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	09/02/2025

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

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interviews, and a review of facility documentation, it was determined that the facility failed to ensure that a facility wide assessment was reviewed and updated to identify the required services and procedures necessary to protect the health, safety, and welfare of all residents to ensure adequate facility resources to provide resident care and services. These failures had the potential to affect all 122 residents who currently live in the facility during the time of the survey. This deficient practice was evidenced by the following:During the entrance conference on 8/26/25 at 9:45 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) documents to complete the survey process which included but were not limited to Facility Assessment (FA). Both the LNHA and DON stated that the facility's census (the number of residents currently under the care of a specific facility) was 122.On 8/26/25 at 12:19 PM, the LNHA provided the surveyor a 35 page FA which included the following:Resident Population Profile-8/7/23-8/6/24Data included the amount of Admissions/Stays, % of Admissions/Stays and Frequency Relative to Benchmark which was rated as N/A, low, very low, high or very high. Additional data under each area of Sufficiency Analysis Categories for Overall Staffing, Staff Training/Competencies/Skill Sets and Services indicated that each was evaluated. There was no additional information for staffing and a staffing contingency plan.The surveyor asked the LNHA if the FA that was provided was the most up to date and included all the information. The LNHA stated that he would check and provide the surveyor the updated one if the one provided was not the correct one. On 9/2/25 at 11:15 AM, the LNHA provided the surveyor the FA with 8/7/23 to 8/6/24 handwritten on the front page. A review of the provided FA included the original 35 page document provided earlier and additional documents that included reports, meetings, sign in sheets and schedules. The provided documents did not include information about staffing amounts related to the resident population, required staffing ratios or a staffing contingency plan. On 9/2/25 at 11:30 AM, the surveyor notified the LNHA, the DON and the Clinical Lead of New Jersey (CLoNJ) the concern that the FA had not been updated annually and that it did not contain information about staffing amounts related to the resident population, required staffing ratios and a staffing contingency plan. On 9/02/25 at 1:02 PM, in the presence of the DON and CLoNJ, the LNHA stated that the FA had not been updated. The LNHA gave additional staffing reports and schedules. The additional documentation did not include a staffing contingency plan or any information on required staffing ratios. The LNHA did not provide any additional information. A review of the facility's Facility Assessment Policy with a reviewed date of 8/7/24, included the following:PolicyCenters will conduct and document a facility-wide assessment. The Center will review and update the assessment annually and whenever there is, or the Center plans for, any change that would require a substantial modification to any part of the assessment.The FA must address or include:The Center's patient/resident (hereinafter patient) population, using evidence base, data driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity (level of severity of patients; illnesses; physical, mental and cognitive limitations and conditions), and other pertinent facts that are present (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	within that population that may affect the services the Center must provide;Staff competencies and skill sets necessary to provide the level and types of care needed for the patient population:.PurposeTo determine resources necessary to competently care for patients suring both day-to-day operations and emergencies.3. The Administrator will lead the FA Team to:3.1 Use the findings of the Assessment to:3.1.1 Determine staffing levels to ensure sufficient number of qualified staff are available to meet each patient's needs;.3.1.4 Inform contingency planning for events that do not require activation of the Center's emergency plan, but do have the potential to affect patient care, as such, but not limited to availability of direct care nurse staffing and other resources needed for patient care. N.J.A.C. 8:39-5.1(a); 27.1

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews on 8/27/25 and 8/28/25 in the presence of the Senior Maintenance Director (SMD) and Maintenance Director (MD), it was determined that the facility failed to ensure that the resident call bell system was properly functioning in all areas. This deficient practice had the potential to affect all (122) residents and was evidenced by the following:Observations on 8/27/25 from 12:44 PM to 12:50 PM, revealed:The call bell system failed to activate for room [ROOM NUMBER] when tested by the MD. The light outside of the room did not turn on, and no audible or visual notification was given at the nurse's station.The call bell system failed to activate for room [ROOM NUMBER] when tested by the MD. The light outside of the room did not turn on, and no audible or visual notification was given at the nurse's station.In an interview at the time, the MD confirmed the observation.The MD then inspected the annunciator panel at the nurse's station. Although the screen was powered on, the call bell system was inactive. Once accessed, the panel displayed a Fault condition for the following locations:410 Bathroom, 409 Pull Station, 406 Bathroom, 414 Bed station, 404-B Bed Station, and 410-A Bed Station.The MD proceeded to restart the system.An observation at 12:50 PM, revealed that the call bell system for room [ROOM NUMBER] functioned properly after the system was reset.An observation at 1:17 PM, revealed that the call bell failed to give audible notification of activation at the nurse's station on Unit 3.In an interview at the time, the SMD confirmed the observation.Two staff members at the nurse's station at the time stated that they typically rely on the annunciator for alerts but confirmed that they could not hear the shower room activation, and they were unaware that we were testing it. Upon further inspection, the SMD discovered that the audio connection was not properly attached. Once corrected by the SMD, the annunciator panel gave audible notifications.An observation at 1:30 PM, revealed that the call bell system on Unit 2 did not correctly identify rooms by their numbers. Activation of the call bell displayed as device 4644-B instead of room [ROOM NUMBER].In an interview at the time, the SMD and MD confirmed the observation.Observations on 8/28/25 from 10:15 AM to 10:20 AM, revealed that the call bell activations of room [ROOM NUMBER] and 106 failed to give audible notification of activation at the nurses' station.In an interview at the time, the MD confirmed the observation.The MD then inspected the annunciator panel at the nurse's station. Although the screen was powered on, the call bell system was inactive. Once accessed, the panel displayed a Fault condition for the following locations:109 Bathroom station, 111-B Bed Station, 101 B- Bed Station, 113-A Bed Station.These faults had been active since 7/30/25 at 8:22:49 AM. Additionally, 106 - A Bed Station showed a fault condition since 8/14/25.Observations from 10:22 AM to 10:25 AM, revealed:. 