STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315328	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Glen Center	12-15 Saddle River Road Fairlawn, NJ 07410

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617 Complaint #: NJ00181779 Based on interviews, record review and review of pertinent facility documents, it was determined that the facility failed to protect the confidentiality and privacy of a resident (Resident #6)) during an investigation of an alleged sexual incident between the Resident and a staff member that is in accordance with the facility's written abuse prohibition policy. This deficient practice was identified for 1 of 6 residents and was evidenced as follows: According to the Admission Record (AR), Resident #6 was admitted to the facility with diagnoses that include but not limited to: Abnormalities of Gait and Mobility, Radiculopathy, Lumbar Region, Benign Prostatic Hyperplasia, Chronic Pancreatitis, Adjustment Disorder with Mixed Anxiety and Depressed Mood, Personality Disorder, and Functional Intestinal Disorder. According to the Resident #6's Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of a resident's functional capabilities, dated 03/06/2025, under Section C-Cognitive Patterns showed that the Resident had a Brief Interview for Mental Status (BIMS) Score of 15 indicating Resident's cognition was intact. According to the Resident's Care Plan (CP), [Resident's name] exhibits psychosocial distress related to alleged sexual abuse with the staff member with date initiated 12/20/2024. A review of the Resident's Progress Notes (PN), dated 12/19/2024 6:08:39 PM [evening], documented and e-signed [electronically signed] by the NP [nurse practitioner] [name redacted], Notified by nursing that another resident [name] complained that this resident [Resident #6 name] was half naked with staff member (CNA) [certified nursing assistant] yesterday. No other staff member witnessed to corroborate events. Investigation ongoing. Residents without injuries and at baseline . (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Resident's PN dated 12/23/2024 14:25 [2:45 pm] [afternoon] Late Entry documented and e-signed by [name redacted] Social Services, showed in Note: On December 19, 2024 at around 3:20pm, patient [name redacted] reported to the nurse that she had witnessed [Resident #6 name] having sex with the CNA [Certified Nursing Assistant][name redacted]. The social services were immediately notified, and resident [name] was further interviewed. During the initial interview, the resident was having a difficult time pointing to the exact date and time of the alleged sexual interaction between Resident #6 and the CNA .she stated that that happened today at 4:30pm when she was passing by. She was redirected to today's date and time, and she stated, ohh that was probably yesterday then. She stated that she believed the sexual interaction had happened multiple times she stated, you know it's just a woman's intuition and I know something is going on.when interviewed further she stated that [Resident #6 name] was wheeling himself out of the room without his T-shirt on and [CNA name] was laying topless in his bed without any T-shirt or a [undergarment]. Resident stated she did not see an actual sexual act between them .she also verbalized she is in love with [Resident #6 name] and this action had hurt her feelings. The PN further revealed Resident #6 was interviewed and verbalized that he/she had never had any sexual interaction with CNA [name] or any other employee working at [facility name] .CNA [name] stated that on 12/19/24 she did not have any interactions with [Resident #6]. She was in the room assisting other residents [in that room]. [CNA] further stated she never had any sexual interaction with [Resident #6] or any other resident .she further stated she never laid in Resident #6's bed and she had never been undressed without a T-shirt or a [undergarment] in front of Resident #6. She [CNA] stated that on 12/19/24 at around 4-4:30pm [afternoon] she was assisting another resident in that room to get ready for a holiday party A review of the facility submitted document to the New Jersey Department of Health (NJDOH), a facility reportable event (FRE), with attached facility's Summary and Conclusion, December 19, 2024, Abuse-Alleged-sexual-staff, under Investigation and Conclusion, After completion of the interviews .the social services had notified police; and police officer completed his investigation without any suspicion of abuse . [Resident #6 name] agreed on a skin check completed by two nurses and there was no bruising, no skin tears, and no swelling observed; he denied any pain or injury .Social services had interviewed the roommates of [Resident #6] and they stated they did not witness any sexual acts between [Resident #6] and [CNA name] at any time .Based on our investigation, there is no reason to suspect any sexual abuse towards [Resident #6 name] .[Resident #6] will be visited by the social services weekly for a month to ensure that he feels comfortable and safe at [facility name] . