normally used to treat psychiatric disorders), that reflected an indication for use of dementia with psychotic features. A review of the resident's progress notes (PN), revealed notes titled Care Plan Meeting (CPM). The most recent CPM reflected that the resident was being followed by psychiatry for depression and psychosis. Further review of PN revealed chronic care management notes which were written by the resident's attending physician, otherwise known as physician progress notes (PPN). A PPN dated 11/15/25, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected a diagnosis of schizoaffective disorder. Further review of PN revealed psychiatric follow up notes (PFN) written by the psychiatric physician's assistant (PA) or nurse practitioner (NP). A PFN dated 11/5/25, written by the PA reflected a diagnosis of schizoaffective disorder in the notes and on an addendum to the note dated 11/6/25. A PFN dated 8/20/25, written by the NP reflected a diagnosis of schizoaffective disorder in the notes. On 12/2/25 at 12:06 PM, S #1 interviewed the Psychiatrist PA by phone. The PA stated the they remember the resident. S #1 notified of the above concerns about the inconsistency with diagnoses for the resident in the notes and medical record. The PA stated that the resident did not have schizoaffective disorder and that they were doing a look back in the medical record and it was unclear, with no proof of it, but they were trying to simplify billing with codes in the addendum. The PA also stated they wanted to be sure the resident had an appropriate diagnosis for the medications that they were taking. The PA stated that they would clean up the notes on the next visit. On 12/8/25 at 12:55 PM, the survey team met with the facility Licensed Nursing Home Administrator (LNHA), the Assistant Director of Nursing (ADON) and the Clinical Lead (CL), and S #1 notified the facility management about concerns with inconsistencies and discrepancies with diagnoses in the medical record and the resident's CP. S #1 asked if the CP should reflect the resident's current condition, including diagnoses, and the CL stated yes, the CP should match the resident's condition. On 12/9/25 at 11:56 AM, the survey team met with the LNHA, Director of Nursing (DON) and CL, and the LNHA stated that the facility reached out to the Psychiatrist PA for correct and updated diagnoses and the diagnoses in the CP were what the resident was admitted with and were not updated when the Psychiatry made changes. The CL stated the CP was now updated after surveyor's inquiry. A review of the facility's Person-Centered Care Plan Policy, revised 9/15/25, reflected under Comprehensive CP .5.1 The CP must be customized to each individual patient's preferences and needs .6.2 Reviewed and revised by the interdisciplinary team.as needed to reflect the response to care and changing needs and goals;. 2. On 12/2/25 at 9:30 AM, Surveyor #2 (S #2) requested from the LNHA for Resident #9's fall investigations. On 12/2/25 at 12:36 PM, S #2 reviewed the EMR of Resident #9. A review of the AR revealed that Resident #9 had diagnoses that included but were not limited to; syncope (fainting), fall, nasal fracture, heart failure, retention of urine, and urinary tract infection. A review of the comprehensive MDS, with an ARD of 10/14/25, indicated a BIMS score of 10 out of 15, which indicated the resident had moderate cognitive impairment. A review of the PN dated 10/24/25 indicated Resident #9 had a fall incident. On 12/2/25 at 10:10 AM, the LNHA provided S #2 with Resident #9's fall investigations, which was a total of one fall incident. (continued on next page)

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the fall investigation completed by the facility dated 10/24/25, the conclusion and summary of the investigation indicated the .Plan of correction/intervention to provide resident with toileting schedule. A review of the resident's CP revealed there was no intervention r/t a toilet schedule being initiated for the resident. On 12/4/25 at 9:42 AM, S #2 observed Resident #9 sitting in a wheelchair at their bedside, dressed in well fitted clothes. The resident was alert, and verbally responsive. A Certified Nurse Aide (CNA) was at the bedside supervising and conversing with the resident. On 12/4/25 at 9:43 AM, S #2 interviewed the Registered Nurse (RN) who stated that the resident was a fall risk, and interventions were in place to prevent falls. The RN stated that they would sometimes provide one on one monitoring of the resident when Resident #9 tried to get up on their own; sit with the resident by nurses' station and provide an activity for the resident to do; and floor mats at the resident's bedside. At that time, S #2 asked the RN if she recalled the resident's 10/24/25 fall and any interventions implemented after the fall. The RN stated she did not recall the details of the fall, or any interventions put into place after the event. S #2 asked about the resident's urinary continence and toileting, and the RN replied, Resident #9 was occasionally incontinent and asked staff to go to the bathroom. S #2 asked the RN if the resident was on a toileting schedule, and the RN replied the resident was not on a schedule; Resident #9 would say when they needed to go to the bathroom and nursing staff checked on the resident a few times on the shift to see if the resident needed to be toileted. The RN was not aware of a toileting schedule being part of the resident's CP. The RN stated the unit managers and nurse supervisors were responsible for initiating and updating CP. On 12/4/25 at 9:59 AM, S #2 interviewed the RN Unit Manager (RN/UM) who stated after a resident's fall, an incident report was completed by the nurse which would be reviewed by the unit manager and the DON. The RN/UM explained an interdisciplinary team (IDT) meeting was then held for a root cause analysis, to determine why the fall happened, interview staff, and obtain statements. The RN/UM stated the IDT planned on what intervention would be implemented to prevent future falls. S #2 asked the RN/UM who reviewed and updated CP. The RN/UM replied, the nurses, and the unit managers