109 bathroom and 113-A Bed Station failed to produce any audible or visual alerts when tested by the MD. 111-B Bed Station was missing a call bell cord entirely.In an interview at the time, the MD confirmed the observations and stated that the missing cord would be replaced immediately.The facility's Administrator, SMD and MD were informed of the deficient practice at the Life Safety Code exit conference on 8/28/25 at 2:00 PM. N.J.A.C 8:39-31.2(e)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding. This deficient practice was identified for 2 of 4 nursing units (Units 2 and 3) observed during environment tour. This deficient practice was evidenced by: 1.On 8/27/25 at 11:35 AM, Surveyor #1 (S#1) with Licensed Practical Nurse #1 (LPN#1) went inside Resident room [ROOM NUMBER] (RR#208) and observed the following: The dresser top area with used coffee cup and plastic wrappers. The 1st drawer of the dresser near the window with peeled wood and there was a coffee cup that was mixed with resident's unfolded clothes. LPN#1 stated that the peeled wood needed a glue. The 2nd drawer of the dresser with small food plastic container (with dried food) that was mixed with unfolded clothes. LPN#1 stated that was probably food that was brought by Resident's Responsible (RR) party and should have been thrown out to garbage. There was a fly inside the resident's room. The bottom drawer with chipped wood and LPN#1 stated that she would notify maintenance department about it. The wall clock was set at 12:07 (the clock was not moving). LPN#1 stated that it was a wrong time and would ask maintenance department for a battery. Inside the toilet room, there was a hole on the ceiling. LPN#1 was unable to state why it was left open. The molding on the toilet floor was peeling off. On that same date and time, LPN#1 stated that she would notify the maintenance department about the environmental concerns inside RR#208. LPN#1 further stated that usually staff enter in computer the work to be done by maintenance department and she was unsure if someone had reported the environment concerns inside RR#208. On 8/27/25 at 11:50 AM, S#1 asked the Registered Nurse/Unit Manager of Unit 2 with regard to facility's practice about reporting environmental concern. The RN/UM confirmed that it was being done electronically, and she stated that she was unaware of those reported concerns with RR#208, unless other staff had reported it. She also stated that it would be maintenance department who can answer those concerns. At that same time, the RN/UM confirmed that the RR were responsible for bringing outside food to RR#208, and the last time probably they were here was over the weekend on Saturday. S#1 asked who was responsible to ensure that there was no garbage mixed in resident's clothes, and she responded it would be the aides. S#1 asked if the aides were responsible for ensuring the resident's (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dresser was organized and clean, why there was a food container with food residue in the resident's drawer if that was from Saturday, and the RN/UM did not respond. On 8/29/25 at 9:31 AM, Surveyor #2 (S#2) notified the Director of Maintenance (DoM) of the above findings and concerns. The DoM informed S#2 that he was unaware of the issue with furniture of RR#208. The DoM also stated that the facility ordered each month a new set of furniture to replace but he had not been getting recently from the supplier. He further stated that the last order of new furniture was received in March 2025 and last one was delivered on July 3rd. On that same date and time, the DoM stated that the furniture in the facility was about 16 years, the goal was to replace dated furniture, and was able to do for about eight months. He further stated that he would follow up regarding the resident's dresser. In addition, the DoM informed S#2 that the maintenance department checked residents' clock only during day light savings time. He stated that he was unaware of the ceiling tile hole in RR#208's toilet room, and he was trying to figure out when and what happened. He further stated that he fixed the hole after surveyor's inquiry. On 8/29/25 at 11:40 AM, S#1 notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Clinical Lead of New Jersey (CLoNJ) of the above findings and concerns. On 9/2/25 at 11:04 AM, the survey team met with the LNHA, DON, and CLoNJ, and the LNHA informed the surveyors that the facility was in a process of renovating residents' bathroom. The LNHA stated that in RR#208, deep cleaning, replaced the dresser drawer with torn corner, ceiling was fixed, and checked all clock in the entire building to ensure they were functioning after surveyor's inquiry. 2. On 8/26/25 at 11:14 AM, S#2 observed Resident #112 lying in their bed, alert, and verbally responsive. The resident verbalized that the toilet was loose. Resident #112 also reported that the shower curtain in the shower room was dirty with a dark discoloration. On 8/26/25 at 11:16 AM, S#2 observed in Resident #112's bathroom, the toilet was slightly wobbled with applied pressure and the bathroom floor had a discoloration, black/gray in color, in front of the toilet and sink. The bathroom floor was dry. On 8/27/25 at 11:15 AM, S#2 observed in Resident #112's bathroom the above concerns remained. On 8/27/25 at 11:21 AM, S#2 interviewed Licensed Practical Nurse #2 (LPN#2) from Unit 3, who was assigned to care for the resident. LPN#2 stated staff reported maintenance concerns via a telecommunication maintenance system (TMS; an application used for reporting and tracking maintenance and building work) to maintenance staff who would address the issue. S#2 asked LPN#2 if she was aware of any issue with the bathroom in Resident #212's room. LPN#2 replied that she was not aware of any issue and was not sure if it was a reported issue previously as she was not the regular nurse and work on different units. At