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	04/03/2024

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 39399 Based on interview and record review, it was determined that the facility failed to complete the Minimum Data Set (MDS) timely for 1 of 27 residents reviewed, Resident #37 and was evidenced by the following: On 3/21/24 at 12:01 PM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS up to 14 days of the assessment being completed. After transmitting of the MDS, it will generate a quality measure to enable a facility to monitor the residents decline and progress. Resident #10 was observed to have an Entry MDS with an Assessment Reference Date (ARD) of 9/19/23 and was due to be completed no later than 9/26/23. The MDS was not completed until 9/28/23. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2023) page 2-18 reflected under Entry tracking record with a MDS Completion Date which stated Entry date + 7 calendar days. Further review of Resident #10's MDS assessment revealed that the resident had an Admission MDS with an ARD of 9/21/23 and was due to be completed no later than 10/4/23. The MDS was not completed until 10/6/23. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2023) page 2-16 reflected under Admission (Comprehensive) with a MDS Completion Date which stated admitted + 13 calendar days. On 3/25/24 at 12:15 PM, the surveyor interviewed the facility's MDS Coordinator #2 who was responsible of completing Resident #10's MDS assessments. The MDS Coordinator could not provide an answer and stated that she will get back to me for further information. On 3/25/24 at 12:57 PM, the surveyor discussed the above concern to the facility's Licensed Nursing Home Administrator and Director of Nursing. There was no further information provided. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	On 3/26/24 at 10:15 AM, the facility's MDS Coordinator #1 provided a copy of the Validation Report of the submitted MDS's which confirmed that Resident #37's above MDS assessments were completed late. NJAC 8:39 - 11.1

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 4 of 30 residents, Resident #32, #33, #95, and #133, reviewed for accuracy of MDS coding. This deficient practice was evidenced by the following: 1. On 3/18/24 at 11:48 AM, the surveyor observed Resident #33 resting in a reclining chair with their eyes closed. The resident was alert and did not verbally respond to the surveyor's questions. On 3/21/24 at 9:40 AM, the surveyor reviewed Resident #33's hybrid (paper and electronic) medical records. The Admission Record (AR) documented the resident had diagnoses that included but were not limited to, unspecified dementia, anxiety disorder, and type 2 diabetes. A review of a Quarterly MDS assessment, dated 2/6/24, indicated the facility completed a Brief Interview for Mental Status (BIMS) with Resident #33. The resident scored a 2 out of 15 which indicated the resident had severe cognitive impairment. In Section P- Restraints and Alarms, under P0100.Physicial Restraints, Resident #33 was coded as using daily bed rails as restraints. A review of the Order Summary Report included a physician's order dated 3/4/22 which read, Two upper side rails up to bed as an enable for turning and repositioning in bed every shift. On 3/21/24 at 12:39 PM, the surveyor interviewed LPN #1 about Resident #33. LPN#1 stated residents had side rails to be used as an enabler for repositioning while in bed. LPN #1 stated the resident was bed bound and was assisted out of bed to the reclining chair daily. The surveyor went with LPN #1 in the room to observe the bed rails. Resident #33 was out of bed in the reclining chair. The resident's bed was observed with upper, quarter length bed rails. LPN# 1 stated the resident had assist side rails used as enabler for repositioning. On 3/21/24 at 1:09 PM, the surveyor interviewed MDS Coordinator #1 who stated bed rails were used to support resident mobility and restraints were not used in the facility. The surveyor reviewed with MDS coordinator #1 the quarterly MDS assessment of Resident #33. MDS coordinator #1 stated the coding was a data entry error and that restraints were not used in the facility. MDS coordinator #1 stated the MDS assessment would be corrected. 2. On 3/18/24 at 11:46 AM, the surveyor observed Resident #95 ambulating in the hallway independently with staff supervision. The resident was alert and verbally responsive. The surveyor observed the resident's bed without bed side rails. On 3/21/24 at 9:40 AM, the surveyor reviewed Resident #95's hybrid (paper and electronic) medical records. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	The Admission Record (AR) documented the resident had diagnoses that included but were not limited to, Alzheimer's Disease. A review of a Quarterly MDS assessment, dated 2/18/24, indicated the facility completed a Brief Interview for Mental Status (BIMS) with Resident #95. The resident scored a 2 out of 15 which indicated the resident had severe cognitive impairment. In Section P- Restraints and Alarms, under P0100.Physicial Restraints, Resident #95 was coded as using daily bed rails as restraints. A review of the Order Summary Report included a physician's order dated 8/17/22 which read, Two upper side rails up to bed as an enable for turning and repositioning in bed every shift. On 3/21/24 at 12:39 PM, the surveyor interviewed LPN # 1 about Resident #95. LPN # 1 stated the resident was alert with periods of confusion and ambulated independently with supervision. The surveyor went with LPN # 1 to observe Resident #95's bed. The resident's bed had no bed rails in use. LPN# 1 explained the resident was independent with bed mobility and getting in and out of bed. On 3/21/24 at 1:09 PM, the surveyor interviewed MDS Coordinator #1 who stated bed rails were used to support resident mobility and restraints were not used in the facility. The surveyor reviewed with MDS coordinator #1 the quarterly MDS assessment of Resident #95. MDS coordinator #1 stated the coding for bed rails as a physical restraint was an error. MDS coordinator #1 stated the MDS assessment would be corrected. 