would. At that same time, the RN/UM confirmed Resident #9 was a fall risk and did have a fall event in October 2025. The RN/UM could not recall the details of the fall. S #2 asked if there were any interventions put into place. The RN/UM replied she was not sure and would have to check the EMR. The RN/UM stated it would be expected for interventions put into place after a fall event to be included in the resident's CP. S #2 asked the RN/UM if the resident was on a toileting schedule, and the RN/UM replied the resident was not on a toileting schedule, usually Resident #9 let the staff know when they needed to go to the bathroom, and when the resident got antsy the staff would take the resident to the bathroom. On 12/4/25 at 10:09 AM, S #2 and the RN/UM were joined by the Clinical Lead (CL). S #2 notified the RN/UM and CL of the concern that Resident #9's 10/24/25 fall investigation indicated an intervention of a toileting schedule would be implemented and there was not documentation of the resident's CP being updated. The CL stated they would review and provide any additional information. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/8/25 at 12:55 PM, S #2 notified the LNHA and the CL of the concern regarding the resident's CP not being updated after their fall incident as indicated. On 12/9/25 at 11:57 AM, the LNHA, the DON, and the CL met with the surveyors. The LNHA stated the CP was updated after the surveyor's inquiry. The DON stated that at the time there was an overlap when the CP was reviewed. The DON further explained the CP should have reflected the new intervention but reflected the section GG assessment of the MDS done at the time of the review. A review of the facility's Person-Centered Care Plan Policy with a last revised date of 10/24/22, under Practice Standards indicated: .7. Care plans will be.7.2 Reviewed and revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments and as needed to reflect the response to care and changing needs and goals; and.7.3 Documented on the CP Evaluation Note. NJAC 8:39-11.1; 11.2(h)(i); 27.1(a)

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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. Complaint # 2682000Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to ensure that a resident received a physician's order for Librium in a timely manner or notify the physician that the ordered medicine was unavailable for additional orders for 1 of 24 sampled residents reviewed (Resident #63). This deficient practice was evidenced by: A review of Resident #63'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; major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities, significantly interfering with daily life, work, and relationships), alcohol abuse (problematic pattern of alcohol use causing significant impairment or distress, diagnosed by 2 or more of 11 symptoms (like craving, tolerance, withdrawal, failing obligations, risky use, social problems) within 12 months, categorized as mild, moderate, or severe), and homelessness (the condition of not having a regular or adequate place to live). A review of Resident #63's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that Resident #63's cognition was intact. A review of Resident #63's Progress Notes (PN) included the following late entry general note with an effective date of 11/22/2025 at 11:17 AM, which included information that the resident asked the Registered Nurse (RN) if the nurse could provide an alcohol, and the RN explained the we cannot provide alcohol in the facility. The resident expressed to the RN their feeling as they were going to crack. The RN asked resident if they felt as if they were having withdrawal symptoms, they just kept expressing they were going to crack. The resident had a history of ETOH (ethanol, the intoxicating alcohol in beverages) abuse with 50 plus history, depression, and PTSD (post traumatic stress disorder), with an appointment with psychiatrist at [name redacted] on 11/26 at 9:30 AM. The RN notified the MD (medical doctor) in regard to resident's needs, with new order for one time dose of ativan to decrease anxiety and librium TID (three times a day). No further seeking of alcohol for the rest of the shift and will continue to monitor. Further review of Resident #63's PN included the following general note with an effective date of 11/23/2025 at 3:19 PM, which included the following: Nurse was called by Receptionist as patient (also known as the resident) was observed walking out of building. The resident wanted to get to a liquor store, both RNs followed and walked with the resident to try to get the resident re-enter the facility. The RN called the MOD (manager on duty) to contact the police, the police came and assisted the nurses to have resident re-entered the facility. The MOD, RN, and NP (Nurse Practitioner) had lengthy conversation with the resident in regards to ETOH addiction, medications (meds), and life in general. Awaiting Librium to start administering. NP will follow up with orders. A review of Resident #63's physician visit PN with an effective date of 11/23/25 at 12:00 AM, included the following: Meds: Ativan oral tablet (tab) 1 mg (milligram), give 1 tab by mouth as needed (PRN) for agitation/anxiety until 12/7/25 11:59 PM. Target behavior: Restlessness, nervousness and overly concerned about anything; ChlordiazePOXIDE HCl (hydrocholoride) capsule (cap) 10 mg, give 1 cap by mouth three times a day for ETOH withdrawal.resident experienced episode of wanting to drink today .they were pleasant but reported being triggered by memories of [name redacted] who passed away in front of them. Librium and ativan ordered.A review of Resident #63's November 2025 electronic Medication Administration Record (eMAR) included the following order Chlordiazepoxide HCl (Librium) cap10 mg, give 1 cap by mouth three times a day for ETOH withdrawal which had a start date of 11/22/25 10:00 PM (10 PM). Further review of Resident #63's November 2025 eMAR included that the medication (med) was not administered on 11/22/25 for the 10 PM dose, on 11/23/25 for the 6:00 AM (6 AM), 2:00 PM (2 PM) and 10 PM doses and on 11/24/25 