that same time, LPN#2 accompanied S#2 to Resident #112's bathroom and the residents in the room were at their bedside. Resident #112 shouted out the toilet rocks as S#2 and LPN#2 entered the bathroom. LPN#2 confirmed the discoloration on the bathroom floor. LPN#2 stated she did not know how it occurred, how long it was there, and did not really notice it before. S#2 and LPN#2 checked the toilet and confirmed the toilet slightly wobbled with applied pressure. S#2 and LPN#2 exited the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's room. LPN#2 stated the concerns with the toileted had not been previously reported to her. LPN#2 explained the residents in the room were alert and verbalized to staff if there were any concerns. LPN#2 stated she did not know if the issue was previously reported to staff as she was not the regular nurse on the assignment, and it would be in the TMS if it was. On 8/27/25 at 11:50 AM, S#2 accompanied by LPN#2 toured the shower room located in front of unit 3's nurses' station (shower room [ROOM NUMBER]). S#2 observed the shower curtain which had discoloration dark brown to black in color towards the bottom of the curtain and an end of the curtain had a torn corner of material missing. On 8/27/25 at 11:57 AM, S#2 interviewed the Housekeeper (HK) working on the unit. The HK was asked about stain on Resident #112's bathroom floor. The HK stated the discoloration on the floor had been there for a long time and could not recall since when. The HK explained her supervisor, the Environmental Services Manager (ESM), was aware of the discoloration and tried to remove it. The HK stated she thought that the ESM followed up with the Maintenance Director about it but was not sure. The HK was not aware of any issue with the toilet in the bathroom. At that time, S#2 asked the HK about who was responsible for the maintenance and changing of shower curtains. The HK stated she was not sure who was responsible and that she had never changed the shower curtains in the shower rooms. On 8/27/25 at 1:58 PM, S#2 requested from the LNHA the TMS report for the last six months to indicate work order reports. On 8/27/25 at 12:03 PM, S#2 interviewed ESM about the observed concerns in Resident #112's bathroom and the shower room. The ESM stated he was unsure how the discoloration occurred. The ESM explained he tried to remove the discoloration with cleaning agents and degreaser, but it did not come out. The ESM stated he mentioned to the DoM about the issue as the floor would need to be replaced. The ESM further explained that he mentioned the issue to the DoM, but they did not really discuss a plan for the floor. The ESM accompanied S#2 to shower room [ROOM NUMBER] to observe the shower curtain. The ESM confirmed the shower curtain was soiled with discoloration dark in color and a corner of the end of the curtain was missing. The ESM stated the facility's maintenance was responsible for maintaining and changing the shower curtains. S#2 asked the ESM if housekeeping was aware of the issue and if it was reported to maintenance. The ESM stated maintenance was made aware, approximately a couple of weeks ago. On 8/29/25 at 9:31 AM, S#2 interviewed the DoM who stated that if an issue was reported about a shower curtain, a replacement would be ordered, and the maintenance staff would change the curtains. On that same date and time, S#2 discussed and showed the picture of the observed shower curtain. The DoM confirmed the curtain was soiled and that the curtain should not be in that condition. The DoM stated he was not informed by anyone of shower room [ROOM NUMBER]'s curtains and that housekeeping was responsible for checking the curtain's condition and notifying maintenance. At that time, S#2 asked the DoM about Resident #112's bathroom floor discoloration. The DoM stated he was aware of the issue. The DoM explained that if there was a stain on the floor, housekeeping (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tried to remove, if unsuccessful then a vendor would be called to try to deep clean or replace the flooring. S#2 discussed interview with HK staff about attempts to clean and mentioning to maintenance. The DoM acknowledged it was mentioned by housekeeping and a plan for the floor was never discussed. The DoM further explained that he did not discuss with the LNHA about the plan for the floor which may need to be replaced. The DoM stated regarding the toilet in Resident #112's bathroom, he was not aware of the issue until informed by LPN#2 two days ago, after surveyor's inquiry. On 8/29/25 at 11:30 AM, S#2 reviewed the provided TMS report of the last six months which revealed no work order related to the toilet being loose or the discoloration on the floor of Resident #112's bathroom. There was no work orders noted for shower curtains. On 8/29/25 at 11:39 AM, S#2 notified the LNHA, the DON, and the CLoNJ about the above concerns. The LNHA stated the shower curtains were replaced. S#2 asked who was responsible for maintaining the curtains, and the LNHA stated that housekeeping was responsible for cleaning the curtains and were to inform maintenance if they needed to be replaced. On 9/2/25 at 11:04 AM, the LNHA, the DON, and the CLoNJ met with the survey team. The LNHA stated that the Resident #112's bathroom floor and toilet redone to address concerns. 3. On 8/26/25 at 10:13 AM, S#1 observed Resident #14 lying on the bed, observed a clock hanging on the wall above the resident's bed. The clock's two hands were frozen at 3:31. On 8/29/25 at 12:41 PM, Surveyor #3 (S#3) in the presence of the RN/UM of Unit 2, entered Resident's #1's room and observed the clock on the wall, above the bed with the time stuck at 3:31, and the hands were not moving. The resident entered the room and sat down on the bed and confirmed that the clock was not working. S#3 asked the resident and the RN/UM how long it had not been working, and the resident did not reply. The RN/UM was unable to state how long it was not working. S#3 asked if there was a work order put in for the clock not working and the RN/UM replied, I did not put one myself, but I will let maintenance know now to fix it. On 9/2/25 at 10:23 AM, the LNHA reviewed with S#3 the electronic system for work orders for 7/1/25-8/2/25, and found no work order entered for Resident #14's clock. The LNHA stated We replaced all the batteries in the clocks last Friday. The LNHA further stated that the Housekeeping Director went around and replaced each clock. He also added that he went personally around yesterday to make sure it was completed. S#3 notified the LNHA regarding Resident's #14 clock not working on the initial tour on 8/26/25 by S#1 and was again observed on Friday 8/29/25 (3 days later) by S#3 that the clock was still not working. On 9/2/25 at 11:40 AM, the survey team met with LNHA, DON, RCLoNJ, and the MDS (Minimum Data Set) Coordinator, and S#3 notified the administrative staff regarding Resident #14's clock not working and was confirmed by the RN/UM. A review of the facility's Accommodation of Needs Policy that was provided by the CLoNJ, with revision date of 2/1/23, revealed, the resident has the right to safe, clean, comfortable, and homelike environment including, but not limited to, receiving treatment and support for daily living safely.Process:.