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/06/2025 at 12:38 pm, the Surveyor interviewed Resident #6. Resident #6 stated that On 12/19/2024 at 3:30 pm he/she was on the telephone when the social worker (SW) [name redacted] came in my room and told me to meet her in the conference room with another resident. In the conference room was the resident (this resident was obsessed with me), the SW, Supervisor in Unit 4 (Supervisor), Unit Manager [name] in Unit 2 (UM), and a front office person [name redacted]. Resident #6 stated he/she felt disrespected that there were a lot of people in the room. He/she further stated the only people that should be there should be my UM, since the LNHA was not around at that time. The SW asked the other resident who accused me in front of other people about the incident and she was descriptive about the incident which was not true. I felt disrespected, humiliated, undignified. I felt like I was garbage even if it was false, I felt embarrassed like other people would make jokes. The SW asked me in front of the other resident and other staff members who I thought should not be involved because they had nothing to do with me. It was an embarrassment. The Resident further stated the interrogation was totally unprofessional, I felt ambushed and totally humiliated because the other resident was saying she/he saw me naked and saw the [CNA] naked and having sex numerous times with me which was ridiculous. They won't let me record in the conference room so I made notes. I still listen to jokes, they [other staff] call me names such as sex machine, love machine. I was embarrassed because the police department had to come and interviewed me and make a police report. I have no idea why SW brought these people in the conference room. I felt it was a violation of my resident rights. On 03/06/2025 at 2:36 pm, the Surveyor interviewed the LNHA regarding Resident #6 incident. LNHA stated on that day he was not in the facility and the SW was here. Surveyor informed LNHA about what Resident #6 stated regarding five people in the conference room when the resident was interrogated. The LNHA stated Resident #6 [name] had accusatory behavior against the SW that was probably the reason why SW [name] called in witnesses but I do not know why SW called so many people. The LNHA agreed to a private and confidential investigation should have been done. On 03/06/2025 at 3:32 pm, the Surveyor interviewed the SW regarding the incident. The SW stated the Assistant Director of Nursing (ADON) came to my office and told me that a resident told her that she saw CNA#1 in bed naked with Resident #6. I took [the other resident] to the conference room but I needed some witnesses, so I got the Supervisor and Unit Manager in unit 2 (UM 2). The resident wanted Resident #6 in the conference room, so I had to go to Resident #6's room and asked him/her to come to conference room. When we got to the conference room, the Supervisor has to stepped out since she had an emergency and since business manager (BM) was here, I asked her to step in the conference room. I asked them (Resident #6 and the other resident) if it is ok to have witness and both agreed with it. I explained to Resident #6 I am not comfortable talking to him alone without witness because he had accused us before. The SW stated Resident #6 was aware that the other resident would be in the conference room. The Surveyor informed SW that Resident #6's statement that he/she felt embarrassed and humiliated because the other resident recounted the alleged sexual incident, very descriptive with a lot of other people in the room. Surveyor asked SW what was the facility's policy in investigating allegations and maintaining confidentiality and residents' privacy. The SW did not provide any answer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Abuse Prohibition, with revision date of 10/24/22, .The Center will implement an abuse prohibition program .Investigation of incidents and allegations .protection of patients during investigations; and .under Federal Definitions: .Mental Abuse includes, but is not limited to humiliation, harassment, threats, and threats of .Mental abuse may occur through either verbal or non-verbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation .; under Process: .8. The Center will protect patients from further harm during an investigation. 8.1 Provide the patient with a safe environment by identifying persons with whom he/she feels safe and conditions that would feel safe .9. The Administrator or designee will: 9.1 Take all necessary corrective action depending on the results of the investigation. 