STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060224	A. BUILDING: _____ B. WING _____	11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GLEN CENTER	12-15 SADDLE RIVER ROAD FAIRLAWN, NJ 07410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA staffing for 14 of 14 day shifts as follows: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. This Plan of Correction constitutes the facility□s credible allegation of compliance.	12/17/21

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

Electronically Signed | 11/29/21

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/17/21 and 10/24/21, the staffing to resident ratios did not meet the minimum requirement of 1 CNA to 8 residents for 14 of 14 day shifts as documented below: -10/17/21 had 8 CNAs for 100 residents on the day shift, required 13 CNAs. -10/18/21 had 11 CNAs for 100 residents on the day shift, required 13 CNAs. -10/19/21 had 10 CNAs for 100 residents on the day shift, required 13 CNAs. -10/20/21 had 12 CNAs for 98 residents on the day shift, required 13 CNAs. -10/21/21 had 12 CNAs for 97 residents on the	S 560	1. How the Corrective action will be accomplished for the residents found to have been affected All residents have the potential to be affected by this deficient practice 2. How the facility will identify other residents having the potential to be affected All residents have the potential to be affected by this deficient practice 3) What measures will be put into place or systematic changes made to ensure the deficient practice will not recur " Director of Nursing/Nursing Home Administrator and staffing coordinator were re-educated on NJ staffing mandate " Center will continue recruiting functions, which drive various forms of media to increase the number of applicants: - Continue posting various nursing positions on corporate site, with links to internet searches. - Continuous advertising on: approximately a dozen websites. - Continue to work with various Agencies to fill open positions - Signs posted throughout facility offering large bonuses to new hires and those employees that refer them. " Forms external partnerships with schools to training Students and	

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MAPLE GLEN CENTER	12-15 SADDLE RIVER ROAD FAIRLAWN, NJ 07410

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S 560	Continued From page 2 day shift, required 13 CNAs. -10/22/21 had 12 CNAs for 97 residents on the day shift, required 13 CNAs. -10/23/21 had 9 CNAs for 97 residents on the day shift, required 13 CNAs. -10/24/21 had 7 CNAs for 97 residents on the day shift, required 13 CNAs. -10/25/21 had 11 CNAs for 97 residents on the day shift, required 13 CNAs. -10/26/21 had 11 CNAs for 97 residents on the day shift, required 13 CNAs. -10/27/21 had 10 CNAs for 97 residents on the day shift, required 13 CNAs. -10/28/21 had 10 CNAs for 99 residents on the day shift, required 13 CNAs. -10/29/21 had 9 CNAs for 99 residents on the day shift, required 13 CNAs. -10/30/21 had 11 CNAs for 99 residents on the day shift, required 13 CNAs. On 11/9/21 at 9:51 AM, the surveyor, in the presence of the survey team, interviewed the Payroll and Staffing Coordinator who stated that she was aware of the required minimum direct care staff to resident ratios. She stated that the facility was trying to meet the ratios. At 11:04 AM, the surveyor, in the presence of the survey team, interviewed the Licensed Nursing Home Administrator who stated that she was aware of the required minimum direct care staff to resident ratios. A review of the facility provided policy titled, "Staffing/Center Plan", with a revised date of 9/1/13, included the following: "1. The Center meets or exceeds the staffing levels mandated by state and federal staffing requirements."	S 560	transitioning them into CNAs. ; and Convert temporary C.N.A.s into permanent C.N.A.s " Weekly Staffing calls with regional support team 4) How the facility will monitor its corrective actions to ensure compliance The Director of Nursing, staffing coordinator and HR coordinator/designee will maintain a listing of current recruiting efforts, and document 3 days a week the results of these efforts. The Administrator will audit these efforts weekly one month, 2 X monthly for 2 months to ensure the Center team is following up on all recruitment tasks. The Administrator /Director of Nursing or Designee will report findings to the Performance Improvement Committee monthly for three months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to provide two evening activity programs per week. This deficient practice was identified for 3 of 3 months reviewed, September 2021, October 2021 and November 2021, as evidenced by the following: On 11/5/21 at 11:00 AM, the surveyor conducted a group meeting with five residents who were part of the facility's resident council. Four of five residents stated that "there were no evening activities" in the facility. Review of the September 2021 activity calendar provided by the LNHA indicated the last activity scheduled was 4 PM. Review of the October 2021 activity calendar indicated that at 6 PM Monday through Friday "evening activities per residents request. Monday: nail care, Tuesday: game night, Wednesday: card game, Thursday: game night, and Friday: movie night." Review of the November 2021 activity calendar indicated that at 6 PM Monday through Friday "evening activities per residents request. Monday: nail care, Tuesday: game night,	S 720	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. This Plan of Correction constitutes the facility□s credible allegation of compliance. 1. How the Corrective action will be accomplished for the residents found to have been affected Activities Director was re educated on the state requirement for Mandatory Resident activities. Center initiated evening activities twice a week on 12/13/21. 2. How the facility will identify other residents having the potential to be affected All residents have the potential to be affected by this deficient practice. 3) What measures will be put into	12/17/21