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.the Center's efforts to individualize (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the patient's physical environment. This includes the physical environment of the patient's bedroom and bathroom, as well as individualizing as much as feasible the Center's common living areas . On 9/2/25 at 1:31 PM, the survey team met with the LNHA, DON, and CLoNJ for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-31.2(d)(e), 31.4(a)(f)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. REPEAT DEFICIENCYBased on interview and record review, it was determined that the facility failed to submit the Minimum Data Set (MDS) assessments in a timely manner for 2 of 27 residents reviewed (Resident # 74 and Resident #109).The deficient practice was evidenced by the following:On 8/29/25 at 10:16 AM, the surveyor reviewed the most recent MDS's, an assessment tool used to facilitate the management of care, for the timeliness of submission for three system-selected residents.Information in the electronic medical record and additional information provided by the facility revealed the following for two of the residents:1. Resident #74 had a discharge (d/c) MDS with an Assessment Reference Date (ARD) of 3/28/25. The MDS was completed but had not been submitted.2. Resident #109 had a d/c assessment with an ARD of 4/9/25. The assessment had been inactivated after completion and was not submitted.On 8/29/25 at 10:52 AM, the surveyor interviewed the MDS Coordinator (MDSC) regarding the residents' d/c MDS. The MDSC stated that she had started at the end of May. The MDSC stated that a d/c MDS should be submitted (transmitted) as it was completed as much as possible. The MDSC stated that she follows the RAI manual. The surveyor requested information regarding Resident #74 and #109. On 8/29/25 at 12:07 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and Clinical Lead of New Jersey (CLoNJ) the concern that Resident #74's and Resident #109's d/c MDS were not submitted. On 8/29/25 at 12:31 PM, the MDSC stated that the previous MDSC might have just hit no instead of yes to transmit the d/c MDS for Resident #74. She stated that she could not give an answer about Resident #109's d/c MDS. On 9/2/25 at 11:04 AM, in the presence of the LNHA, DON and CLoNJ, the MDSC stated that she transmitted Resident #74's d/c MDS after surveyor inquiry. The MDSC stated that Resident #109's d/c MDS was inactivated in error. She added that the plan was to activate it and transmit it. The LNHA did not provide any additional information.A review of the facility's MDS Remote Completion Policy with a review date of 12/16/24, included the following:PolicyCenters will follow all .System Processes related to MDS 3.0 completion. Centers will also follow the RAI (Resident Assessment Instrument) Manual for instructions for completing the assessment process.PurposeTo ensure compliance with the RAI process and timely completion of the MDS.N.J.A.C. 8:39 -11.2

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to maintain professional standards of clinical practice by failing to a.) update a physician order for wanderguard with the correct expiration date for 1 of 1 resident, (Resident #12), reviewed for elopement and b.) ensure a medication was administered to a resident and not left at the bedside for 1 of 24 residents (Resident #13).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 stated, 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. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, 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. On [DATE] at 9:32 AM, Surveyor #1 (S#1) observed Resident #12 ambulating in the hallway with a wanderguard bracelet (a bracelet or anklet that triggers alarms and can have the capability to lock monitored doors to prevent a resident from leaving a facility unattended) was on the resident's left ankle. S#1 observed the Station 4 Unit Clerk redirect Resident #12 to the resident's room and gave the resident their sweater. A review of Resident #12's admission Record (AR, an admission summary) or face sheet, reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; tracheostomy status (has undergone a tracheostomy procedure, which is a surgical opening in the neck to provide an alternative airway for breathing), vascular dementia (common type of dementia that happens when there's decreased blood flow to areas of your brain), and osteoporosis (condition that causes bones to become weak and brittle, increasing the risk of fractures). A review of Resident #12's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision making was severely impaired. Further review of the qMDS indicated that the resident had a wander/elopement alarm used daily. A review of Resident #12's [DATE] and [DATE] electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) including the following: Wander guard to left ankle due to exit seeking behavior Expiration date: [DATE] every shift check placement with a start date of [DATE] and was signed as checked each shift of each day of the month of July and August until [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wander guard to left ankle due to exit seeking behavior Expiration date: [DATE] every night shift check function with a start date of [DATE] and was signed as checked each night shift of each day of the month for July and each day of August until [DATE]. The two orders indicated that the wanderguard had expired at the end of [DATE]. Further review indicated that both orders were discontinued (d/c'd) on [DATE] and the following orders were started on [DATE]: Wander guard to left ankle due to exit seeking behavior Expiration date: [DATE] every shift check placement. Wander guard to left ankle due to exit seeking behavior Expiration date: [DATE] every night shift check function. On [DATE], S#1 interviewed Licensed Practical Nurse #1 (LPN#1) regarding the process for the wanderguard. LPN #1 stated that the wanderguard was checked for placement every shift and the expiration date was checked. S#1 asked LPN #1 if the function of the wanderguard was also checked. LPN #1 stated that she believed that the night shift tested