9.2 Report findings of all completed investigations within five (5) working days .9.2.1 All phases of the reporting process will be kept confidential. NJAC 8:39-4.1 a(5)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617 Complaint #: NJ00175767 Based on interviews, record review, and review of pertinent facility documents on 03/11/2025, it was determined that the facility failed to develop a baseline care plan with a focus [problem area] to address a special procedure, Pleurex Drainage (the process of removing excess fluids from spaces around the lungs) specific for a newly admitted resident (Resident #1) who had diagnosis of pleural effusion (a condition where excess fluids accumulates in spaces around the lungs). Resident #1 was not in the facility during the survey. This deficient practice was identified for 1 of 6 residents and was evidenced as follows: According to Resident #1's Admission Record (AR), the resident was admitted to the facility with the following diagnoses that included but not limited to: Pleural Effusion, End Stage Renal Disease, Dependence on Renal Dialysis, and Chronic Atrial Fibrillation. According to Resident #1's Minimum Data Set (MDS) dated [DATE], an assessment tool used by facility to facilitate a resident's functional capabilities and management of care, indicated under Section C- Cognitive Skills for Decision Making indicated Resident was independent in his/her decision making. The Resident's MDS further showed under Section GG that Resident required assistance from staff for completion of his/her Activities of Daily Living (ADLs). A review of Resident #1's Order Summary Report (OSR) with admitted [DATE] revealed a verbal order entry: -Dialysis days: MWF [Monday, Wednesday, Friday] Time for Pick up:4PM Transport to [dialysis center] with order date 07/19/2024. -Drain Pleurex 2x/week [two times a week] one time a day every Tue [Tuesday], Sat [Saturday] with order date 07/19/2024 and start date of 07/20/2024. A review of the Resident's Baseline Care Plan (BCP) initiated on 07/19/2024 showed the following: -Focus [Problem/Need Area]: [Resident's name] requires assistance for ADL care in bathing, grooming, personal hygiene .related to recent hospitalization , resulting in fatigue, activity intolerance, limited mobility and weakness - Date initiated 07/19/2024. -Focus: [Resident's name] has a Full Code Status - Date initiated 07/19/2024. -Focus: [Resident's name] is at risk for falls due to impaired mobility and weakness- Date initiated: 07/19/2024. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-Focus: Resident requires assistance/is dependent for mobility related to .- Date Initiated: 07/19/2024. -Focus: [Resident's name] is at risk for alterations in comfort related to occasional body aches and pleurx drainage- Date initiated: 07/19/2024. -Focus: [Resident's name] exhibits and is at risk for impaired renal function and is at risk for complications related to renal insufficiency- Date initiated: 07/19/2024. -Focus: [Resident's name] has Chronic Obstructive Pulmonary Disease (COPD) - Clinical Management - Date initiated: 07/19/2024. -Focus: [Resident's name] at risk for skin breakdown and has an actual skin breakdown related to advanced age (greater than [AGE] years), decreased activity, frail fragile skin on admission: Pleurx R [right], fistula to L [left] forearm, petechia]. The BCP revealed there was no care plan with a Focus/Goal/Interventions created for the Resident's need for special procedure, Pleurex Cath or Drainage, which was indicated for his/her diagnosis of Pleural Effusion. On 03/11/2025 at 2:53 pm, the Surveyor interviewed the Director of Nursing (DON). The DON stated that she knew Resident #1 had pleurex catheter and drainage two times a week on non-dialysis days. The DON further stated that the baseline care plan is created within forty-eight [48] hours a resident was admitted to the facility to identify potential/actual problems of the resident based on whatever the resident had on admissions. The Surveyor showed the DON the Resident's BCP that has not included a focus on the pleurex drainage. The DON stated that the Resident's BCP should include the pleurex catheter drainage as special procedure upon admission. The DON further stated that when a resident was admitted to the facility, the BCP was initiated by the admission nurse on that shift and that after 48 hours the BCP would proceed to comprehensive care planning within seven days. A review of the facility's policy titled, Person-Centered Care Plan, with revision and review date of 10/24/22, under its Policy: The Center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care . The facility's policy further stipulated under Practice Standards: 1. A baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient including, but not limited to: 1.1 Initial goals based on admission orders; 1.2 physician orders . N.J.A.C 8:39-11.2 (d) N.J.A.C 8:39-27.1(a)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617 Complaint #: NJ00175767 Based on interview and review of pertinent facility documents, it was determined on 03/11/2025 that the facility failed to ensure that a licensed nurse had the specific competency and skills set necessary to care for a resident's needs involving a Pleurex drainage (the process of removing excess fluids from spaces around the lungs) specific for Resident #1who had a diagnosis of pleural effusion (a condition where excess fluids accumulate in spaces surrounding the lungs). Resident #1 was not in the facility during the survey. This deficient practice was identified for 1 of 6 residents and was evidenced as follows: According to Resident #1's Admission Record (AR), the