for the 6 AM, 2 PM and 10 PM doses. A total of seven doses were not given. The eMAR indicated that on 11/25/25 the nurses signed that all three doses were given on 11/25/25. A review of Resident #63's eMAR (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notes for the reason chlordiazepoxide was not given included awaiting pharmacy delivery and not delivered for five of the seven missed doses. The remaining two doses indicated that the nurse called the pharmacy on 11/24/25 at 2:34 PM and at 9:10 PM meds not given, will be delivered by pharmacy tonight. A review of Resident #63's declining inventory sheet for Chlordiazepoxide HCL included, issue 11/23/25; date received 11/25/25. Further review indicated that on 11/25/25 only two doses were given not the ordered three doses, and the three doses that were signed for on the eMAR. On 12/4/25 at 9:11 AM, the surveyor interviewed the Sub Acute Rehab Unit Manager (SARUM) regarding Resident #63, and the surveyor asked the SARUM about the Librium order for Resident #63. The SARUM stated that the med was ordered that day and came a couple days later. On 12/4/25 at 9:38 AM, in the presence of the Licensed Nursing Home Administrator (LNHA), the DON stated that Resident #63 had a long history of depression and alcohol abuse. The DON also stated that the physician ordered Librium and Ativan as a stat (immediate) order. The surveyor asked the DON what the expectation was for a delivery of a med. The DON stated that there would be a 4-6 hour window but that they could not control delivery. The DON stated that the med was ordered on 11/22/25 and was administered on 11/25/25. The DON added that she did an in-service if a med was not available. The DON stated that she was not in the building [at the time] and that it was ordered and not delivered. On 12/4/25 at 1:39 PM, the surveyor called the pharmacy for information on Resident #63's order for Librium. On 12/8/25 at 12:49 PM, the surveyor received an email from the pharmacy which included the following:Librium was filled and attempted delivery on 11/24 (manifest that was posted). Med was then returned to pharmacy because [facility name redacted] could not produce the original script. Librium was redelivered on 11/25 11:30 PM. On 12/8/25 at 12:56 PM, the surveyor notified the LNHA and Clinical Lead (CL) the concern that Resident #63 order for Librium was not given for seven shifts and the physician was not notified for further orders. On 12/9/25 at 11:57 AM, in the presence of the DON and CL, the LNHA stated that education was provided regarding substance abuse. The DON stated that Resident #63's order for Librium was ordered by the NP on 11/22/25 but that the NP did not bring the physical prescription to the facility until 11/23/25. The DON added that when the pharmacy originally delivered the medicine, the facility did not have the physical prescription to give the pharmacy, and that the pharmacy could not leave the medicine and left the facility. The DON stated that the medicine was delivered on 11/25/25 at 1:37 PM. The surveyor asked what the expectation was if there was a delay in obtaining or administering an ordered med. The DON stated that the expectation was to notify the physician. She added that she had done an in-service of the staff and a QAPI (Quality Assurance Performance Improvement). The LNHA did not provide any additional information. A review of the facility's Medication Shortages/Unavailable Medications with a revised date of 10/1/18, included the following: Policy, when meds are not received or are unavailable for the customers, the licensed nurse will urgently initiate action in cooperation with the attending physician and the pharmacy provider. N.J.A.C. 8:39-27.1 (a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to complete post dialysis communication record assessments upon the resident's return from the dialysis center for 1 of one 1 resident, (Resident #6), reviewed for dialysis services, and consistent with professional standards of practice. 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 12/1/25 at 10:55 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) of unit 1, who informed the surveyor that Resident #6 was at dialysis every Monday, Wednesday, and Friday (M-W-F). On 12/1/25 at 10:59 AM, the surveyor observed an enhanced barrier precautions (EBP) posted sign outside the resident's room, the resident was not inside the room. The surveyor reviewed the medical record of Resident #6. A review of the admission Record (an admission summary) documented that the resident had diagnoses that included but were not limited to, end stage renal [kidney] disease, type 2 diabetes mellitus with hyperglycemia (or high blood sugar, occurs when there is too much glucose in the bloodstream, often due to insufficient insulin or insulin resistance), and neuromuscular dysfunction of bladder (commonly referred to as neurogenic bladder, occurs when nerve damage affects bladder control, leading to issues with urine storage and release) unspecified. A review of the most comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 10/15/25, reflected a Brief Interview Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. A review of the December 2025 Order Summary Report included a physician's order dated 10/8/25, hemodialysis [name of dialysis center] M-W-F 2 PM (2:00 PM) chair time. On 12/2/25 at 11:49 AM, the surveyor asked the RN/UM about the resident's dialysis communication records. The RN/UM stated that the dialysis communication records were filed in the resident's chart. Both the surveyor and the RN/UM reviewed the resident's Hemodialysis Communication Records (HDCR) forms. The RN/UM informed the surveyor that the facility's process and standard of practice, the facility's morning nurse will prepare the HDCR form and fill up entirety the top part, then the form will be sent to the dialysis center which the middle part of the form will be filled out by the dialysis nurse, then when the resident returned at the facility, the nurse from the facility will fill out the bottom part of the form and ensure the form will be filled out entirely. At that same time, after both the surveyor and the RN/UM reviewed the HDCR forms, and there were days that the forms were not filled out thoroughly by the nurse when the resident returned to the facility. The RN/UM confirmed that the forms were not completed accordingly according to the facility's practice and should have been completed to include resident's vital signs and dialysis site assessment upon return to the facility for safety of the resident. A review of the HDCR form revealed the following information that were not thoroughly filled out, To be completed by Licensed Nurse post dialysis treatment:-Access site: boxes to be checked either for swelling, drainage, and pain.