the function. S#1 then asked about the order that had the expiration date of [DATE]. LPN #1 stated that yesterday they changed the order and now it has an expiration of March. S#1 asked if the order should have been updated when the wanderguard expired. LPN #1 stated that it should have been. On [DATE] at 9:44 AM, S#1 interviewed the Registered Nurse/Unit Manager (RN/UM) of Station 4. The RN/UM stated that a new wanderguard had been placed prior to the expiration date when the resident had taken the wanderguard it off and would find out the exact date. S#1 asked about the order that was not updated until [DATE]. The RN/UM stated that she had just updated the order yesterday. S#1 asked if the order should have been updated at the time that the wanderguard was replaced. The RN/UM stated that it should have been. On [DATE] at 10:07 AM, the RN/UM provided the surveyor documentation that the wanderguard was replaced on [DATE]. On [DATE] at 12:07 PM, S#1 notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and Clinical Lead of New Jersey (CLoNJ) the concern that Resident #12 orders for checking the placement and function of the wanderguard had an expiration date that was [DATE] and was being signed as performed until [DATE]. On [DATE] at 11:25 AM, in the presence of the LNHA and CLoNJ, the DON stated that Resident #12's wanderguard was changed on [DATE], prior to the expiration date of [DATE], when the strap was loose but that the order was not updated in the electronic medical record at that time. She added that the device was functioning. The DON stated that staff were educated. The LNHA did not provide any additional information. A review of the facility's Patient Security Bracelet Policy with a reviewed date of [DATE], included the following:PolicyPatients will be evaluated for the need for a wandering security bracelet to serve as a safety measure to prevent elopement and wandering in unsafe areas of the Center. Patients approved for wandering security bracelets will have an individualized plan of care to address wandering and the use of the bracelet as an intervention. Wandering security bracelets will be (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inspected per manufacturer's recommendations but at a minimum of:Every shift for placement, andDaily for function.The expiration date, placement checks, and function inspections of the bracelet will be documented in the medical record.PurposeTo ensure patient safety. 2. On [DATE] at 10:05 AM, Surveyor #2 (S#2) observed Resident #13 lying in their bed. The resident was alert and verbally responsive. S#2 observed on the resident's bedside table next to their water cup a clear medicine (med) cup which contained two orange-colored capsules (caps). S#2 asked Resident #13 about the med cup and its content. Resident #13 replied it was med from that morning that the nurse administered at breakfast. The resident stated it was their seizure med, and they left the med at the side to take later. Resident #13 stated they forgot to take the med, and the resident was agreeable to wait for the nurse prior to taking the med. On [DATE] at 10:10 AM, S#2 interviewed the DON about med administration protocol, and the DON stated the nurse was to observe a resident take their med, and it should not be left at the resident's bedside. On [DATE] at 10:11 AM, S#2, in the presence of the DON, interviewed LPN#2 who stated it was protocol for the nurses to observe residents take their medications (meds) and they were not allowed to be left at the bedside. S#2 discussed the observation of med at the resident's bedside. LPN #2 confirmed the orange caps were the resident's seizure med, phenytoin (Dilantin, a seizure med). LPN #2 showed the surveyor Resident #13's Dilantin med from the med cart to confirm the orange caps med. There was no additional verbal response from LPN #2 about the meds observed at the resident's bedside. The DON and LPN#2 went to Resident #13's bedside to observe the meds and speak with the resident. Upon exiting the room, the DON confirmed the meds observed at the bedside and stated LPN#2 would be in-serviced. On [DATE] at 1:30 PM, S#2 reviewed the electronic medical record (EMR) of Resident #13. A review of the AR reflected Resident #13 had diagnoses that included but were not limited to, epilepsy (a seizure disorder) and generalized muscle weakness. A review of the qMDS, with an assessment reference date (ARD) of [DATE], reflected a Brief Interview Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the physician's order dated [DATE] indicated phenytoin 100 mg (milligram), give 2 caps (a total of 200 mg) by mouth two times a day for seizure. The med was scheduled for 8:00 AM (8 AM) and 8:00 PM (8 PM). A review of the [DATE] eMAR revealed the phenytoin cap entry was signed by the nurse as administered for the [DATE], 8 AM dose. A care plan (CP) with a focus area, Resident #13 exhibits and/or is at risk for seizure activity related to history of seizures, head injury had an initiation date of [DATE]. An intervention of the CP indicated to medicate as ordered and monitor for effectiveness as well as side effects and report to physician as needed. On [DATE] at 1:06 PM, S#2 reviewed the Med Administration Audit Report which revealed for the phenytoin entry on [DATE] at 8 AM, LPN #2 signed the med as administered at 10:08 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:39 AM, S#2 notified the LNHA, the DON, and the CLoNJ of the observed concern with med left at the bedside of Resident #13. On [DATE] at 11:04 AM, the LNHA, the DON, and the CLoNJ met with the survey team. The DON stated LPN#2 was interviewed, the resident's physician was notified, there was no adverse effect to the resident and re-education was provided to nurses. A review the facility's Medication Administration Policy with a date of [DATE], revealed under Med Administration:.14. Meds are administered within 60 minutes of scheduled time.20. The resident is always observed after administration to ensure that the dose was completely ingested. NJAC 8:39-11.2 (b); 29.2(d)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to: a) administer tube feeding per the physician's order (PO) and b) document the total volume according to PO and standards of clinical practice for 2 of 2 residents (Residents #2 and #9), reviewed for receiving nutrition via tube feeding, and was evidenced by the following:1.On 8/26/25 at 10:32 AM, Surveyor #1 (S#1) observed Resident #2's room was closed with an Enhanced Barrier Precautions (EBP) posted sign outside the door. Inside the resident's room, the resident's privacy curtain was pulled halfway, the resident's eyes were closed, tube feeding (TF, nutrition received through a flexible tube surgically inserted into the stomach) pump was on at 40 ml/hr (milliliter/hour), and Jevity 1.5 container was hung on the pole. S#1 reviewed the medical records of Resident #2, and revealed: A review of the admission Record (AR; an admission summary) or face sheet reflected that the resident was admitted to the facility with diagnoses that included other cirrhosis of liver (late stage of scarring (fibrosis) of the liver caused by many diseases, including hepatitis and chronic alcohol abuse, leading to impaired liver function), other cerebrovascular disease (stroke), vascular dementia, moderate, with mood disturbance, gastrostomy status, and epilepsy, unspecified, not intractable, without status epilepticus. 