39399 3. On 3/18/24 at 11:41 AM, the surveyor observed Resident #32 in the room with eyes closed. The resident was also observed with a tracheostomy in place (a medical device inserted into a surgically created opening in the trachea to facilitate breathing) in place. The surveyor also observed that Resident #32 was in the process of receiving their feed of Glucerna at a rate of 75 ml/hr via feeding pump. The surveyor reviewed Resident #32's hybrid medical records. The AR reflected that Resident #32 was admitted to the facility with medical diagnoses which included but not limited to Sepsis, Chronic Respiratory Failure, Dysphagia and Type II Diabetes Mellitus. A review of the Quarterly MDS (Q/MDS), an assessment tool used to facilitate the management of care, dated 12/28/23 reflected that the resident had a BIMS score of 03 out of 15 indicating that the resident had severely impaired cognition. A review of the December 2023 Treatment Administration Record revealed a physician's order dated 5/9/23 for Tracheostomy Care every day and evening shift for trach care which were signed by the nurses indicating that the tracheostomy care was done. Further review of the Q/MDS under Section O0110E1 for Tracheostomy Care which was coded NO. On 3/25/24 at 12:15 PM, the surveyor interviewed the facility's MDS Coordinator #2 who was responsible of completing Resident #32's MDS assessments. The MDS Coordinator could not provide an answer and stated that she will get back to me for further information. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	On 3/26/24 at 10:15 AM, the DON stated to the surveyor that it was coded in error. 44605 4. On 3/25/24 at 9:42 AM, the surveyor reviewed the closed medical chart for Resident #133 whose discharge MDS was coded for discharge to acute hospital. The surveyor reviewed the Social Workers (SW) Discharge Plan Documentation (DPD) created on 12/20/23 by the SW for Resident #133. The DPD documented that Resident #133 was discharged home with family. Review of the 12/20/2023 Nursing Progress Note (PN), indicated that Resident #133 Picked Up (P/U) by ambulance and transported home. Review of Resident #133's Face Sheet (FS) (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility on [DATE] with diagnosis that included but were not limited to fracture of unspecified part of neck of left femur, pain in left leg, and difficulty walking. Review of the A section of the 12/20/23 Discharge MDS for Resident #133 revealed that section A2105 Discharge Status documented, 04. Short-Term General Hospital. On 3/25/24 at 10:39 AM, the surveyor interviewed the MDS coordinator. The MDS coordinator stated, That resident was discharged home. I must have entered that incorrectly; it was a typo. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 . According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023). This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. Code 04, Short-Term General Hospital (acute hospital/IPPS): if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care and accepts a predetermined rate as payment in full. On 3/25/24 at 10:15 AM, the Director of Nursing (DON) provided the surveyors with a facility policy titled, MDS Remote Completion with a revision date of 12/27/21. The policy stated under the purpose section, To ensure compliance with the RAI process and timely completion of MDS. On 3/25/24 at 12:57 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON to discuss the MDS coding error. The DON acknowledged the errors and stated they would fix errors that were discovered. No further comment made. NJAC 8:39-11.1, 11.2(e)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 31656 Based on observation, interview, and record review, it was determined that medication orders that included parameters were not followed by the medication administering nurse. This was observed in 1 out of 3 nurses during medication administration. This 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 or 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. 1. On 3/22/24 at 8:11 AM, the State Surveyor observed the start of medication pass with the Registered Nurse (RN#1) on the X00 unit. RN#1 prepared medication for Resident #186 who had a Physician Order (PO) for Zestril 2.5 mg daily for Hypertension with parameters to hold for Systolic Blood Pressure (SBP) less than (<) 100 and Heart Rate (HR) <55 started on 3/20/24. RN#1 proceeded to review the SBP and HR for Resident #186, that was written on a white piece of paper along with vitals for other residents on the unit. RN#1 informed the surveyor that the documented SBP was 109 and the HR was 86 for Resident #186. RN#1 informed the surveyor that the vitals for Resident #186 were taken early in the morning, in the beginning of the shift and that was not an issue. The surveyor asked that RN#1 retake the vitals, which were SBP 119 and HR 83 prior to administering the Zestril 2.5 mg to Resident #186. A review of the Admission Record for Resident #186 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Heart Disease, Congestive Heart Failure (CHF), Essential Hypertension and Ventricular Tachycardia. A review of Resident #186's Comprehensive Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/23/24, reflected that Resident #10 had a Brief Interview for Mental Status score of 15 out of 15, indicating an intact cognition. The surveyor reviewed of Resident #186's Care Plan initiated on 3/19/2024 and titled, Resident #186 exhibits or is at risk for cardiovascular symptoms or complications related to diagnosis of Coronary Artery Disease, Cardiomyopathy, CHF, Hypertension, Chronic Obstructive Pulmonary Disease, Iron Deficiency Anemia Epilepsy, Anxiety. The documented Goal was, Resident #186's blood pressure will remain within baseline parameters for 90 days. Interventions included, Assess and monitor vital signs as ordered and report abnormalities to physicians. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility's Policies and Procedure titled, General Dose Preparation and Medication Administration. Documented under 4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including but not limited to the following: 4.1.5 If necessary obtain vital signs. On 3/22/24 at 3:30 PM, the surveyor informed the Licensed Nursing Home Administrator and Director of Nursing of the issue. There was no additional information provided. NJAC 8:39 - 27.1