-AV shunt (an arteriovenous (AV) fistula, is a surgical connection between an artery and a vein, primarily used for hemodialysis access) only: boxes to be checked either for bruit and thrill (indicate + [positive] or (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [negative] (Bruit and thrill are essential indicators of a properly functioning dialysis fistula, reflecting turbulent blood flow and ensuring effective dialysis treatment).-New orders from dialysis center: boxes to be checked for yes or no. On 12/2/25 at 12:00 PM, the surveyor observed Resident #6 lying on the bed with indwelling catheter hung on the below the right side of the bed with privacy bag. The resident informed the surveyor that they go to dialysis every M-W-F. On 12/2/25 at 12:05 PM, the RN/UM informed the surveyor that Resident #6 was cognitively intact and dialysis every MWF at 11:00 AM pick up time and return around 3-4 PM. On 12/8/25 at 10:54 AM, the surveyor reviewed the provided handwritten unit 1 Resident #6's HDCR list of nurses who had an incomplete post dialysis vital signs and assessment of dialysis access site and revealed that 3 of 8 incomplete HDCR forms were unable to locate documentation that the vital signs (provides critical information for assessing health status, detecting changes, and guiding clinical decisions) and dialysis access site assessment were done (for dates 10/17/25, 11/12/25, and 11/26/25). 1 of 6 Registered Nurse (RN) did not thoroughly complete the assessment post dialysis. On 12/8/25 at 12:55 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), the Clinical Lead (CL; also known as the regional director), and they were notified of the above findings and concerns with regard to residents' HDCR forms. On 12/9/25 at 11:56 AM, the survey team met with the LNHA, Director of Nursing (DON), and the CL, and the LNHA stated that 1:1 education was provided to the RN who did not thoroughly complete the post dialysis HDCR to include resident's vital signs and assessment of dialysis access site. A review of the facility's Hemodialysis: Graft and Fistula Care Policy that was provided by the LNHA, with a revision/review date of 11/14/25, revealed, center staff will communicate with the certified dialysis facility regarding the ongoing assessment of the patient's condition by monitoring for complications before and after hemodialysis (HD) treatments received at a certified dialysis facility .Practice Standards: 1. Prior to a patient leaving the center for HD, a licensed nurse will complete the HDCR or electronic pre/post dialysis evaluation and send with the patient to their HD facility visit. 2. Following completion of the HD, the dialysis facility should complete and return the form and/or other communication to the Center with the patient. 3. Upon return of the patient to the Center, a licensed nurse will: 3.1. Review the certified dialysis facility communication; 3.2 Evaluate/observe the patient; and 3.3 Complete the post-hemodialysis treatment evaluation using the HDCR or electronic pre/post dialysis evaluation .5. Maintain the HDCR or state required form in the patient's medical record. On 12/9/25 at 1:55 PM, the survey team met with the LNHA, DON, and CL for exit conference and there were no additional information provided by the LNHA. N.J.A.C. 8:39-27.1(a)

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily for 3 of 5 days in a prominent place within the facility readily accessible and visible to the residents and the visitors.This deficient practice was evidenced by the following: On 12/1/25 at 10:55 AM, Surveyor #1 (S #1) interviewed Registered Nurse/Unit Manager #1 (RN/UM #1) in unit 1 nursing station, who informed S #1 that the unit's census was 16, with two Certified Nursing Aides (CNAs) for 7:00 AM-3:00 PM (7-3) shift. On 12/1/25 at 11:08 AM, S #1 interviewed RN/UM #2, who informed the surveyor that the unit's census was 26 in unit 4, with three CNAs for 7-3 shift. On 12/1/25 at 2:14 PM, during team meeting of surveyors, S #1 reported that per RN/UM #1 there were two CNAs in unit 1 and RN/UM #2 there were three CNAS in unit 4. S #2 stated that there were three CNAs in unit 2. S #3 stated that there were three CNAs in unit 3. The total CNAs on 12/1/25 were 11. On 12/1/25 at 2:35 PM, S #1 observed the posted Nursing Home Resident Care Staffing Report (NHRCSR) in the reception area dated 12/1/25, census 98, and with 14 CNAs. A review of the 12/1/25 NHRCSR for Day Shift, included information: census 98 with 14 CNAs. A review of the facility's provided Daily Staffing Sheet dated 12/1/25, executed at 11:01 AM, included total CNAs on the schedule: unit 1 with 2 CNAs, unit 2 with 4 CNAs, unit 3 with 4 CNAs, and unit 4 with 3 CNAs with a total 13 CNAs. Further review of the above staffing reports, the total CNAs on 12/1/25 were 11 which did not match the posted 12/1/25 NHRCSR (14 CNAs) that was provided by the Receptionist, and the Daily Staffing Sheet (13 CNAs) that was provided by RN/UM #3. A review of the NHRCSR 12/2/25 Day Shift, census 99, with 12 CNAs, while the provided Daily Staffing Sheet of the LNHA for 12/2/25 executed 9:25 AM, unit 1 with 2 CNAs, unit 2 with 3 CNAs, unit 3 with 3 CNAs, and unit 4 with 3 CNAs for a total 11 CNAs. The NHRCSR and Daily Staffing Sheet f or 12/2/25 was inaccurate and did not match. On 12/8/25 at 6:47 AM, S #1 observed the posted sign for NHRCSR dated 12/8/25-Day Shift with census of 98 and total of 12 CNAs. On 12/8/25 at 6:50 AM, S #1 interviewed Licensed Practical Nurse #1 (LPN #1), who informed S #1 that census in unit 1 was 16 with 2 CNAs. On 12/8/25 at 6:54 AM, S #1 went to 2nd floor and met with LPN #2, who informed S #1 that she was the assigned nurse in unit 4 and half of unit 3. LPN #2 stated that she worked 11:00 PM-7:00 AM (11-7) and there were total of three CNAs in their shift who worked last night on the 2nd floor, one in each unit (unit 2, 3, and 4). A review of the provided Daily Staffing Sheet by the Director of Nursing (DON) revealed, 12/7/25 for 11-7 shift there were total of 5 CNAs with no call outs. The provided NHRCSR by the DON revealed that on 12/7/25 Night Shift (11-7) there were total of 7 CNAs. Both provided reports was inaccurate and did not match. On 12/9/25 at 10:17 AM, S #1 interviewed the Licensed Nursing Home Administrator (LNHA) regarding the facility's practice of NHRCSR posting and if she was aware of the requirement of the regulation. The LNHA stated that the Staffing Coordinator (SC) was responsible for posting the NHRCSR during weekdays and for the weekend I have to be honest I do not have anyone. She further stated that we have to train the Manager on Duty (MOD) for the weekends. She added that every center I worked, we correct the NHRCSR in the morning of Monday for that past weekend. The LNHA also stated, I have to be refreshed with the regulation for posting. S #1 notified the LNHA of the above concern with inaccurate staffing posting for three days of observation. On 12/9/25 at 11:56 AM, the survey team met with the LNHA, DON, and the Clinical Lead (CL), and the LNHA stated we will do an in service with the SC to ensure assignments were reconciled and matched. A review of the facility's Posting Staffing Policy that was provided by the DON, with a review and revised date of 8/7/23, revealed, in accordance with federal and state regulations, Centers will post the census, shift hours, number of staff, and total actual hours worked by licensed and unlicensed nursing staff who are directly responsible for patient care for each shift and on a daily basis. If a state requirement exists for posting staffing that is different from the federal requirement, both reports will be posted with an explanation of the differences.Process: .3. The posting should be: .3.3. Completed on a daily (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	basis at the beginning of each shift; and 3.4 Adjusted either upward or downward if staffing changes. On 12/9/25 at 1:55 PM, the survey team met with the LNHA, DON, and CL for exit conference and there were no additional information provided by the LNHA. N.J.A.C. 8:39-41.2 (a)(b)(c)(d)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observation, interview, review of the medical records, and other facility documentation, it was determined that the facility failed to; a.) provide adequate monitoring for the use of psychoactive medication for 1 of 5 residents (Resident #7), b.) review duplicate orders for the as needed (PRN) bowel regimen medications for 2 of 5 residents (Residents #7 and #35), and c.) review, clarify, and sequenced the PRN pain medications for 1 of 5 residents (Resident #7), reviewed for unnecessary medications. The deficient practice was evidenced by the following: 1.On 12/1/25 at 11:00 AM, Surveyor #1 (S #1) observed Resident #7 lying on bed, awake, and informed S #1 that they were at the facility for short term rehabilitation. S #1 reviewed the medical records for Resident #7. A review of the admission Record (AR, an admission summary) reflected that Resident #7 was admitted to the facility with the diagnoses which included but not limited to; unspecified sequelae of nontraumatic intracerebral hemorrhage (stroke), post traumatic stress disorder (PTSD) unspecified, restlessness and agitation, adjustment disorder with anxiety, and mood disorder due to known physiological condition with mixed features. A review of the most recent comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of 9/18/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderate cognitive impairment. The MDS further reflected the resident received psychoactive medications (meds) which were antipsychotic and antidepressant, opioid (controlled medication), and routine and PRN pain meds. A review of the November and December 2025 electronic Medication Administration Record (eMAR) revealed that the resident was on olanzapine (antipsychotic medication) oral tablet (tab) 5 mg (milligram), to give one tab by mouth at bedtime (HS) for mood adjustment disorder with mixed anxiety target behavior for delusions, hallucinations, and paranoia. The above olanzapine order in the November and December 2025 eMAR was plotted at 9:00 PM (9 PM), signed by nurses as administered and no behavior was noted. There were no further documentation in the eMAR for other shifts that the behavior was monitored for use of antipsychotic medication (med). A review of the November and December 2025 eMAR revealed the following orders for PRN pain meds: -start date 9/30/25, acetaminophen 325 mg, give two tablets (tabs) orally every six hours PRN for mild pain. -start date 9/30/25, oxycodone oral tab 5 mg, give one tab by mouth every six hours PRN for moderate to severe pain. -start date 10/15/25, tramadol oral tab 50 mg, give one tab by mouth every six hours PRN for pain. Further review of the above PRN pain meds revealed that the PRN tramadol had no indication of what kind of pain, it was not sequenced from other PRN pain meds. (continued on next page)

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	315036	A. Building B. Wing	12/10/2025