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 7/24/25, reflected a brief interview for mental status (BIMS) score of 11 out of 15, which revealed that the resident cognition was moderately impaired. The qMDS revealed that the resident had a TF. A review of the August 2025 Order Summary Report (OSR) revealed a PO: Order date 6/23/25, enteral feed order one time a day downtime 4:00 PM (4 PM) or when total volume (TV) of 800 ml delivered. Order date 6/23/25, enteral feed order one time a day Jevity 1.5 cal. Administer continuous via pump at 40 ml/hr over 20 hours (hrs) or until TV of 800 ml delivered. Order date 7/17/25, flush tube with 80 ml every two hrs during continuous feeding times 20 hrs. TV of flush equals 800 ml/24 hrs. TV of nutrient plus flush equals 1600 ml/24 hrs. Every shift. [The order was plotted for Day shift, Evening, and Night shift. From 8/1 to 8/6/25, day shift, it was documented TV of 1600 ml, from 8/1-8/14/25, evening shift, it was documented 1600 ml, from 8/1-8/25/25, night shift, except 8/15/25, it was documented 1600 ml.] The PO to flush tube 80 ml every two hrs was not followed. Further review of the above, revealed that the PO were transcribed to the August 2025 electronic Medication Administration Record (eMAR) and signed by nurses as administered. On 8/27/25 at 12:12 PM, S#1 and the Registered Nurse/Unit Manager (RN/UM) went inside the resident's room. Both S#1 and RN/UM observed the resident on bed with head of bed slightly elevated and with TF of Jevity 1.2 hung on a pole via pump infusing at 40 ml/hr. The RN/UM confirmed Jevity 1.2 was not according to the PO, and it should have been Jevity 1.5. She also stated that the TV fed (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was 591 ml and left 209 ml to complete the 800 ml according to the pump monitor. The RN/UM also confirmed that the TF container hung with handwritten information for 8/26/25 at 8 PM. In the nursing station, the RN/UM reviewed the electronic PO and confirmed that the order was for Jevity 1.5 at 40 ml/hr and not Jevity 1.2. She stated that the nurse probably made a mistake last night in hanging the TF. At that same time, S#1 asked about the order for flushing of 80 ml in the eMAR for total of 1600ml/24 hours and what was in the eMAR. The RN/UM reviewed the PO and she stated that what the nurses were documenting every shift were incorrect because the 1600 ml should be the total for 24 hours and not for each shift. On 8/29/25 at 11:42 AM, S#1 notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Clinical Lead of NJ (CLoNJ) of the above findings and concerns. On 9/2/25 at 11:04 AM, the survey team met with the LNHA, DON, CLoNJ. The DON stated that we interviewed Licensed Practical Nurse (LPN) via phone interview, and she informed us that she was unable to find Jevity 1.5 at that time that was why she hung Jevity 1.2. The DON further stated that there was a Jevity 1.5 supply and the LPN just did not look. The DON also stated that the TF water flushed was via pump and it was set up automatically flush according to the order and that the resident was received the required amount. She further stated the problem was that the nurses were documenting the number of flushes in the eMAR inaccurately. The DON added that the order for flushes were modified to make it clearer. 2. On 8/26/25 at 11:14 AM, Surveyor #2 (S#2) observed Resident's #9 door with EBP sign on the door, alcohol base hand rub (ABHR) on the wall, and personal protective equipment (PPE-equipment worn to minimize exposure like gowns and gloves) by the doorway. S#2 observed the resident sitting on high back wheelchair, and resident alert with confusion. The Registered Nurse (RN) stated that the TF goes up at night and stops at around 6:00 AM-7:00 AM, that the resident also had oral meal (food consumed by mouth), not very good with eating, and was picky. RN#1 also stated that the resident was being followed up by the Dietician and the Speech Language Pathologist (SLP). On 8/27/25 at 10:37 AM, S#2 interviewed the Registered Dietician (RD), who stated that the resident came in with a TF because of dysphagia (swallowing difficulty) from multiple cerebrovascular attack (CVA-a stroke) and seizure disorder. The RD further stated that they tried to get the resident off the TF, but was not getting enough intake. The RD stated the feeding goes up at 8:00 PM, with a total volume of 650 ml/24-hour period and goes down in the morning. A review of the AR revealed diagnoses which included but not limited to; other hereditary CVA disease, cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (Cadasil/Carasil- a rare, inherited disorder affecting the brain's small blood vessels, leading to strokes, dementia, and migraines with aura), unspecified sequelae of cerebral infarction (necrotic tissue in the brain), dementia (decline in cognition) in other diseases classified elsewhere severe with mood disturbance, other frontotemporal neurocognitive disorder (brain disorders that damage the frontal and temporal lobes of the brain, leading to changes in behavior), and dysphagia oropharyngeal phase, gastrostomy, status (surgical opening (gastrostomy) has been created in the stomach to provide a direct route for feeding). A review of the modified qMDS, with an ARD of 7/3/25, revealed a BIMS score of 5 out of 15 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating severe cognitive impairment. A review of the PO revealed the following: Flush tube with 200 ml of water every 2 hrs during continuous feeding x 10 hrs. Total volume of flush = 1000 ml/24hrs (excluding medication flushes). TV of nutrient + flush = 1650 ml/24hrs, every evening and night shift, ordered 7/14/25. Enteral feed order one time a day downtime: when TV of 650 ml is delivered -Start Date 7/14/25. Enteral feed order one time a day Jevity 1.5 cal. Administer continuous via Pump at 65 ml per hour over 10 hrs., or until total nutrient of 650 ml delivered. -Start Date 7/14/25. Total nutrient 650 ml/24 hrs. Total Calories 975 Cal/24hours one time a day -Start Date 