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S 720	Continued From page 4 Wednesday: card game, Thursday: game night, and Friday: movie night." Review of the recreational departments work schedule for 11/3/21 through 11/17/21 indicated the two recreational aides worked no later than 5:30 PM. Review of the Director of Recreation's work schedule for 8/1/21 through 11/8/21 indicated the Director worked no later than 5:30 PM. On 11/8/21 at 1:17 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and the Regional Nurse and discussed the above concern. On 11/9/21 at 8:50 AM, the LNHA provided the survey team a statement regarding "Evening Activity Definitions" which indicated the following: "Nail care: Hand sanitizing, light nail filing and applying nail polish. Movie night: YouTube or Netflix, movie of resident choice. Game night: Resident choice of game. Bingo Night: Bingo. Evening activities are available five times weekly per resident request. However, since COVID lockdown residents have become used to being in their rooms making a challenge for them to participate in evening activities. Residents prefer to spend their time in their rooms mostly watching the news or relaxing after dinner. Residents offered night activities Monday to Friday during morning coffee hour and trivia and during room visits. Recreation Director ensures she is in the facility every Wednesday evenings encouraging residents to participate/attend	S 720	place or systematic changes made to ensure the deficient practice will not recur Activities director re educated activities staff the requirement to offer evening activities twice weekly on 12/13/21. 4) How the facility will monitor its corrective actions to ensure compliance Activities director will audit activities schedule twice weekly x 4 weeks, weekly x 2 weekly then monthly for 1 month to ensure evening activities are being offered. Activities Director or designee will report findings at the monthly Quality Assurance Performance Improvement Meeting x 3 months.	

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S 720	Continued From page 5 evening activities. Last successful attempt was on Oct 12, where one resident scheduled nail care. Recreation will continue to invite and encourage residents to participate in evening activities 2-3 times weekly." No additional information was provided.	S 720		
S2120	8:39-31.1(c) Mandatory Physical Environment (c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, P.O. Box 809, Trenton, New Jersey 08625-0809. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 11/08/21, it was determined that the facility failed to ensure that their building was inspected by a	S2120	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the Provider	11/16/21

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S2120	Continued From page 6 local fire code official each quarter in accordance with the quarterly inspection requirement of the Uniform Fire Code (NJAC 5:18).This deficient practice was evidenced by the following: A review of the facility's quarterly fire code inspection reports, and related documentation indicated that the last inspection for 2021 was documented as 03/31/21, almost 8-months from the current date of 11/08/21. During an interview with the (new) Maintenance Director, he confirmed that he was unsure if the building was inspected since 03/08/21 and he would call the fire official to see if they inspected the facility after that time. The surveyor informed the Administrator of this finding during the Life Safety Code survey exit conference and she could not provide any updated information indicating the building was inspected after 03/08/21. NJAC 8:39-31.2(e)	S2120	of the truth of the facts alleged or conclusion set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. This Plan of Correction constitutes the facility□s credible allegation of compliance. 1. How the Corrective action will be accomplished for the residents found to have been affected All residents have the potential to be affected by this deficient practice 2. How the facility will identify other residents having the potential to be affected All residents have the potential to be affected by this deficient practice 3) What measures will be put into place or systematic changes made to ensure the deficient practice will not recur The New Jersey Uniform Fire Code Certificate of Inspection was obtained on November 16, 2021. 4) How the facility will monitor its corrective actions to ensure compliance The Maintenance Director perform audits monthly to ensure timely compliance with the Uniform Fire Code. The Maintenance Director or Designee will report findings monthly at the Quality Assurance Performance Improvement Meetings.	

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S2120	Continued From page 7	S2120	Administrator will take corrective action as needed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315328 Y1	A. Building B. Wing Y2	2/7/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GLEN CENTER	12-15 SADDLE RIVER ROAD FAIRLAWN, NJ 07410

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0695	Correction	ID Prefix F0761	Correction	ID Prefix F0880	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	12/17/2021	LSC	12/17/2021	LSC	02/03/2022
ID Prefix F0919	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(g)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/17/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/9/2021	☐ YES ☐ NO