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the November and December 2025 eMAR revealed the following orders for PRN bowel regimen meds: -start date 9/9/25, Dulcolax suppository 10 mg, insert one suppository rectally every 24 hours PRN for constipation if no result from MOM (milk of magnesia). -start date 9/9/25, miralax powder, give 17 gram by mouth every 24 hours PRN for constipation in 4 to 8 ounces (oz) of fluid if resident has not had a bowel movement (BM) in past 72 hours. -start date 9/30/25, MOM suspension 400 mg/5 ml (milliliters), give 30 ml by mouth every 24 hours PRN for constipation give at HS if no BM in three days. Further review of the above PRN orders revealed duplicate orders for constipation meds. On 12/8/25 at 12:55 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), the Clinical Lead (CL; also known as the regional director), and S #1 notified the LNHA, DON, and CL of the above findings and concerns with regard to Resident #7's duplicate orders for bowel regimen meds, no adequate monitoring for antipsychotic med, and sequencing of PRN pain meds. 2. On 12/1/25 at 10:38 AM, Surveyor #2 (S #2) observed Resident #35 sitting in a chair, in their room watching TV. S #2 attempted to interview the resident, the resident answered yes or no but otherwise did not engage in a conversation. S #2 reviewed the medical records for Resident #35. A review of the AR reflected that Resident #35 was admitted to the facility with the diagnoses which included but not limited to essential hypertension (high blood pressure) and hypothyroidism (a condition when the thyroid does not produce enough hormones resulting in a lower metabolism). A review of the most recent quarterly MDS, with an ARD of 10/10/25, reflected that the resident had a BIMS score of 3 out of 15, which indicated severe cognitive impairment. A review of the resident's care plan (CP) dated 10/14/25, revealed a focus that reflects the resident was at risk for complications related to constipation. A review of the resident's eMAR for December 2025, revealed orders that reflected: MOM Suspension 400 mg/5 ml, give 30 ml by mouth every 24 hours PRN for constipation give at HS if no BM in 3 days -Start Date-1/3/25 MiraLax Powder (Polyethylene Glycol 3350) give 17 gram by mouth every 24 hours PRN for constipation in 4 to 8 oz of fluid-if resident has not had a BM in past 72 hours -Start Date-1/3/25 Further review of the above orders revealed duplicate orders for constipation meds with no indication of which to use first. On 12/8/25 at 12:55 PM, the survey team met with the LNHA, ADON, the Clinical Lead (CL; also known as the regional director). S #2 notified the LNHA, DON, and CL of the above findings and concerns regarding Resident #35's duplicate as needed orders for bowel regimen meds and no indication of which to use first. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/25 9:59 AM, S #2 interviewed the facility Consultant Pharmacist (CP) by phone. S #2 asked if they reviewed PRN orders for sequencing or clarification if duplicate instructions or insufficient indications such as pain scale. The CP stated yes, they would usually ask for a clarification of an order to sequence it if it was incomplete or to eliminate duplication. On 12/9/25 at 11:56 AM, the survey team met with the LNHA, Director of Nursing (DON), and the CL, and the DON stated that the PRN bowel regimen meds were updated and that the PRN laxatives were updated with corrected directions. The LNHA stated that we contacted the CP who will do thte audits on PRN meds for proper sequencing, review duplicate orders, and to ensure the PRN meds were appropriate. The LNHA had no response with regard to antipsychotic med concern for Resident #7. On 12/9/25 at 1:55 PM, the survey team met with the LNHA, DON, and CL for exit conference and there were no additional information provided by the LNHA. A review of the facility's Consultant Pharmacist Provider Requirements, revised 3/1/11, the policy revealed under 2.4 Conducting routine med regimen reviews. The policy did not reflect anything specific about clarifying orders. There was no policy provided regarding clarification of orders, duplicate orders or sequencing orders. NJAC 8:39-27.1(a); 33.2(a)

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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** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication per manufacturer specifications and standards of practice. This deficient practice was identified in 1 of 2 medication carts observed on 1 of 1 medication storage areas observed in the facility. This 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 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 [DATE] at 10:25 AM, the surveyor began to inspect selected medication (med) storage areas in the facility. The surveyor observed the following:The surveyor in the presence of Unit 4 Unit Manger (UM4) inspected the refrigerator used to store medications (meds) for the 2nd floor. The surveyor observed a plastic bag containing three bottles of liquid med Acetylcysteine, an inhaled med used to break up mucous in the lungs, two bottles were unopened, and one bottle was opened. The surveyor observed a date opened written on the open bottle that reflected a date of 11/25. The surveyor also observed the manufacturer labeling reflect the statement Warning: Discard opened containers after 96 hours, in bold print. The surveyor showed UM4 the bottle and asked if 11/25 was the date it was opened, and the UM4 stated yes. The surveyor asked UM4 if it was longer than four days (96 hours) that the bottle was opened. UM4 stated yes, they didn't notice it and it should be disposed. On the same date, at 10:37 AM, the surveyor, in the presence of the Registered Nurse assigned to the 1st floor medication cart (medRN). The surveyor observed, in the top drawer of medication cart (med cart), a plastic med cup with four white tablets (tabs), that had a white souffle cup on top with magnesium 400 mg (milligram) handwritten on it. The surveyor asked the medRN if they knew what the tabs were or where they came from. The medRN stated that they did not put them in the med cart and could not positively identify what the tabs were. The medRN stated that meds should not be stored that way and should be thrown out. On [DATE] at 12:55 PM, the survey team met with the facility Licensed Nursing Home Administrator (LNHA), the Assistant Director of Nursing (ADON) and the Clinical Lead (CL) to discuss concerns. The surveyor asked if the Acetylcysteine should have been disposed prior to the surveyor discovery. The LNHA stated yes, it should not have been in the refrigerator. The surveyor asked if meds should be stored in original containers or other