resident was admitted to the facility with the following diagnoses that included but not limited to: Pleural Effusion, End Stage Renal Disease, Dependence on Renal Dialysis, and Chronic Atrial Fibrillation. According to Resident #1's Minimum Data Set (MDS) dated [DATE], an assessment tool used by facility to facilitate a resident's functional capabilities and management of care, indicated under Section C- Cognitive Skills for Decision Making indicated Resident was independent in his/her decision making. The Resident's MDS further showed under Section GG that Resident required assistance from staff for completion of his/her Activities of Daily Living (ADLs). A review of Resident #1's Order Summary Report (OSR) with admitted [DATE] revealed a verbal order entry: -Dialysis days: MWF [Monday, Wednesday, Friday] Time for Pick up:4PM Transport to [dialysis center] with order date 07/19/2024. -Drain Pleurex 2x/week [two times a week] one time a day every Tue [Tuesday], Sat [Saturday] with order date 07/19/2024 and start date of 07/20/2024. A review of Resident #1's Progress Notes (PN), dated 07/20/2024 at 11:06 [morning] documented by [name] Registered Nurse (RN) #1, revealed a note: Pleurex drainage done, output was 5 ml [milliliters]. Vitals . Further review of the Resident's PN dated 07/20/2024 21:37 [9:37 pm] and documented by RN #2 revealed a Note: Pleurx drainage done on the Rt [right] Lung, output was 950ml. Latest V/S (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident's PN dated 07/21/2024 14:04 [2:04 pm] documented by RN #1 indicated Resident's wife [name] insisted on taking him/her home AMA [against medical advice]. Pt [patient] came on Friday 7/19/24 after 3pm with .and chest tube using pleurex and was on dialysis .Saturday 7/20/24 he/she was drained at 11am, with an output of 5cc .the [Resident's wife] came in the evening and asked about Resident's output. Upon telling [her] that the output was 5cc, [wife] insisted on draining him/her again, the night nurse [name] drained the [Resident's pleurex] at about 7 pm and had an output of 950ml. The [Resident's wife] came in Sunday morning .and expressed that she was unhappy the way [Resident #1] was being taken care of .and the drain was not done . A review of Resident #1's Treatment Administration Record (TAR) dated 7/1/2024 - 7/31/2024 indicated an order entry of Drain Pleurex 2x/week one time a day every Tue, Sat. The TAR further showed it was initialed by a nurse [RN #3's initials] with a numeric entry of 5cc [cubic centimeter, a unit of measurement used to measure liquids]. On 03/11/2025 at 12:41 pm [afternoon], in an interview with the Surveyor, RN #1 stated, I was the one who drained the pleurex of Resident #1. I was with RN #3 who was the charge nurse supervisor. She [RN #3] was the one who signed the TAR. We had the training on Pleurex. Our staff educator (SE) [name] gave the education I forgot when she gave the video, with a hands on demonstration, and we usually sign after the video education or demonstration. On 03/11/2025 at 3:55 pm, in an interview with the Surveyor, RN #2 stated, when I came in at 3-11 shift on that day 07/20/24, the wife was with the patient [Resident #1], the report [nurses' report] said the output was only a small amount. The family member [wife] who knew said that in the hospital it [output] was a lot less than a thousand like nine hundred always. The wife was concerned so I drained it and the output was nine hundred fifty [ml]. The resident [Resident #1] appeared ok and stated he was relieved. RN #2 further stated, the SE did a side by side education with the nurses and would let us sign. On 03/11/2025 at 12:26 pm, the Surveyor attempted to call RN #3. RN #3 did not return the call. The Surveyor was informed by the Director of Nursing (DON) that RN #3 was on a medical leave. On 03/11/2025 at 2:30 pm, the Surveyor interviewed the staff educator.The SE stated on 07/19/24 she sent an email containing the video of the pleurex drainage to all the nurses. The SE further stated she did a bedside return demonstration of the pleurex drainage with the nurses. The Surveyor reviewed the nursing department staff competencies with the staff educator. The Surveyor requested that the SE provide documentation of education and competencies regarding the care of residents specific to pleurex drainage. When asked by the Surveyor for the documentation of mentioned return demonstration with the nurses, the SE was unable to provide documentations of the nurses related to clinical competency specific to pleurex drainage procedure. On 03/11/2025 at 2:47 pm, in an interview with the Surveyor, the DON stated, we had our inserviced thru the [Health System], a set of education modules in the computer, and we do some in paper. The SE would let them sign the education and return demonstration. The DON was made aware by the Surveyor that there were no documents (nurses competencies) provided by the SE related to the aforementioned specific pleurex drainage procedure. No additional information was provided by the facility. (continued on next page)

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