7/15/25. A review of the eMAR revealed: On 8/1/25 to 8/26/25, except for 8/5/25, on day shift documented 1650 ml; 8/1/25 to 8/26/25, except for 8/5/25, on evening shift documented 1650 ml; and 8/1/25 to 8/26/25 on night shift documented 1650 ml. (The documentation of nutrient and water flushes exceeded the TV of 1650 ml/24 hrs. as ordered by the physician). On 8/28/25 on evening shift documented 200 ml and night shift documented 610 ml; 8/29/25 on evening shift documented 610 ml and night shift documented 610 ml; 8/30/25 on evening shift documented 610 ml and on night shift documented 800 ml; 8/31/25 on evening shift documented 800 ml and on night shift documented 1155 ml. (The documentation of nutrient and water flushes did not add up to the TV of 1650 ml/24 hrs. as ordered by the physician). On 8/29/25 at 11:11 AM, S#2 attempted to interview the primary nurse regarding TF but was not available. On 8/29/25 at12:29 PM, S#2 interviewed the Station 4 Unit Manager (UM) in her office regarding the TF, and she stated the pump will automatically flush the 200 ml of water while the feeding was going. On 9/2/25 at 9:48 AM, S#2 interviewed the RN in the presence of the UM. The UM stated that the order was adjusted and education was provided to nursing to document the correct TV according to PO. The UM confirmed that the order for 8/27/25, the documented amount for evening and night shift were still not correct and the total amount will have to be corrected. RN #1 stated, I will follow through with that once UM updates it. On 9/2/25 at 11:04 AM, the survey team met with the LNHA, DON, CLoNJ, and MDS Coordinator. S#2 notified the above findings and concerns. The DON responded that the flushes were automatic, the resident received the right amount according to PO, but nurses did not document the right amount properly. The DON further stated that the order was modified to make it more clear. S#2 notified the LNHA, DON, and the CLoNJ the concern on the eMAR incorrect documentation of amount of total flush and nutrition and that order was revised on 8/27/25, and was still incorrect which was confirmed by the UM. A review of the facility's Enteral Management Policy that was provided by the DON, with a (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revision/reviewed date of 7/22/25, revealed, under purpose: to provide safe and effective management of enteral tubes.Practice Standards:.5. The patient's (also known as resident) plan of care will address the use of an enteral feeding tube, including strategies to prevent complications. On 9/2/25 at 1:31 PM, the survey team met with the LNHA, DON, and CLoNJ for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-27.1(a), 27.2(e)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, record review, and a review of pertinent facility documents, it was determined that the facility's Consultant Pharmacist (CP) failed to identify irregularity for 1 of 27 residents (Resident #2), identified during Medication Regimen Review (MRR). This deficient practice was evidenced by the following:A review of the U.S. FDA (United States Food and Drug Administration) medication (med) guide for prevacid delayed release capsules., revised September 2012, reflected the instructions for use.should be taken before eating. Prevacid delayed release capsules through a nasogastric tube or larger, as prescribed by the doctor:.you can only use apple juice. 1. Open the capsule (cap) and empty the granules into a syringe. 2. Do not break or crush the granules. 3. Mix with 40 ml (milliliters) of apple juice. Do not use other liquids. 4. Attach the syringe to the tube and give the med in the syringe through the tube into the stomach. 5. After giving the granules, flush the tube with more apple juice to clear the tube. Prevacid should not be used in foods or liquids not listed above.On 8/26/25 at 10:32 AM, the surveyor observed Resident #2's room was closed with an Enhanced Barrier Precautions (EBP) posted sign outside the door. Inside the resident's room, the resident's privacy curtain was pulled halfway, the resident's eyes were closed, tube feeding (TF) pump was on at 40 ml/hr (milliliter/hour), and Jevity 1.5 container was hung on the pole. The surveyor reviewed the medical records of Resident #2, and revealed:A review of the admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included other cirrhosis of liver (late stage of scarring (fibrosis) of the liver caused by many diseases, including hepatitis and chronic alcohol abuse, leading to impaired liver function), other cerebrovascular disease (stroke), vascular dementia, moderate, with mood disturbance, gastrostomy status, and epilepsy, unspecified, not intractable, without status epilepticus.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 7/24/25, reflected a brief interview for mental status (BIMS) score of 11 out of 15, which revealed that the resident cognition was moderately impaired. The qMDS revealed that the resident had a TF.A review of the August 2025 Order Summary Report (OSR) revealed a physician's orders (PO):Order date 6/21/25, prevacid oral cap delayed release 15 mg (milligram), give one cap via g-tube (gastrostomy tube) once a day for GERD (gastroesophageal reflux disease happens when stomach acid flows back up into the esophagus and causes heartburn). [The med was plotted at 9:00 AM (9 AM) when the resident's TF was ongoing, or the resident was being fed.]Order date 6/23/25, enteral feed order one time a day downtime 4:00 PM or when total volume (TV) of 800 ml delivered.Order date 6/23/25, enteral feed order one time a day Jevity 1.5 cal. Administer continuous via pump at 40 ml/hr (milliliters/hour) over 20 hours or until TV of 800 ml delivered.Further review of the above, revealed that the PO were transcribed to the August 2025 electronic Medication Administration Record (eMAR) and signed by nurses as administered. On 8/27/25 at 12:12 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding the above orders for prevacid that was signed by nurses as administered at 9 AM. The surveyor asked the RN/UM should the med administered in an empty stomach, and she did not respond. The RN/UM confirmed that at 9 AM the resident's TF was ongoing and being fed and that was the time the prevacid was ordered to be administered. On 8/29/25 at 11:42 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Clinical Lead of NJ (CLoNJ) of the above findings and concerns. The surveyor asked the LNHA, DON, and CLoNJ, what the expectation was when administering the prevacid. Both the DON and the CLoNJ stated that it should be given in an empty stomach. Both the DON and CLoNJ also acknowledged that the expectation was the consultant pharmacist to identify the irregularity for prevacid. On 8/29/25 