packaging from the pharmacy. The LNHA stated yes, meds should be in proper packaging until used. On [DATE] at 9:59 AM, the surveyor interviewed the facility Consultant Pharmacist (CP) by telephone. The surveyor asked the CP if they checked the storage areas and med cart during visits, and the CP stated yes, they do. The surveyor asked if the CP was familiar with Acetylcysteine and the expiration when opened. The CP stated yes, dispose after 96 hours, the facility should have disposed of the open bottle in time. The surveyor asked the CP if meds should be stored in med cups in the cart. The CP stated no, they should only be in original or appropriate containers, not left in any med cups or pre-poured for use. On [DATE] at 11:56 AM, the survey team met with the LNHA, Director of Nursing (DON) and CL, and the LNHA stated that staff were educated on expired meds, unlabeled meds and meds found outside of packaging. The surveyor requested a facility policy for Medication Storage and Labeling. The LNHA provided a form dated 6/2023 titled Medication Storage and Labeling. The form reflected, were meds.labeled in accordance with currently accepted professional principles. multi-dose vials which have been opened.should be dated and discarded.unless the manufacturer specifies a different.date for that opened vial. NJAC 8:39-29.4(d)(g)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to retain health files for staff that were no longer employed with the facility for the timeframe required, for 2 of 20 new employee files reviewed. This deficient practice was evidenced by the following: On 12/1/25 at 10:14 AM, during entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the medical files of the facility's 20 new hire employees since their last recertification survey. On 12/4/25 at 10:18 AM, the surveyor asked the LNHA for additional files for employees that were not given to the surveyor. The LNHA stated that the files were sent to storage if they were no longer employed with the facility and that she was calling to get the files. On 12/8/25 at 11:26 AM, the surveyor interviewed the Nurse Practice Educator (NPE) regarding process for health files. The NPE stated that when the staff member was no longer employed, she gave the file to human resources. On 12/8/25 at 1:00 PM, the surveyor notified the LNHA and Clinical Lead (CL) the concern that the facility could not provide 2 of the 20 medical files requested. On 12/9/25 at 12:00 PM, in the presence of the Director of Nursing (DON) and CL, the LNHA confirmed that she did not have the two medical files requested. The LNHA did not provide any additional information. N.J.A.C. 8:39-5.1 (a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to follow appropriate infection control practices for soiled linens and waste to decrease the possibility of spreading infection. The deficient practice was observed during tour on 1 of 4 units. This deficient practice was evidenced by the following: On 12/8/25 at 11:17 AM, the surveyor observed with a Registered Nurse Unit Manager (RN/UM) the soiled utility room of Unit #1. The RN/UM stated the designated room was the only soiled utility room on the unit. The room had signage which indicated storage room and was secured with a keypad lock. Upon entering the room, the surveyor accompanied by the RN/UM observed on the front, right side of the room, one covered yellow colored bin with signage indicating only soiled diapers please; a large transport bin with a couple of clear plastic bags containing linen items; and three smaller covered garbage bins including one with signage labeled soiled gowns. The surveyor observed to the left side of the room, storage racks with containers and boxes; piled boxes and containers; including uncovered and exposed items. Visible items included recreation and decor items. The back right side of the room contained a large storage cabinet and cardboard items. The RN/UM stated that the soiled utility bins were previously kept in the shower room and were moved into the storage room. The RN/UM could not speak to why the soiled utility area was kept there and acknowledged that clean and soiled items should be stored in separate areas. On 12/8/25 at 11:23 AM the surveyor interviewed the Infection Preventionist (IP) about the soiled utility area. The IP stated she was not familiar with Unit #1's soiled utility area. The IP accompanied the surveyor to observe the room. The surveyor asked the IP about the storage of soiled items with stored, clean items in use and the facility's policy. The IP referred the surveyor to ask the LNHA who could speak to designated storage areas in the facility. On 12/8/25 at 12:35 PM, the surveyor interviewed a Certified Nurse Aide (CNA) assigned to work on Unit #1 who stated soiled linens including personal clothing items in plastic bags were placed in the soiled utility area in the storage room. The CNA further explained soiled diapers were also disposed in the designated bin in the soiled utility area. The CAN stated there were no other soiled utility areas on the unit. On 12/8/25 at 12:55 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), and the Clinical Lead (CL) of the concern regarding the designated soiled utility room on Unit #1 which also stored (clean) items used within the facility. There was no verbal response by the facility at this time. On 12/9/25 at 11:57 AM, the LNHA, the Director of Nursing (DON) and the CL met with the surveyors. The LNHA stated the soiled utility area would be moved from the storage room to keep it in a separate room away from non-soiled items. There was no additional information provided by the facility. The surveyor reviewed the facility's Soiled Linen Handling Policy with a last revised date of 3/1/2024, under Policy revealed: Centers/Communities will handle, store, and transport linen in a safe and sanitary method to prevent the spread of infection. The provided facility policies did not further address soiled utility and storage areas. N.J.A.C. 8:39-19.4