at 1:24 PM, the surveyor interviewed the CP about MRR. The surveyor notified the CP of the above findings and concerns with regard to prevacid. The CP stated that usually she would recommend (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering prevacid on an empty stomach, and for Resident #2, she did not recommend it because the resident was on TF. The CP also stated that the resident was on TF for a long period of time. She acknowledged that it should be given on an empty stomach.A review of the facility's Enteral Management Policy that was provided by the DON, with a revision/reviewed date of 7/22/25, revealed, under purpose: to provide safe and effective management of enteral tubes.Practice Standards:.5. The patient's (also known as resident) plan of care will address the use of an enteral feeding tube, including strategies to prevent complications.On 9/2/25 at 1:31 PM, the survey team met with the LNHA, DON, and CLoNJ for an exit conference, and there was no additional information provided by the LNHA.NJAC 8:39-29.3(a)(1)

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	09/02/2025

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

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 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. Based on interview and document review it was determined that the facility failed to ensure a Surety Bond was in place to provide coverage to protect resident personal needs account funds held by the facility. The deficient practice could affect all residents who had personal needs funds held by the facility and was evidence by the following:During the entrance conference on 8/26/25 at 9:45 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) documents to complete the survey process which included but were not limited to the facility's Surety Bond. On 8/27/25 at 8:53 AM, the surveyor reviewed the facility provided document titled Surety Bond Report for the facility which included under insurance carrier [name redacted] no bond on file which was dated 8/26/25 10:10:13 AM.On 8/27/25 at 9:16 AM, the surveyor asked the LNHA about the Surety Bond Report that was provided. The LNHA stated that the facility had a Surety Bond and that he would provide it. 08/27/25 11:03 AM, the LNHA provided the surveyor two documents which included the following:Power of Attorney dated 12/11/23Verification Certificate for Indefinite Term Surety Bond which included Sufficient premium has been paid to satisfy the requirements of the carrier for this bond to 2/28/25. Signed 12/11/23. On 8/27/25 at 11:34 AM, the surveyor interviewed the LNHA regarding the surety bond provided with the date of 2/28/25. The LNHA stated that corporate had sent the surety bond. The LNHA stated that he called the corporate staff and they said that the surety bond was indefinite.On 8/28/25 at 8:53 AM, the LNHA provide the surveyor an additional two documents which included the following:Power of Attorney dated 8/27/25Verification Certificate for Indefinite Term Surety Bond which did not include a line regarding sufficient premiums and was dated 8/27/25 (after surveyor inquiry). On 8/28/25 at 9:36 AM, the surveyor interviewed the Business Office Manager (BOM) regarding the surety bond. The BOM stated that she was working with the Regional Business Office Advisor since she was new and started in July. She added that when the LNHA asked her for the surety bond that she had to have the Regional print it because she could not locate the surety bond. The BOM stated that she did not know about it [surety bond] as of yet.On 8/29/25 at 12:07 PM, the surveyor notified the LNHA, the DON, and Clinical Lead of New Jersey (CLoNJ) the concern that the facility did not have documented evidence that the facility had a Surety Bond in effect from 2/28/25 until surveyor inquiry. A review of the facility's Resident Funds Policy with a reviewed date of 1/16/23, included the following:13. Surety Bond: The facility will maintain a surety bond in accordance with the Centers for Medicare and Medicaid Services (CMS) regulation 42.CFR 483 and state specific requirements. 13.1 The amount for the surety bond must be reviewed on a quarterly basis by the Administrator and BOM to ensure that the amount is appropriate.13.2 On an annual basis, the facility must receive evidence of renewal from the [company name] Risk Management Department. This notice must be filed along with the facility's surety bond as backup documentation. N.J.A.C. 8:39-9.5(c)3

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	09/02/2025

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, it was determined that the facility failed to issue the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) for 2 of 3 residents (Residents #71 and #113), reviewed for beneficiary notification. The deficient practice was evidenced by the following:On 9/2/25 at 10:01 AM, the surveyor reviewed the beneficiary notification of three randomly selected residents from a facility provided list of residents who were discharged (d/c'd) from Medicare Part A services in the last six months which revealed the following: 1. Resident #71 had a last covered day from Medicare Part A services of 8/15/25 and remained a resident in the facility. There was no documentation that the resident received a SNF ABN.2. Resident #113 had a last covered day from Medicare Part A services of 8/18/25 and remained a resident in the facility. There was no documentation that the resident received a SNF ABN.On 9/2/25 at 10:33 AM, the surveyor interviewed the Business Office Manager (BOM) who was responsible for providing beneficiary notifications to residents. The BOM stated she was not aware of the SNF ABN, and not aware that it had to be provided to residents who had skilled benefit days remaining when being d/c'd from Part A services and continued to reside at the facility. The BOM confirmed that Residents #71 and #113 did not exhaust their skilled benefit days and remained at the facility. The BOM acknowledged that a SNF ABN was not issued to Resident #71 and Resident #113.On 9/2/25 at 11:23 AM, the BOM provided an undated facility chart related to beneficiary notices titled Valid Forms of Delivery and Required Follow Up. For SNF ABN the chart indicated Medicare Part A only (days remaining and will remain in the center at least one billable day); to be given prior to last covered day and preferably with the Notice of Medicare Non-Coverage (NOMNC).On 9/2/25 at 11:35 AM, the surveyor notified the Licensed Nursing Home Administrator, the Director of Nursing, and the Regional Clinical Lead of the above concern for Resident #71 and Resident #113 not receiving a SNF ABN. There was no additional information provided by the facility. NJAC 8:39-5.1