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a clean, safe, and sanitary environment for a.) 2 of 2 dining areas, b.) 1 of 4 unit hallways, and c.) and 2 of 21 sampled residents (Residents #20 and #33) rooms. This deficient practice was evidenced by the following: 1.On 12/2/25 at 11:23 AM, Surveyors #1 (S #1) and Surveyor #2 (S #2) in the presence of the Registered Nurse/Unit Manager (RN/UM) observed the 2nd floor dining (also known as the activity room) area with 10 residents and one activity staff. The surveyors and the RN/UM observed the six heating system inside the grill with dried leaves, plastics, pieces of puzzles, papers, and grayish substances which the RN/UM confirmed that was accumulation of dust and should have been cleaned. At that same time, the surveyors and the RN/UM observed there were multiple boxes of different kinds of puzzles on top of one of the heating system. The RN/UM stated that those different boxes of puzzles that the activity department were being used for residents' should not be stored on top of heating system and there should be no plastic and other materials inside the grill of the heating systems for safety reasons. Furthermore, the surveyors and the RN/UM observed on the other side of the dining area cobweb on the ceiling and ripped wallpapers. The floor inside the dining area had blackish and grayish dried substances which the RN/UM confirmed and stated that she would notify the housekeeping department. On 12/2/25 at 11:45 AM, S #1 interviewed the Director of Housekeeping (DH), who informed the surveyor that he was a contract from [name of company] and had been working in the facility for 5-6 months. S #1 notified the DH of the above findings and concerns, and he stated that the blackish grayish substances on the floor was due to the chemicals that were sprayed to clean the floor and was probably due to too much chemical made them sticked to the floor. He further stated that it was a germicidal spray and should not be like that. On that same date and time, the DH stated that it was the responsibility of the housekeeper on the 2nd floor to ensure cleanliness, mopped, and sweep it daily. S #1 asked if there was an accountability log for daily cleaning of the dining area, and he said there was none. The surveyor asked for policy about environment, good housekeeping, and he said he would get back to S #1. At that same time, the DH also stated that it was the responsibility of the maintenance department to maintain the heating system. On 12/4/25 at 12:28 PM, S #1 interviewed the Director of Maintenance (DoM) regarding the above concerns, and he stated that it was the responsibility of the housekeeping department to ensure cleanliness of the heater, we do change the filter every three months. 2.On 12/4/25 at 12:23 PM, after the resident council meeting, S #1 observed the 1st floor dining room floor with blackish grayish substances and the chair stained with blackish substances. 3.On 12/8/25 at 6:56 AM, during incontinence round of S #1 and the RN/UM, both observed Resident (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#20's overhead metal light string was short. The RN/UM confirmed that the metal light string was approximately three centimeters long and it should not be like that. She further stated that she would notify the maintenance department to fix it. On 12/8/25 at 12:55 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), and the Clinical Lead (CL; also known as the regional director), and they were notified of the above findings and concerns with regard to environmental tour in 1st and 2nd floor dining rooms and Resident #20's light string. On 12/9/25 at 11:56 AM, the survey team met with the LNHA, Director of Nursing (DON), and the CL, and the LNHA stated, about housekeeping issues, we did thorough cleaning yesterday and ceiling tiles changed yesterday. The LNHA also provided a blank copy of Dining Room Cleanliness Audit form that included floor swept and mopped, walls clean, horizontal surfaces clean, windows clean, and trash emptied as part of the audit tool which will be checked off either satisfactory or unsatisfactory, to include Managers signature and date. The LNHA confirmed that the audit tool was formulated after surveyor's inquiry. 4.On 12/1/25 at 9:16 AM, during initial tour, S #2 observed two air circulation vents in the ceiling of the Unit 2 hallway had an accumulation of gray/brownish substance on and inside. On that same day, at 10:43 AM, S #2 observed, from the doorway of Resident #33's room, assorted trash and paper on the floor of the resident's room and on the bathroom floor. On 12/1/25 at 11:00 AM, S #2 observed a ceiling tile with a large brownish stain outside the door of the ice room near the Unit 2 hallway. S #2 also observed a ceiling tile with a brownish stain near a doorway marked door 4 in the Unit 2 hallway. On 12/8/25 at 12:55 PM, the survey team met with the LNHA, ADON, and CL, and S #2 showed the LNHA the photographs of the air vents and asked if they saw the accumulation and should it be there. The LNHA stated, no, it should not be like that. S #2 showed the LNHA the photographs of the ceiling tiles and asked of they should be that color, and the LNHA stated, no. S #2 showed the LNHA the photographs of the floor of Resident #33's room, that was taken at 10:43 AM, and asked if residents' rooms should look that way, and the LNHA stated no, the floors should be clean. The LNHA stated that a thorough cleaning was done on 12/8/25 and the ceiling tiles were replaced. A review of the facility's Safe and Homelike Environment Policy that was provided by the LNHA, with a review and revised date of 11/14/25, revealed, the resident/patient has the right to a safe, clean, comfortable, and homelike environment that de-emphasizes the institutional character of the setting.Process:.1.1.1 This includes ensuring that the patient can receive care and services safely.and does not pose a safety risk.1.1.3.5 Perform other desired tasks such as turning a table light on and off.1.2 Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1.2.1 Ensure that furniture and fixtures in common areas frequented by patients are accommodating of physical limitations of patients. There were no additional information provided by the LNHA. NJAC-8:39-31.2(e), 31.4(a)(b)(f)